

Why Invest in Nutrition?

- Of the 7.2 million children under 5 years of age in Vietnam, approximately 1.6 million (23%) are stunted. These undernourished children have an increased risk of mortality, illness and infections, delayed development, cognitive deficits, poorer school performance, and fewer years in school.
- The mortality rate for children under 5 years is 16 per 1,000 live births—nearly 45% of these child deaths are attributable to various forms of undernutrition.
- Malnutrition undermines human capital and economic productivity and can limit progress in achieving at least 6 of the 8 Millennium Development Goals and targets set by the World Health Assembly.
- Investing in nutrition in Vietnam can significantly reduce child mortality, improve children's school performance, and result in greater economic productivity for the nation, enabling Vietnam to achieve its national development goals.

Summary of Nutritional Status and Priorities

Vietnam has exhibited good progress in reducing stunting since 2000, which was reduced to 23% in 2011. Overweight and obesity have become a national concern, affecting 5% of children and 8% of women, while at the same time twice as many women are underweight (referred to as the double burden of malnutrition). Iodine deficiency has resurfaced as a significant public health concern due to a relaxing of mandatory salt iodization laws. Anemia continues to affect 29% of children under 5 and non-pregnant women, caused by micronutrient deficiencies such as iron and vitamin A and potentially other non-nutritional factors. Approaches to improve nutrition in Vietnam should focus on continued improvement of infant and young child feeding (IYCF) practices (particularly early initiation of breastfeeding, exclusive breastfeeding, timely introduction of complementary food, and feeding frequency) through policy and programmatic interventions, a focus on strengthening universal salt iodization policies and implementation, and addressing high rates of malnutrition among ethnic minorities and the poorest segment of the population.

Iodine deficiency. Iodine deficiency is of significant concern in Vietnam. According to a national survey on iodine deficiency, the median urinary iodine concentration among the general population was 83 ug/L in 2008 (Fisher et al. 2011), which is below adequate levels established by WHO. The proportion of school-age children with low urinary iodine concentration is estimated to be 54% (National Hospital of Endocrinology). Changes in mandatory

salt iodization laws and financing in 2005, making salt iodization voluntary, have caused the increase in iodine deficiency (Tran 2012).

Stunting. One in five children are stunted in Vietnam, although this masks disparities by wealth, region, and ethnicity. Stunting is 41% in the lowest wealth quintile compared to 6% in the highest (the proportion of the population below the national poverty line is 17%, and 50% of ethnic minorities are poor) (United Nations). In addition, roughly 1 in 3 children in the Northern Midland and mountain areas and the Central Highlands are stunted, and 41% of ethnic minority children under 5 are stunted, 14% severely so. Postnatal factors (as opposed to prenatal factors) appear to be greater determinants of stunting in Vietnam, most importantly IYCF practices including delayed initiation of breastfeeding, very low rates of exclusive breastfeeding, delayed introduction of complementary food, and insufficient feeding frequency of complementary food.

Maternal underweight. The prevalence of underweight among women of reproductive age (18%) still exceeds the prevalence of overweight in Vietnam and is highest among younger women (under 30) and in the North Central and Coastal areas and the Red River delta (National Institute of Nutrition [NIN] and UNICEF 2011).

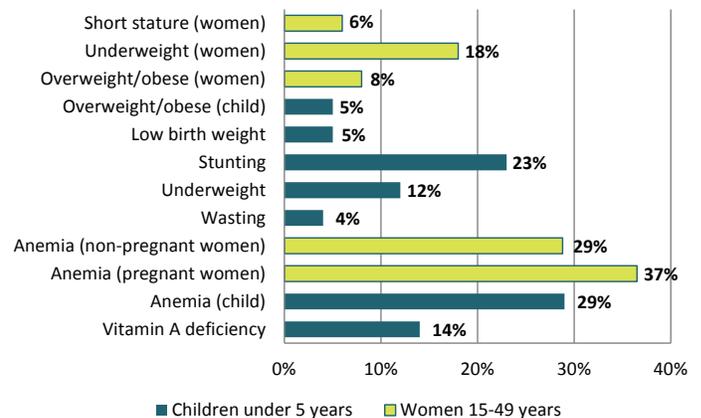
Anemia and micronutrient deficiencies. Close to a third of children under 5 and women of reproductive age are anemic, with little progress in reducing these numbers in recent years among either group according

