Professional self-efficacy for responding to child abuse presentations

Jennifer Anne Fraser, Tara Flemington, Diep Thi Ngoc Doan, Van Minh Tu Hoang, Binh Thi Le Doan and Tuan Manh Ha

Abstract

Purpose – The purpose of this paper is to validate measures of professional self-efficacy for detecting and responding to child abuse and neglect presentations, and then evaluate a clinical training programme for health professionals in a tertiary-level hospital in Vietnam.

Design/methodology/approach – A prospective, cohort design was used and professional self-efficacy was measured immediately prior to, and shortly after, training 116 nurses and doctors in emergency settings. Longer-term follow-up was measured six months later.

Findings – Linear mixed modelling showed that there was a statistically significant improvement in efficacy expectations for both suspected and known cases of child abuse and neglect between the pre- and post-test measures at zero and six weeks. These improvements did not persist to the six-month follow-up.

Research limitations/implications – The training succeeded in improving detection and clinical response to child abuse and neglect presentations but not faith in the provision of ongoing support for children and families.

Practical implications – Practice change in emergency settings in Vietnam can be achieved using a sustainable theoretically driven training programme.

Social implications – Building the capacity of health professionals to respond to cases of child abuse and neglect relies on the strength of the community and support services within which the hospital is located.

Originality/value – Measures of self-efficacy expectations and outcome expectations for responding to child abuse and neglect presentations in emergency settings in Vietnam are now validated.

Keywords Vietnam, Child abuse, Healthcare professional, Efficacy expectations, Outcome expectations, Professional self-efficacy

Paper type Research paper

Introduction

Translating clinical research evidence into healthcare practice is essential in public health and clinical healthcare. For this to occur, healthcare professionals must initiate and sustain changes to their professional practice behaviours. Improvements in practice can be achieved through theoretically based training interventions (Colquhoun et al., 2017) that aim to improve perceived professional self-efficacy. Bandura’s theory of self-efficacy has been used extensively in public health research. Self-efficacy and its relationship to human behaviour were first described by Bandura in the 1970s as an explanatory mechanism for the adoption of new behaviour patterns (Bandura, 1977). It has since been applied in a number of settings, including healthcare professional practice. Professional self-efficacy refers to the individual’s belief in their capability to exercise control over their professional conduct and events in the workplace that impact on their performance.

Application of the theory to professional practice and professional behaviour has gained momentum as more is understood about the influence of personal beliefs on one’s ability to perform work confidently. Increasing research effort now points to the success of improving professional behaviours and practice by targeting professional self-efficacy because of its influence on attitudes and performance. For example, a training intervention for third-year nursing...
students in Canada was associated with high levels of self-efficacy when acting in a mass immunisation clinic (Babenko-Mould et al., 2014). The considerable degree of impact suggests that when self-efficacy is high, healthcare professionals are able to translate theory into practice (Babenko-Mould et al., 2014). Similarly, an Australian team evaluated the impact of an online mental healthcare training programme on professional self-efficacy for healthcare professionals (Murphy et al., 2017). Participants reported improved self-efficacy for treating and detecting the “Cardiac Blues” in patients at risk of depression during cardiac rehabilitation.

Derscheid et al. (2014) developed a tool to measure preschool teacher self-efficacy and knowledge of healthy eating and exercise patterns in the USA. Knowledge of healthy practices was significantly related to self-efficacy, suggesting that appropriate training that improves knowledge may lead to changes in professional practice. For example, higher levels of self-efficacy significantly predicted improvements in clinical practice skills over time amongst behavioural health professionals in the USA (Lee et al., 2016). Self-efficacy has also been implemented as a model to both measure and improve the knowledge and practice of healthcare professionals and their response to child abuse and neglect presentations in the hospital setting.

A Child Abuse and Neglect Reporting Self-Efficacy (CANRSE) questionnaire was developed in Taiwan to measure professional self-efficacy in relation to child abuse and neglect response among nurses (Lee et al., 2007, 2012). After finding that more than 70 per cent of Taiwanese nurses felt that they needed more child protection education, a training programme based on the theory of self-efficacy was implemented using a quasi-experimental design (Lee and Chou, 2017). Nurse self-efficacy to report child abuse and neglect was significantly different in the intervention group compared to the control group at both post-test and follow-up (Lee and Chou, 2017). This was the first reported evaluation of a child protection training intervention for nurses grounded in self-efficacy theory, and has significant implications for future practice given previous findings in Taiwan that reporting self-efficacy may influence nursing confidence and decision-making in cases of child abuse and neglect (Lee et al., 2012).

