The Public Relations Capacity Gap in Policy Communication on Infectious Disease Prevention and Control in Vietnam

MA. Nguyen Thi Phuong Thao
Office of the Ministry of Health
Email: phuongthao.moh@gmail.com

Abstract: Government public relations in infectious disease prevention and control extends beyond the dissemination of official information. It encompasses the institutional and operational capacity to facilitate dialogue, uphold accountability and foster public trust. Drawing on a survey of 306 health officials across three administrative levels and 27 in-depth interviews, this study examines government public relations capacity along six dimensions. Transparency and accountability received the highest self-rating, at 4.04 on a five-point scale, whereas individual communication capacity ranked last at 3.48. A multiple regression model shows that administrative level and the frequency of specialised training are both associated with individual capacity, although together they explain only eight per cent of its variance. The raw difference between men and women in overall capacity disappears once position and training are controlled, but the difference in confidence in speaking publicly persists. Interview evidence attributes the gap to the dissolution of dedicated communication units and the resulting reliance on staff who perform communication duties alongside clinical work. The findings rest on self-report and should be read as evidence of perceived rather than demonstrated capacity. They indicate that the health communication system satisfies those requirements an institution can meet by regulation, and falls short on those that depend on the competence of the individual official.

Keywords: government public relations; operational public relations capacity; policy communication on disease prevention and control; capacity gap; Vietnam's health sector

1. Introduction

Effective government public relations depend not only on the substance of public policy or the volume of information disseminated, but also on the communicative competence of the officials responsible for engaging with citizens. Unlike commercial public relations, government PR is accountable to citizens rather than to shareholders, operates under statutory disclosure duties, and must manage approval chains that constrain both speed and tone [1].

Research on health communication in Vietnam has approached the field principally from journalism, public health and public policy perspectives, focusing on media coverage, health literacy and policy design. Three gaps follow. First, the communicator has rarely been the unit of analysis: studies examine what was published rather than whether the officials who produce and deliver those messages are equipped to do so. Second, government PR as a distinct body of theory [2], [1], [3] has seldom been applied to the Vietnamese health sector. Third, no published empirical study known to the author measures the PR competence of Vietnamese health officials across administrative levels. The existing Vietnamese literature illustrates this pattern: studies have examined the Ministry of Health's use of social media during COVID-19 [4], the role of online newspapers in pandemic information

governance [5], the use of social media to communicate political decisions [6], the application of risk communication theory to information crises [7], and the effects of misinformation on social media users [8]. All take the message, the channel or the audience as the unit of analysis; none measures the capacity of the officials who produce and deliver those messages. This study addresses that gap directly and contributes evidence to the first two.

To address this gap, the present study adopts a mixed-methods design combining a survey of 306 health officials and 27 in-depth expert interviews, within a government PR framework. The study asks: (1) How do health officials at different administrative levels assess their own PR capacity across six dimensions? (2) Which institutional and individual factors are associated with differences in that self-assessment? (3) How do practitioners themselves account for the gaps the survey reveals?

2. Theoretical Basis and Analytical Framework

This study adopts government PR as its primary analytical perspective. Government PR is fundamentally concerned with serving the public interest through transparency, accountability and civic engagement [2]. The Government Communication Decision Wheel further specifies the environmental attributes that distinguish public-sector communication from its commercial counterpart: statutory mandates, political oversight, formal approval procedures, and accountability to the citizenry rather than to a market [1], [3]. These attributes are directly relevant to the Vietnamese case, where the authority to speak publicly is regulated by a formal spokesperson regime [9].

The analytical framework integrates two complementary theoretical perspectives: Grunig and Hunt's two-way symmetrical model and the Crisis and Emergency Risk Communication (CERC) model [10], [11]. Rather than functioning as background, the two models generate the measurement instrument used here: each of the six capacity dimensions is derived from a specific theoretical requirement, as set out in Table 1, and the results in Section 4 are interpreted against those requirements.