to the 2009–2010 General Nutrition Survey. The survey shows that anemia prevalence among both women and children is highest in the Northern midlands and mountain areas. Another survey (Laillou et al. 2012) showed that for the youngest children (under 2 years of age), iron deficiency is the cause of one-third of anemia cases, and more than half of children under 2 are iron-deficient. Among women of reproductive age, roughly half of anemia cases are caused by iron deficiency. Vitamin A deficiency among preschool-age children affects roughly 14% of children, indicating a problem of moderate public health importance according to WHO classifications (NIN and UNICEF 2011). However, close to half of children under 5 have “marginal” vitamin A status, and children 6–17 months are most at risk of suboptimal vitamin A status (Laillou et al. 2012). Additional micronutrient deficiencies that appear to be of public health significance in Vietnam include zinc deficiency (estimated to affect 67% of women of reproductive age and 52% of children under 6 years) and B12 deficiency (affecting 12% of women of reproductive age) (ibid).

Wasting among infants. The prevalence of wasting is more than two times higher among children 0–5 months (9% affected) than among all children under 5 in Vietnam. Regional and ethnic variation are not as evident for levels of wasting as they are stunting.

Overweight and obesity. Overweight and obesity has become a national concern, as outlined in the current National Nutrition Strategy for 2011–2020. Roughly 5% of children under 5 are overweight/obese nationally and 8% are affected in urban areas. Approximately 8% of women of reproductive age are also either overweight or obese and rates increase with increasing age (NIN and UNICEF 2011).

Maternal and Child Malnutrition Indicators in Vietnam



Sources: General Statistics Office 2011; vitamin A deficiency, anemia, women underweight, and women overweight/obese: NIN and UNICEF 2011; short stature: Nguyen et al. 2011

Notes: National data on iodine levels among pregnant women in Vietnam have never been published; however, a national survey on iodine deficiency reported a median urinary iodine concentration of 83 ug/L in 2008 in the general population (Fisher et al. 2011). The proportion of school-age children with low urinary iodine concentration (less than 100 ug/L) is 54% (National Hospital of Endocrinology).

Due to discrepancies between the MICS and national nutrition data, additional data include the following: a NIN report, *A Review of the Nutrition Situation in Viet Nam 2009–2010*, indicates that underweight for children under 5 is 17.5%, stunting is 29.3%, and wasting is 7.1%. Data from a NIN et al. report, *Nutrition Surveillance 2010* indicate that anemia is 47% for pregnant women and 10% for non-pregnant and non-lactating women. Data from the NIN and UNICEF *General Nutrition Survey 2009–2010* indicate that overweight/obesity for women 20–60+ is 6%.

Key Drivers of Maternal and Child Malnutrition in Vietnam

Immediate and Underlying

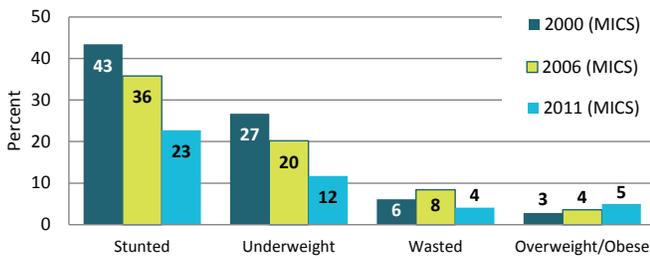
- Suboptimal IYCF practices including delayed initiation of breastfeeding, low rates of exclusive breastfeeding, delayed introduction of complementary food, and insufficient frequency of feeding complementary food
- Maternal malnutrition including underweight and anemia
- Low vaccination coverage
- Early marriage among ethnic minorities

Basic

- Maternal employment and maternity leave laws which had previously required women to return to work less than 6 months postpartum
- Poverty that affects the lowest wealth quintile
- Change in legislation making iodization of salt voluntary rather than mandatory
- Commercialization and aggressive marketing of infant feeding products, particularly formula
- Insufficient priority/importance given to nutrition (particularly breastfeeding) by policymakers

Child Nutrition

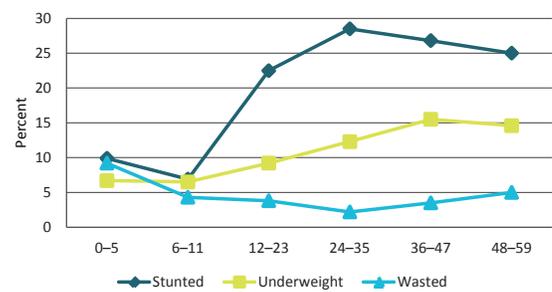
Trends in Nutritional Status of Children Under 5, 2001–2011