The properties of the CANRSE measure have not yet been tested outside these Taiwanese healthcare settings. When a clinical training and capacity-building programme for healthcare professionals in paediatric emergency settings in Vietnam (Safe Children Vietnam study) was conducted between 2013 and 2015, the opportunity to further test the CANRSE was presented. Results from the Safe Children Vietnam study needs analysis and overall evaluation have been published previously (Flemington and Fraser, 2017; Flemington et al., 2017). The focus of this paper is to highlight the extent to which a theoretically driven clinical training intervention can influence professional self-efficacy to detect and respond to child abuse and neglect presentations.

**Study rationale**

Child abuse and neglect is a problem of considerable concern in Vietnam, with over 70 per cent of children experiencing physical abuse in the family home (Tran et al., 2017). The study herein was implemented as a precursor to the Children’s Law, which was enacted in mid-2017. According to the Children’s Law, child abuse and neglect is now comprehensively outlawed for the first time, and the crucial role of healthcare professionals in its identification and prevention is identified. At the time of the study, torturing, maltreating, trafficking and sexually abusing children was illegal under the Law on Child Protection, Care and Education (National Assembly of Vietnam, 2004). These terms did not explicitly protect Vietnamese children from child abuse and neglect. The Safe Children Vietnam training programme was developed in coordination with the Vietnam Ministry of Health and the planned enactment of the Children’s Law that replaced the Law on Child Protection, Care and Education in mid-2017. The Children’s Law explicitly prohibits all types of child abuse (physical, sexual, emotional and neglect). Importantly, it states that it is the responsibility of healthcare professionals to gather information of suspected abuse cases, provide free healthcare for children experiencing abuse and protect them where possible (National Assembly of Vietnam, 2016).

To assist with the preparation of healthcare professionals for their expanded role, a relationship between the study site and the University of Sydney was established and the Safe Children Vietnam training and capacity-building programme was developed (Flemington et al., 2017). In order to maximise the clinical validity of the programme, a needs analysis was conducted with
senior healthcare professionals at the study site prior to the development and implementation of
the training. The needs analysis revealed an almost complete absence of child protection training
for healthcare professionals in Vietnam, and healthcare professionals identified a need for a
capacity-building-style training programme that would improve knowledge and confidence when
responding to child abuse and neglect presentations (Flemington et al., 2017).

Study aims and design

There were two aims: validate measures of self-efficacy expectations and outcome expectations
of detecting and responding to child abuse and neglect presentations in emergency settings in
Vietnam, and evaluate the impact of the Safe Children Vietnam training programme on healthcare
professional self-efficacy to recognise and respond to known and suspected cases of child
abuse and neglect. To test the hypothesis that there is a relationship between implementing a
clinical training programme based on Bandura’s theory of self-efficacy and self-efficacy
expectations and outcome expectations for recognising and responding to child abuse and
neglect cases in the emergency setting in Vietnam, a prospective, cohort design was employed.
Measures of professional self-efficacy were collected immediately prior to the training intervention
in March 2014 (zero weeks), post-test measures collected shortly after the training intervention in
May 2014 (six weeks) and longer-term follow-up in November of the same year (six months).

Methods

Participants and setting

Healthcare professionals were eligible to participate in the study if they were a nurse or a doctor
working in an emergency setting at the study site. To maximise the generalisability of the study
and also effectiveness of the training, nurses at all levels, from healthcare assistants to tertiary
qualified registered nurses were invited to participate. All medical doctors from the emergency
settings were also invited to join the study. At Time 1, a total of 116 participants gave consent and
were recruited into the study. Baseline characteristics of the sample are presented in Table I.

