Viet Nam’s multi-faceted Provincial Child Friendly Program (PCFP) used an Integrated Behavior Change Communication approach that included mass media, interpersonal communication through village health workers and other partners, and community-based programs, to increase knowledge and improve attitudes and practices around child health issues.

The Issue: Poor Child Survival and a Lack of Child Protection

Viet Nam has been making promising progress toward achieving the Millennium Development Goals (MDGs). The rate of improvement, however, has not been uniform throughout the country. The country’s maternal and child death rates remain high, especially in underserved areas. The Infant mortality rate is 14 per 1,000 live births, and the under-five mortality rate is 16 per 1,000 live births. Ethnic minority and migrant children are especially marginalized and disadvantaged, and are three times as likely as Kinh/Hoa children to die before their first and fifth birthdays. Children in the poorest households are twice as likely to die before reaching one and five years old compared to children who live in better-off families. Most of the poorest provinces are located in hard-to-reach and mountainous areas.

Viet Nam’s 63 provinces and five centrally governed cities have the autonomy to prepare and implement their own development plans, but the capacity of local staff to plan, allocate resources, and execute programs is limited. Vietnamese children still do not have equal access to public services in education, health and nutrition, water and sanitation, and protection.

In September 2007, UNICEF staff from such sectors as Communication for Development (C4D), Health, Nutrition, Child Injury Prevention, Child Protection, Education, and Water, Sanitation & Hygiene (WASH), in collaboration with the Provincial People’s Committee and relevant Provincial Departments, conducted a meeting to identify key health issues in Ninh Thuan Province. The key health issues identified were:

- Poor antenatal care attendance
- Poor school attendance/high drop-out rates
- Poor sanitation practices
- Child injuries (unsafe home environments)
- Unsafe drinking water
- Child labor
The Provincial Child Friendly Program (PCFP) was launched in 2006 with an investment of about US$2.2 million dollars from UNICEF and the Government of Viet Nam. The Integrated Behavior Change Communication (IBCC) intervention was an evidence-based strategy implemented as part of the Provincial Child Friendly Program (PCFP) whose aim was to increase awareness and improve attitudes and practices regarding the key health issues among local political leaders and government officials, communities, and families. The Program was developed and implemented from 2006 to 2011 in Ninh Tuan, Dien Bien and An Giang, three provinces representing the coastal region, Mekong Delta, and northern mountainous regions of the country.

The IBCC interventions were conducted in a total of 34 communes in 10 districts, covering roughly 25,000 households or approximately 125,000 individuals. Cross-sectoral departments at the provincial and village levels executed the IBCC activities.

The IBCC strategy focused on implementing a package of communication interventions in the following areas:

- **Education**: Promoting children’s rights, especially the right to an education (with a focus on the education of girls); increasing the community’s participation in education; and addressing school dropout rates.

- **Health and Nutrition**: Increasing utilization of antenatal care services; improving nutrition-related knowledge and practices (with a focus on promoting breast feeding); improving health workers’ communication capacity for conducting health promotion; and increasing communication around HIV/AIDS prevention and uptake of PMTCT.

- **Water, Sanitation and Hygiene**: Motivating behavior change to use safe drinking water; improving hand washing practices; and increasing the use of latrines.

- **Child Protection**: Raising awareness about child labor (and the related issues of school drop-out rate and seasonal migration); Promoting birth registration; preventing child marriage; preventing child abuse; and increasing social inclusion of children living with HIV.

- **Child Injury Prevention**: Reducing the incidence of drowning, animal bites, traffic accidents, and burns.

The PCFP was based on the idea that for change and positive development to occur there is a need for effective communication at three levels of the social system:

1. **The individual level**: Changing the knowledge, attitudes and practices of individuals and families;
2. **The community level**: Mobilizing organizations and groups around children’s rights; and
3. **The societal level**: Engaging with local authorities to ensure an enabling environment for behavior change.