Sources: UNICEF Vietnam 2004; General Statistics Office 2006 and 2011

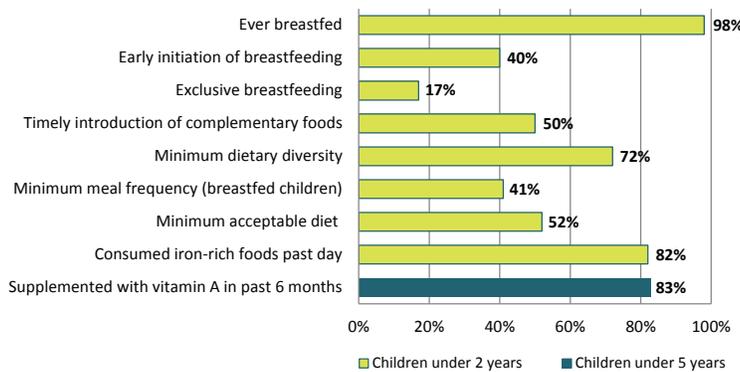
Note: Data collected before 2006 were reanalyzed to account for a change to the 2006 WHO Child Growth Standards so they can be comparable across the years.

Nutritional Status of Children by Age (in Months)



Source: General Statistics Office 2011

Dietary Practices of Children

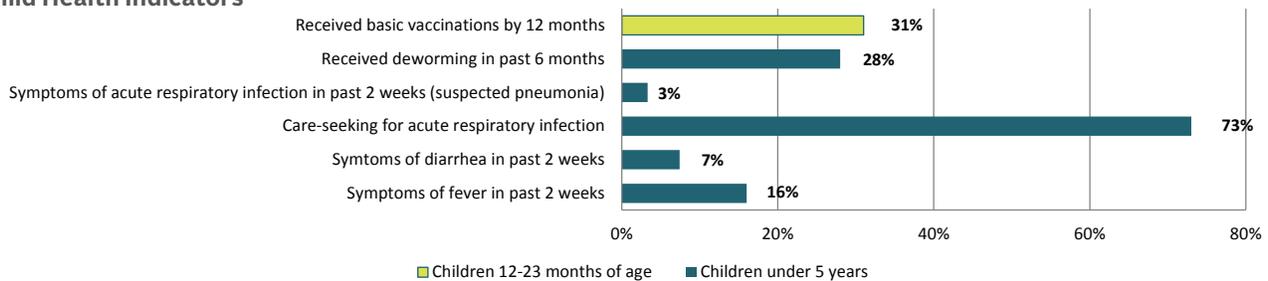


Sources: General Statistics Office 2011; minimum dietary diversity, minimum acceptable diet, and iron-rich foods: NIN et al. 2010

Note: Additional data include the following from the Nutrition Surveillance 2010 (NIN et al. 2010) and Alive & Thrive Baseline Survey Report (11 Provinces) (Nguyen et al. 2011):

	Nutrition Surveillance 2010	Alive & Thrive Baseline Survey
Early initiation of breastfeeding	61.7%	50.5%
Exclusive breastfeeding (0–5 months)	19.6%	20.2%
Continued breastfeeding at 1 year (of children 12–15 months)	77.0%	79.5%
Continued breastfeeding at 1 year (of children 20–23 months)	22.0%	18.2%
Timely introduction of solid/semi-solid/soft foods at 6–8 months	92.0%	96.1%
Minimum meal frequency	85.6%	94.4%
Minimum acceptable diet (did not indicate breastfeeding/non-breastfeeding)	51.7%	70.9%
Under-5 vitamin A supplementation	76.1%	

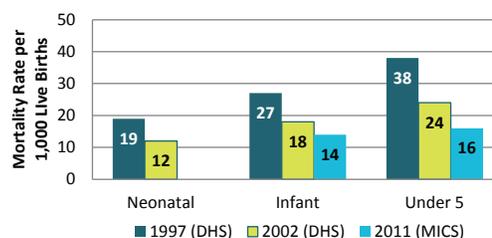
Child Health Indicators



Sources: General Statistics Office 2011; deworming: NIN et al. 2010

Note: Basic vaccinations include BCG, measles, and three doses each of DPT and polio vaccine.