The settings were the emergency settings of a tertiary paediatric hospital in the south
of Vietnam. Children between 4,500 and 5,000 were present there for daily treatment.
More than half of these children travel from rural areas, and 250–300 are admitted to the
hospital for treatment per day. Three emergency settings were identified as responsible for
the emergency care of children in the participating hospital. These were the outpatients,
emergency and burns departments. Only critical cases were treated in what is named the
hospital emergency department, the equivalent to the “resuscitation” or “trauma” areas of
the emergency department in other countries. In addition, children with burns injuries were
triaged directly to the burns unit. For this reason, health professional staff from all three
emergency settings were invited to participate in the study.

Ethics approval was gained before the commencement of this study. The participating hospital’s
ethics committee approved the study as did the University of Sydney Human Research Ethics
Committee (Project No. 2013/025). Healthcare professionals were invited to join the study by the
chief investigator (JF), with the support of nursing and medical directors of participating
departments. A research assistant performed the role of interpreter during participant
recruitment, communicating to participants the voluntary nature of the study and the right to
withdraw at any time without penalty. All information, such as participant information statements
and consent forms, was presented in Vietnamese. This information was back-translated
(English–Vietnamese–English) and also checked by key stakeholders for consistency of content
and cultural relevance.

The intervention

The Safe Children Vietnam training programme was a multi-modal intervention that aimed to
improve healthcare professional knowledge and self-efficacy to recognise and respond to child
abuse and neglect cases in the emergency setting. Following participation in the programme,
staff were expected to display improvements in knowledge, attitudes, professional self-efficacy and reporting behaviour. All participants received a take-home workbook, and senior staff participated in a two-day interactive workshop. To maximise accessibility of the training, short in-service presentations were also offered in participating departments. As a capacity-building programme, senior staff who completed all components of the intervention were then qualified to implement ongoing training in the future, under the supervision of department directors.

Training content included an overview of Vietnamese child protection legislation, definitions of child abuse and neglect and common presentations and consequences of abuse. Training was delivered in Vietnamese by trained, senior medical professionals, local university academics, representatives from social welfare organisations and public health research assistants in the Safe Children Vietnam team. Cultural and clinical validity was maximised through regular, extensive input from local stakeholders and feedback from participants. Programme fidelity was monitored with a close supervision by the chief investigator (JF) and the Safe Children Vietnam Project Manager and PhD Student (TF).

Measures

Child Abuse and Neglect Reporting Self-Efficacy (CANRSE) scale. In total, the CANRSE questionnaire was comprised of 44 items that measured perception of the ability to manage child abuse and neglect cases in the clinical setting. The items were clustered into three domains: self-efficacy of suspected (EES) cases (16 items comprising four subscales), self-efficacy of known (EEK) cases (16 items comprising four subscales) and outcome expectations (OE) with 12 items comprising 3 subscales (see Table II). Each item was presented
as an 11-point Likert scale from 0 to 10, with higher scores indicating higher self-efficacy (0 = not confident at all, 10 = extremely confident). In the sample of Taiwanese nurses, the content validity index of the scale was 0.89, and the test–retest reliability coefficient was 0.91 (Lee et al., 2012).

Questionnaires to measure demographic data, healthcare professional training in child protection, attitudes towards reporting, knowledge of shaken baby syndrome and knowledge of child abuse and neglect presentations are detailed elsewhere (Flemington and Fraser, 2017). For the purpose of this paper, only the relevant measures of professional self-efficacy to detect and respond to child abuse and neglect presentations will be presented.

This battery of questionnaires was completed by participants onsite before and after scheduled work shifts before the intervention (zero weeks), and at six weeks and six months following the intervention. Questionnaire items were in Vietnamese and back-translated for accuracy (English–Vietnamese–English). Prior to implementing the intervention, advice was sought from Vietnamese members of the Safe Children Vietnam research team to maximise the clinical and cultural validity of the content. Surveys were collected and stored at a secure location in Ho Chi Minh City. Data were entered twice into SPSS (Version 23.0) by bilingual (Vietnamese/English) research staff. After testing for invalid codes and missing values, discrepancies were resolved by cross-checking with hard copy surveys.