In principal, working at these three levels of the social ecological system (Figure 1 below) in Viet Nam represented a solid strategy. In practice, the focus of the PCFP was only at the individual level, that is, on efforts directed at changing the knowledge, attitudes, and practices of individuals and families, facilitated through community outreach workers and schools.

**The IBCC Process**

Following the initial planning meetings in 2007, stakeholders agreed on a set of priorities, namely maternal and child issues throughout the lifecycle (pregnancy and delivery, nutrition, hygiene, and sanitation for children 0-5 years, and hand washing, child injury prevention, child labor, and school
mountainous regions, the population of Dien Bien H’Mong ethnic minorities spread across
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The
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the key health issues.
At the beginning of 2008 a knowledge, attitudes and practices (KAP) survey was conducted in Ninh Thuan. The survey focused on the five programmatic areas on which the BCC interventions were to be based. The KAP survey was conducted in Dien Bien and An Gang in 2009.

An IBCC Working Group was formed in each of the provinces. These groups were responsible for developing communication interventions for mothers, children, caregivers, and teachers, and coordinating, supervising and implementing the activities of the IBCC initiative. The groups were led by the Department of Planning and Investment (DPI), and coordinated by the Centre for Health and Education (CHE) in collaboration with various participating line departments. An intended outcome of the IBCC working group was to build BCC capacity in planning, budgeting, and monitoring at the local level.

A summary report for Ninh Thuan Province showed that, from 2008 to 2011, the province conducted 1,444 group discussions, 44,331 household visits, nine community/school events (e.g., forums, competitions, Breastfeeding Week), broadcast a radio program 12 times, transmitted key messages 9,540 times via a loud-speaker system, and distributed flyers, mounted display panels and posters, and provided communication materials for outreach workers.

The Creative Connection Pilot (CCP) was a school-based initiative that was implemented in three schools in Ninh Thuan Province as part of the IBCC program between August 2009 and January 2010. The CCP consisted of after-school workshops where teachers and students could creatively explore child protection issues. This approach was new to Viet Nam and an evaluation of the CCP showed that it was a successful pilot program.

The social and environmental context in Dien Bien Province was different from Ninh Thuan Province. With its high poverty rate and large population of H’Mong ethnic minorities spread across mountainous regions, the population of Dien Bien required a slightly different communication approach. Between 2010 and 2011, there were five group discussions in each village each month (for a total of 1,119 meetings that reached 38,022 people). Representatives of the relevant sector departments led the group discussions for the community. Every month, each village held a village meeting at the house of the village leader; at least 80% of residents attended those meetings (although sometimes the larger groups were divided into smaller groups so not all attendees were exposed to the same messages). The IBCC activities, however, were only a small part of the meetings; the village leader was also responsible for discussing and disseminating information related to broader development priorities in the province, the head of the village Women’s Union (WU) was responsible for summarizing WUs activities, and the local Healthcare Workers discussed local healthcare issues. The villagers in Dien Bien also received community events, loudspeaker transmissions, radio broadcasts (20 times), television broadcasts (24 times), posters, panels, flyers and outreach worker materials.

In 2010, a specialized Mother’s Support Group was piloted in two communes of An Giang province (approximately 7,116 households in total) where the exclusive breastfeeding rate was zero percent at baseline. The purpose of the Group was to promote early and exclusive breastfeeding. The provincial Centre for Health Education and the Nutrition Department mobilized local mothers who had recently exclusively breastfed their children to become Key Informant Mothers (KIMs). These KIMs served as role models and peer support group members to pregnant women and mothers with babies under the age of 6 months. The components of this intervention included regular community support meetings, one-on-one counseling about breastfeeding, support by Health Center staff for breastfeeding mothers, and breastfeeding promotion through media and household outreach efforts.