Child Mortality, 1997–2011

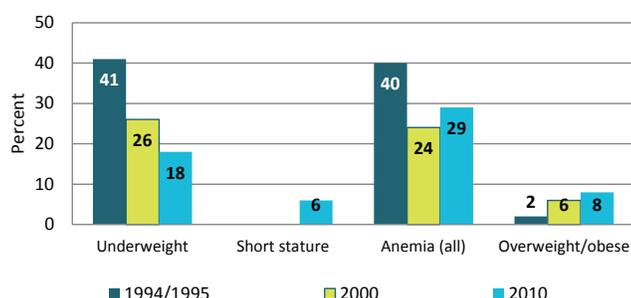


Sources: Committee for Population, Family and Children and ORC Macro 1999 and 2003; General Statistics Office 2011

Note: Data are for the time period within the previous 4 years of the survey.

Maternal Health and Nutrition

Trends in Nutritional Status Among Women of Reproductive Age (15–49 Years), 1994–2010



Sources: 1994 and 2000 data: Nguyen; 2010 data: NIN and UNICEF 2011

Note: Overweight/obesity data from 2010 is among mothers with children under 5 years of age. The 2000 anthropometric data refer to women 20–49 years of age.

Maternal Health Indicators

Maternal mortality ratio (per 100,000 live births)	59
Total fertility rate (children per women)	2.0
Median age at first marriage	No data
Median age at first birth	No data
% of women (15–49 years) who gave birth by 18 years of age	3.9
% of women 15–19 years who have begun childbearing by 19	7.5
Median number of months since preceding birth	No data
% of married women currently using any method of family planning	77.7
% of married women with an unmet need for family planning	4.3
% of women 15–49 years with live birth in the past 2 years receiving antenatal care from a “medically-trained” or “skilled” provider (doctor, nurse, or midwife)	93.7
% of women 15–49 years with birth in the past 2 years who delivered in a health facility	92.4
% of women 15–49 years with birth in the past 2 years who delivered with a “medically-trained” or “skilled” provider (doctor, nurse, or midwife)	92.9

Maternal Health Indicators

% anemic (pregnant: Hb < 11 g/dL; non-pregnant: Hb < 12 g/dL)	Non-pregnant	28.8
	Pregnant	36.5
% of women with birth in the last 5 years given vitamin A supplementation after birth of last child		51.4
% of women with birth in the last 5 years given any iron supplementation during last pregnancy		60.4
% of women with birth in the last 5 years who took at least 90 days of iron supplementation during pregnancy of last child		No data
% of women with birth in the last 5 years who took deworming medication in last pregnancy		No data
% living in houses with iodized salt (above 15 ppm)		45.1

Sources: General Statistics Office 2011; maternal mortality: UNICEF 2012; anemia and iron supplementation: NIN and UNICEF 2011; vitamin A supplementation: NIN and UNICEF 2012

Food Security; Diet Diversity; and Water, Sanitation, and Hygiene

Food Security Indicators	
Global Hunger Index (2013)	7.7 (moderate level of hunger)
% of households with poor or limited food consumption (food insecure)	No data
% undernourished in total population (2011–2013)	8.3
Food supply (kcal/capita/day) (2009)	2,690
Depth of food deficit (kcal/capita/day) (2011–2013)	63
Diet Diversity Indicators	
% of dietary energy supply from cereals, roots, and tubers (2008–2010)	61
Average supply of protein from an animal source (grams/capita/day) (2008–2010)	29
Water, Sanitation, and Hygiene Indicators	
% of population with access to improved drinking water sources (2011)	92
% of population with access to sanitation facilities (2011)	74
% of population using appropriate treatment method for drinking water (2011)	90

Sources: FAO 2013; Global Hunger Index: von Grebmer et al. 2013; food supply: FAOSTAT (<http://faostat3.fao.org/faostat-gateway/go/to/browse/FB/FB/E>); water, sanitation, and hygiene indicators: General Statistics Office 2011

Gender

As Vietnam has experienced rapid economic development in recent years gender equality has improved in many respects. There is far greater parity in men and women's education relative to other countries in the region. Women's participation in the workforce exceeds 70%, however, the type of employment women have access to is often in the informal and quasi-informal sectors (such as agricultural daily wage labor and garment workers) and much less in the formal sectors. This has implications for the rights they have as workers with regard to parental leave, and in this regard women are limited in their ability to provide optimal care for their young children, such as exclusive breastfeeding. The data for nutrition show that the most significant pathway to improve young child nutrition would be through improving IYCF practices. However, optimal IYCF practices require time, and in this evolving context mothers often do not have enough time to provide this level of optimum care.