Data analyses

All analyses were completed using the IBM SPSS Statistics Package 24.0 (SPSS (IBM Corp. Released), 2016). Psychometric properties were tested using Cronbach’s α for internal consistency of the CANRSE scales and subscales. Convergent validity was tested using the general self-efficacy scale (GSE) with Pearson’s correlation. The ten-item GSE is based on Bandura’s social cognitive theory and is a measure of GSE and optimism as the name suggests (Luszczynska et al., 2005; Schwarzer and Jerusalem, 1995). It is available in a number of different languages although we had to translate it to Vietnamese for this study.

Due to the longitudinal nature of the research, linear mixed models (LMMs) were used to assess the change in mean scores over the three time points. Each of the three outcomes (dependent variables) were analysed separately. The only fixed factor in the models was Time, categorically coded as T1 (zero weeks), T2 (six weeks) and T3 (six months). A random intercept was included in each model to account for clustering of the observations within individuals. LMMs are more appropriate than repeated measures ANOVA when there is missing data (Serroyen et al., 2009) as all cases are retained. Pre-planned post hoc analyses were conducted for all outcomes to compare T1 and T2, T1 and T3 and T2 and T3. Estimated marginal means, standard deviations and Cohen’s d (as a measure of effect size) are reported for each pairwise comparison (Cohen, 1992). α was set at 0.05.

Content validity testing

Items from the CANRSE were reviewed in both English (original version) and Vietnamese by bilingual content experts (DD, VH, BD) trained in medicine, paediatrics and emergency care. Content validity and clinical utility were reviewed and considered appropriate and relevant to the Vietnamese paediatric emergency setting. No revision of the items was considered necessary by the content experts.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Subscale 1</th>
<th>Subscale 2</th>
<th>Subscale 3</th>
<th>Subscale 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Efficacy expectation for suspected cases</td>
<td>Prioritise my workload</td>
<td>Colleague support</td>
<td>Seek senior medical staff opinion</td>
<td>Confidence to report</td>
</tr>
<tr>
<td>2. Efficacy expectation for known cases</td>
<td>Prioritise my workload</td>
<td>Colleague support</td>
<td>Seek senior medical staff opinion</td>
<td>Confidence to report</td>
</tr>
<tr>
<td>3. Outcome expectations</td>
<td>Child benefit</td>
<td>Family benefit</td>
<td>–</td>
<td>Faith in services</td>
</tr>
</tbody>
</table>
Results

All eligible staff at the study site completed surveys at zero weeks (n = 116, 100 per cent). Following the intervention 92 (79 per cent) participants completed the questionnaires and at six months only 73 (63 per cent) participants completed the Time3 questionnaires. As there was loss to follow up, Little’s MCAR test was used to ascertain whether the missing data could be considered missing completely at random (MCAR); that is, the missingness does not depend on any other variable, either observed or unobserved (Garson, 2015). This is a null hypothesis test that the data are MCAR, and was not rejected (p = 0.086). This suggests that data were likely to be missing at random and unlikely to bias results.

Internal consistency of the CANRSE

Each of the three scales for efficacy expectations showed strong internal consistency (> 0.9, see Table III). Next, to test the convergent validity of the Vietnamese CANRSE, the efficacy expectation scales were correlated with the GSE Scale (Vietnamese version) and moderate correlations were found (see Table IV).

Intervention impact on healthcare professional self-efficacy

There was a statistically significant improvement in efficacy expectations for both suspected and known cases of child abuse and neglect between the pre- and post-test measures at zero weeks and six weeks, respectively. These improvements were no longer significant at the six-month follow-up. There were no differences detected between any time points for the measures of outcome expectations.

For suspected cases of child abuse and neglect, there was a statistically significant improvement between pre- and post-test measures at week 0 and week 6 (p = 0.005), but not between week 0 and six months (p = 0.557). At week 0, week 6 and six months, the 95% CIs were [99.28, 110.72], [109.11, 121.60] and [96.04, 109.60], respectively (Figure 1). This also applied to known cases of child abuse and neglect, where there was a statistically significant improvement between pre- and post-test measures at week 0 and week 6 (p = 0.015), but not between week 0 and six months (p = 0.814). At week 0, week 6 and six months the 95% CIs were [108.84, 120.67], [117.65, 130.40] and [108.85, 122.54], respectively (Figure 2). The hypothesis that the intervention would influence efficacy expectations for suspected and known cases was thus supported in the short term only. There were no statistically significant differences detected between week zero and week six (p = 0.093) and week zero and six months for