A household survey of 200 mothers in the two communes in An Giang showed that the rates of early initiation of breastfeeding increased to 70% (from a baseline of 52%), and exclusive breastfeeding rates for six months increased from 0% to 13%.
IBCC Challenges

In both regions, household visits were problematic. In Ninh Thuan the difficulty was finding an appropriate time for the household visits. Evenings were the only times an outreach worker could spend time with individuals/families in their homes. Household visits were conducted once every quarter, with a follow-up to assess the impact of the messages in the following quarter. In Dien Bien, the H’Mong households were so spread out that it was difficult for outreach workers to visit each household. In 2011, the project stopped funding household visits, and no visits were made. The literacy rates among the populations of interest in the selected provinces was relatively low for reading Vietnamese, H’Mong or Thai and the materials developed for the IBCC initiative were not tailored enough to be well-received by the intended participant groups.

The harsh physical environment, rainy-season disruptions to IBCC implementation, and the limited access to mass media by the populations in the interventions sites presented challenges to reaching individuals and families with relevant IBCC interventions.

In 2012, a process evaluation to assess the relevance, efficiency, and effectiveness of using the IBCC approach in the selected provinces showed that the approach (1) was appropriate given the stage of development in each province, (2) fit with the decentralization efforts in effect throughout Viet Nam, and (3) was successful in fostering cross-sectoral synergies at the village level. The IBCC initiative resulted in an increased awareness about child health, nutrition, hygiene, protection, and education among provincial officials, and improved participation among women, children, and community members in activities related to child health.

The process evaluation also revealed that the IBCC initiative lacked efficiency with regard to intersectoral coordination, capacity building of outreach workers/promoters, monitoring and evaluation (M&E), and budgeting.

To date, there have been no evaluations of the effects of the key IBCC activities on changes in the knowledge, attitudes, and practices of populations in the intervention provinces.

The Way Forward

The UNICEF Country Program for Viet Nam for the period 2012-2016 has an increased emphasis on Communication for Development (C4D). Current thinking and practice in the field of development communication advocates for a social ecological approach to changing behaviors and social norms.

The Social Ecological Model (Figure 1 above) is a
framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations. By identifying these leverage points, program planners can influence how, and how well, C4D child health interventions are designed, received, adopted, and supported by individuals, groups, communities, organizations, donors, and policymakers.

The C4D approaches (advocacy, social mobilization, social change communication (SCC), and behavior change communication (BCC)) are interrelated and interactive and using them in a well-planned program produces a synergistic effect. Simple preventive actions by the individual, family and community, stimulated by BCC and SCC, are the most immediate means for improving child morbidity and mortality rates. SCC can be used to create public dialogue that allows groups of individuals or communities to define their needs and collaborate to transform the way their social system is organized, including the way power is distributed, and provide a way for the community to collectively exercise their rights. Advocacy strategies can pave the way for new laws or change a policy that may be impeding change. Multi-level approaches help shift community and organizational norms to ensure that behavior changes are sustained over time.

The initial PCFP/IBCC approach outlined interventions to address the individual, family, and community levels of the SEM. Due to time, capacity, geographic, and political context restraints, the program was only able to address individual-level knowledge, attitudes and practices, and did not include community mobilization activities, or engage in changing social norms.

The next phase of the PCFP should work toward developing mechanisms for (1) reaching individuals and families more efficiently and effectively with relevant messages and through culturally-, linguistically-, and access-appropriate channels, (2) engaging communities in continuous and focused dialogue about the key health issues, and motivate collective action to address the issues, (3) identifying and addressing social norms, both positive and negative, that can be leveraged or changed, and (4) developing a robust evaluation for the interventions at all levels of the SEM.

Given Viet Nam’s increasing decentralization, there should be an emphasis on (1) advocating for national-level support for local-level capacity building to strengthen the delivery of child friendly interventions and services at the individual, community, and organizational levels of the SEM, (2) advocating for support to maintain an efficient and standardized system for collecting and analyzing data on child injuries and protection, (3) creating child protection safety nets through community-based organizations, including reporting mechanisms that promote organizations that foster quality care for children, and bring to light organizations whose actions are harmful to children in order to change the social norms and practices at the community/organizational level, (4) promoting children’s rights and participation toward creating self- and collective- efficacy around child safety and survival, among children, families, schools, and the broader communities, and (5) engaging individuals/families in meaningful dialogue around child protection, survival, and development issues.

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