Another aspect that threatens a mothers' ability to provide young children with optimum care is domestic violence. In Vietnam, recent survey data indicate that 32% of women have ever experienced domestic violence. This reflects deep rooted gender norms that define men and women's roles in society that persist. Another trend that reflects that progress on gender equality is uneven, is the sex ratio between men and women, indicating strong son preference. With smaller family size being encouraged, more families are using sex-selective abortion to ensure they have a son, a trend which has been increasing at a steady pace in

recent years. Over the long term this is expected to have adverse implications on gender equality as there are fewer women relative to men, increasing the risk of sex work and trafficking and potentially increasing the risk of sexual violence (The World Bank 2011).

Government Policies and Program Environment: Needs and Challenges

Policies. In past assessments of its strength of nutrition governance, Vietnam has been rated "strong" based on factors such as the presence of a national nutrition strategy (Engesveen et al. 2009). Vietnam's National Nutrition Strategy 2011–2020, which followed on a previous strategy covering 2001–2010, was developed under the coordination of the National Institute of Nutrition with support from UNICEF and was approved in February 2012. In January 2014, Vietnam joined the Scaling Up Nutrition (SUN) movement. The National Institute of Nutrition, under the Ministry of Health, is the leading institution responsible for research, training, and implementation activities in the fields of nutrition, food sciences, and clinical nutrition. The main objectives of the current national nutrition strategy are to:

- Improve both quantity and quality of the Vietnamese diet
- Improve the nutrition of children and women (as measured through underweight among women of reproductive age; low birth weight; and stunting, underweight, and overweight among children)
- Improve micronutrient status (including vitamin A, anemia, and iodine)

- Control overweight and obesity
- Increase nutrition knowledge and practices among the population
- Reinforce the capacity and effectiveness of nutrition services (Medical Publishing House 2012)

Programs. Primary health care is delivered mainly through commune health stations and include hygiene education, vaccinations, antenatal care, safe delivery, health education, and nutrition services. There is extremely high coverage of the commune health network with 99% of communes having a health station, 70% have a doctor, and 79% have active village health workers (WHO and Ministry of Health 2012). The program for “energy malnutrition control” (also referred to as the “child malnutrition control program”) is overseen by Vietnam’s National

Nutrition-Specific Policies

National IYCF Action Plan, 2006–2010 (revised in 2013)

Law on Advertisement, 2012 (expanded the ban on the advertisement of breast milk substitutes for children 6–24 months)

Labor Code (amended in 2012 to extend maternity leave from 4 to 6 months)

National Nutrition Strategy for 2011–2020 with a Vision Toward 2030

National Plan of Action for Nutrition 1995–2000 (revised in 2013)

Health Sector Plan 2011–2020

National Child Survival Action Plan 2010–2015

The National Plan of Action for Food Hygiene and Safety (2010)

Government Decree on Trading In and Use of Nutritious Products for Infants, 2009–2013

National Nutrition Action Plan, 2006–2010

National Program for Food Hygiene and Safety, 2006–2010

Socio-Economic Plan (2006)

Decree on the Production and Supply of Iodized Salts (2005)

National Nutrition Strategy, 2001–2010

Institute of Nutrition, is implemented at the commune level, and implements growth monitoring as well as micronutrient supplementation.

Needs and challenges. Implementation of the national nutrition strategy is still in the early stages so problems with coordination and implementation may not yet be evident. However, there is not currently a high-level intersectoral coordination mechanism in place for nutrition in Vietnam. Despite policies in place to address nutrition, according to an analysis of opinion leaders in Vietnam (including Ministry of Health leaders as well as policymakers), nutrition and breastfeeding were unanimously not priorities (Alive & Thrive 2012). Continued advocacy and raising awareness around nutrition and IYCF among policymakers may be needed. At the program level, from an in-depth assessment of barriers and facilitators to improved IYCF in Vietnam, commune health center staff and village health workers seemed to have a “reasonably good core of knowledge on IYCF and nutrition,” although knowledge gaps existed around exclusive breastfeeding and maternal nutrition and there was a lack of training in maternal nutrition, IYCF, and counseling skills (Nguyen et al. 2011). Program monitoring and evaluation has also been identified as an area that could be strengthened.