### Table III

<table>
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<tr>
<th>Scale</th>
<th>Cronbach’s α</th>
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<tr>
<td>Total Items</td>
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<tr>
<td>Efficacy–expectations (EES)</td>
<td>0.97</td>
</tr>
<tr>
<td>Efficacy–expectations (EEK)</td>
<td>0.98</td>
</tr>
<tr>
<td>Outcome–expectations (OE)</td>
<td>0.96</td>
</tr>
</tbody>
</table>

### Table IV

<table>
<thead>
<tr>
<th>Scale</th>
<th>GSE</th>
</tr>
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<tbody>
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<td>Efficacy–expectations (EES)</td>
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<tr>
<td>Efficacy–expectations (EEK)</td>
<td>0.401</td>
</tr>
<tr>
<td>Outcome–expectations (OE)</td>
<td>0.570</td>
</tr>
</tbody>
</table>
outcome expectations for efficacy expectations. At week 0, week 6 and six months the 95% CIs were [81.29, 89.62], [86.01, 95.10] and [83.08, 93.11], respectively (Figure 3). The hypothesis that the intervention would influence outcome expectations was, therefore, rejected.

Discussion

The CANRSE measure of professional self-efficacy expectations and outcome expectations, as explained through Bandura’s (1977) theory of self-efficacy was developed by Lee et al. (2012)
in Taiwan. The potential for CANRSE to be successfully translated to other languages and used internationally has been supported by the findings of our study in Vietnam. The Vietnamese version of CANRSE was found to have utility as a reliable and valid instrument for use in measuring professional self-efficacy for detecting and responding to child abuse and neglect presentations in emergency settings in Vietnam. We also used the Vietnamese sample of 116 emergency healthcare professionals to test the convergent validity of this measure with the GSE to test if it measured the underlying construct of self-efficacy and it appeared to do so. Specifically, the measure of professional self-efficacy correlated moderately with GSE. As previously noted by the original developers (Lee et al., 2012), the CANRSE subscales of suspected and known abuse and neglect cases could be merged to reduce the number of items without creating instability of the measure.

The study extends our understanding of a training strategy aimed at influencing internal attributions, raising awareness and improving detection and response to child abuse and neglect in the following ways. The Safe Children Vietnam training programme had a significant impact on healthcare professional self-efficacy to respond to child abuse and neglect cases in the short-term but not at six-month follow-up. At the same time, no intervention effect was achieved for outcome expectations in either the short or longer-term. This was not the case in research conducted in a Taiwanese healthcare setting by Lee and Chou (2017). Following their ten-hour workshop-based child abuse and neglect training for registered nurses measures of both efficacy expectations and outcome expectations improved. In total, 80 participants were randomly allocated into two groups of 40, with one group acting as the experimental group and the other control. Statistically significant differences were found between pre- and post-test measures collected at baseline and four weeks for both efficacy expectations and outcome expectations. It could be argued that there is some concordance with our findings because the impressive results in the Lee and Chou's (2017) study were found at one time point and at only one month after the training, at least for efficacy expectations. The key difference between the findings from the Taiwanese and Vietnamese studies was the impact of their ability to recognise and respond to child abuse and neglect in their professional role on outcome expectations. That is, the healthcare professional’s perception of the benefits to the child and family and their faith in child protection authorities to protect and provide ongoing services to the families.

This is most likely due to the vast differences between the existing child protection systems in each country. At the time of the study reported herein, Vietnam was strengthening its
commitment to primary, secondary and tertiary efforts to prevent child abuse. A new Children’s Law has now been enacted that emphasises risk reduction, and prevention and early support for the treatment of children identified as victims of child abuse. On the other hand, child protection research and practice, in particular on the role of health professionals in detecting and referring cases, has been receiving much attention in Taiwan over the past two decades (Chang et al., 2016).

The ability of the Safe Children Vietnam programme to influence the expectations of the emergency staff in a tertiary referral paediatric hospital in Vietnam to have faith in the benefits of detecting and reporting child abuse and neglect to authorities may be explained in two ways. Firstly, support services for children in an abusive situation are few, and there is a lack of coordination between agencies. While children are able to access assistance from the police, their Commune People’s Committee or the Vietnam Women’s Union, they are most likely to seek informal support from family and friends (Vu, 2016; Huynh and Morch, 2008).