Development Partner Support

- The Asian Development Bank implements an early childhood care and development project which seeks to improve the health, nutritional status, and cognitive and social development of Vietnamese children.
- The EU funds a nutrition and livelihoods project for ethnic minorities which includes a focus on nutrition during the first 1,000 days (from pregnancy through the first 2 years of life).
- The Bill and Melinda Gates Foundation funds an IYCF project which is evaluating models for delivering integrated breastfeeding and complementary feeding interventions at scale through policy engagement, implementation of a franchise model, and fortified complementary foods and related products.
- The Department of Foreign Affairs, Trade and Development Canada provides funding to improve food security.
- UNICEF supports nutrition education, anemia prevention and control, and bi-annual vitamin A supplementation.
- FAO works to improve the monitoring of food security, to improve nutrition and health, and to

increase the government's capacity to deliver critical health and nutrition services such as the appropriate care of the sick and malnourished, the promotion of optimal IYCF practices, and the adequate intake of iron, vitamin A, and iodine for mothers and children. FAO also seeks to improve food security by increasing homestead food production and linking this to the increased consumption of a variety of safe good-quality food.

- WHO assists the government in the development of plans, policies, and strategies for improving the health, survival, and nutrition of women and children. WHO has called for increased investment in 2012–2025 to expand nutrition interventions with targets to substantially reduce the double burden of malnutrition and related mortality and morbidity, including reducing stunting, wasting, anemia in women, and low birth weight, and increasing exclusive breastfeeding.

Recommended Nutrition Priorities

Key nutrition priorities for Vietnam include focusing on suboptimal IYCF practices, stunting, overweight and obesity among women and children, maternal underweight, anemia, and micronutrient and iodine deficiencies. Programs and activities should be focused on ethnic minority populations and women and children in the lowest wealth quintile who are disproportionately affected by malnutrition. USAID has invested in supporting health programs and activities, however, none of these resources were allocated to nutrition specifically. Increasing the allocation for nutrition could be used to implement key targeted activities. Among existing USAID-funded activities and programs this includes integrating evidence-based nutrition-specific interventions and actions. Additional opportunities include:

- Investing in advocacy and social and behavior change communication interventions to increase rates of exclusive breastfeeding, improve IYCF practices, and increase use of iodized salt
- Expanding support for integrated management of acute malnutrition, but with a specific emphasis on children under 6 months of age, who have the highest rates of wasting

In terms of opportunities to support the Government of Vietnam, opportunities include:

- Engaging in advocacy with policymakers to highlight the importance of exclusive breastfeeding and other IYCF practices
- Engaging on revising the policy guidance on salt iodization
- Supporting the expansion of immunization coverage and deworming campaigns
- Engaging with the government to strengthen multisectoral coordination for nutrition

USAID can also work in close coordination with other donors to:

- Support Government of Vietnam initiatives to promote greater coordination for nutrition service delivery across the health system
- Align on a policy level to advocate for critical investments in nutrition
- Align resource allocation to limit duplication of activities and leverage donor investments to strategically invest in nutrition, focusing on areas that need added resources such as advocacy on nutrition of children under 2

Recommended Indicators to Monitor Nutritional Impact

It is recommended that USAID incorporate the following key nutrition indicators into new and existing implementation plans in order to specifically monitor the impact of USAID programs on maternal and child nutrition status.

1. Prevalence of underweight children under 5 years of age (< -2 SD)
2. Prevalence of stunted children under 5 years of age (< -2 SD)
3. Prevalence of stunted children under 2 years of age (< -2 SD)
4. Prevalence of wasted children under 5 years of age (< -2 SD)
5. Prevalence of underweight women (BMI < 18.5)
6. Women's dietary diversity: mean number of food groups consumed by women of reproductive age
7. Prevalence of exclusive breastfeeding of children under 6 months of age
8. Prevalence of children 6–23 months receiving a minimum acceptable diet

While nutrition-sensitive interventions can have an impact on the indicators listed, it is critical to implement nutrition-specific activities that address the direct causes of malnutrition in order to see reductions in these key indicators.

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