Second, in the only exploration to date of Vietnamese healthcare professional experiences in responding child abuse and neglect, participants in the Safe Children Vietnam needs analysis felt that many support agencies were ineffective (Flemington et al., 2017). This perception is exacerbated by a largely reconciliatory approach of authorities to women seeking assistance in cases of intimate partner violence (Vu et al., 2014), and the relatively recent introduction of social work as a discipline in Vietnam. Effecting change in healthcare professional outcome expectations may best be achieved through the adoption of a systems-wide approach that includes the creation of supportive environments for children and strengthening communities to respond to the needs of children experiencing abuse.

**Strengths and limitations**

Findings from the study make an important contribution to the literature in two ways. First, the ability to measure professional self-efficacy for recognising and responding to child abuse and neglect in the emergency settings of Vietnamese hospitals using a valid and reliable measure of the concepts in Bandura’s theory of self-efficacy is an important development in this field of research. It makes an excellent contribution to the significant effort being made to build capacity in the health workforce in Vietnam. Next, the findings have illuminated the importance of providing sustainable training efforts for this particular workforce. Emergency settings are intense, high energy, highly emotional workplaces that demand speedy, accurate and streamlined medical and nursing practice. There are many demands placed on the emergency settings to provide timely care. Referral to specialist care and child protection services must be embedded in a system of support. The success of any training programme that builds the capacity of hospital staff to better respond to cases of child abuse and neglect relies on the strength of the community and support services within which the hospital is embedded.

The relationship between capacity building of hospital staff and developing community and child protection systems is an important consideration in the interpretation of the results of this study. The unique context of the intervention site means that the results may not be generalisable to other tertiary paediatric hospital sites in Vietnam or indeed internationally. This study was undertaken in a context of developing community and social services that were not clearly connected to the hospital. Social work is a growing profession in Vietnam. As more social workers are employed and more resources become available to support the integration of these services and the hospital the ability to improve outcome expectations for child abuse recognition in emergency settings will become more likely. Nevertheless, the insights that this study brings to identifying the limitations of efforts to build workforce capacity are very worthy.

**Conclusion**

The ability to influence professional self-efficacy to detect and respond to child abuse and neglect presentations using a theoretically driven clinical training intervention in Vietnam is promising. But it needs to be sustainable. The success of the intervention was in its ability to influence internal attributions, raise awareness and improve detection and response to child abuse and neglect...
(efficacy expectations). On the other hand, more research will be needed to improve staff perceptions of the benefits to children and their families when they can identify and report cases of child abuse and neglect in the emergency setting (outcome expectations).

A train the trainer model is recommended for ongoing implementation of the programme. But it is acknowledged that the longer term results were disappointing and sustainability of the intervention is important. The programme could be strengthened with a robust implementation plan that considers barriers to longer-term sustainability. The barriers to healthcare professionals' reporting of child abuse and neglect cases to authorities have been well documented. Lack of confidence in services for children at risk of abuse and neglect (Jones et al., 2008; Nayda, 2002; Flaherty et al., 2006; Flaherty et al., 2004), fear of retribution (Schols et al., 2013; Nayda, 2004), collegial support (Feng and Levine, 2005; Flaherty et al., 2004) and a pre-existing relationship with the child and family (Jones et al., 2008) are examples the well-known barriers. This study goes some way towards strengthening the evidence base needed for better child protection practice in acute health settings.

### Implications of the research for policy and practice

- Professional self-efficacy to detect and respond to child abuse and neglect presentations can be achieved with clinical training.
- Clinical training can influence internal attributions, raise awareness and improve detection and response to child abuse and neglect.
- A train the trainer model is recommended for ongoing implementation of the programme.
- Clinical training should be strengthened with a robust implementation plan that considers barriers to longer-term retention of knowledge and skills.
- Reporting of child abuse and neglect will be improved through increasing clinicians’ confidence in community services for children, addressing fear of retribution, improving collegial support, increasing clinician resilience.

### References


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