The two-way symmetrical model conceptualises public relations as reciprocal communication between an organisation and its publics rather than one-way dissemination, and requires that the organisation both disclose information and adjust its own conduct in response to feedback [10]. It therefore yields two measurable requirements: transparency and accountability, and feedback and dialogue. The CERC model addresses communication under uncertainty and urgency, and specifies that a credible designated source must speak early, consistently and in a coordinated manner across the responding system [11]. It yields a further three requirements: coordination and message consistency, spokesperson and press relations, and -applied to the contemporary information environment, in which misinformation spreads as fast as the pathogen [12] -digital communication capacity. Garnett's operational layer of government communication supplies the sixth: the individual competence of the official who actually speaks [2].

Taken together, these perspectives define PR capacity as a multidimensional construct in which institutional provisions and individual competence are distinct and may diverge. That possibility of divergence is the analytical core of this article.

Table 1. Theoretical derivation of the six capacity dimensions

Capacity dimension	**Theoretical source**	**What it measures**
Transparency and accountability (TRANS)	Two-way symmetrical model [10]	Proactive disclosure of epidemiological information; timeliness and completeness of information supplied to the public and the press
Feedback and dialogue (RESP)	Two-way symmetrical model [10]	Capacity to receive, process and act upon public feedback; degree of genuine two-way exchange
Coordination and governance (COOP)	CERC, principle of message consistency [11]	Mechanisms for coordinating information across administrative levels and across sectors; consistency of messages
Spokesperson and press relations (SPOK)	CERC, principle of credible source [11]	Preparation and delivery of official statements; working relationships with the press under epidemic conditions
Digital communication capacity (DIGI)	CERC applied to the digital environment; infodemic management [12]	Use of digital platforms, social listening, and handling of misinformation
Individual communication capacity (COMP)	Operational layer of government public relations [2]; operational communication skills [13]	Message editing, public speaking, handling public reactions, and individual situational judgement

Source: Compiled by the author

3. Research Methodology

This study employed a mixed-methods research design to integrate quantitative and qualitative evidence. All quantitative analyses were conducted in IBM SPSS Statistics.

3.1. Survey of health officials

A structured questionnaire was administered to health officials between 1 December 2025 and 18 January 2026; the dataset was compiled and cleaned in April 2026. The population of officials holding designated communication duties in the public health system is finite and enumerable, and a complete frame of mandated units was constructed for the study. At central level it comprises 20 departments and

agencies of the Ministry, three specialised media units (Sức khỏe & Đời sống newspaper, the National Centre for Health Communication and Education, and the Journal of Medicine and Pharmacy), and 100 public service units of the Ministry (hospitals, institutes, academies, colleges and centres) -123 units in all. At provincial level it comprises the 34 provincial Departments of Health and the 34 provincial Centres for Disease Control, 68 units in all. At service-delivery level it comprises commune and ward health stations. The sampling problem was therefore not one of random scale but of structural representation of the policy chain from advisory bodies to implementing units.

The study applied stratified sampling combined with purposive selection of key units and role quotas. The stratifying variable was administrative level, dividing the population into three homogeneous strata: central, provincial and service-delivery. Stratifying a heterogeneous population before sampling reduces error and improves representativeness relative to simple random sampling [14]. At the central and provincial levels, where the number of mandated units is finite, all key units were included, approximating a census of focal points and thereby eliminating sampling error in the two decisive strata; the service-delivery stratum, being very numerous, was sampled. Within each unit one manager and one specialist were invited, so that the planning tier and the implementing tier could be observed in parallel. The sampling unit was thus the organisation holding a communication mandate, not the respondent's place of residence. Recruitment proceeded in two steps. The health sector's vertical administrative system was first used to identify the designated communication focal point of every unit in the frame. Each identified official was then contacted individually, informed of the purpose of the study and asked to take part; the questionnaire link was sent only to those who agreed. The instrument was therefore never released as an open link, and every respondent was a named official holding communication duties in a unit within the sampling frame.

Within every unit in the frame two officials were invited, one manager and one specialist: 246 invitations at central level and 136 at provincial level, together with commune and ward health stations, for which the number approached was not recorded. Three hundred and six officials returned responses, all of which were complete and retained for analysis; because the service-delivery denominator was not recorded, no overall response rate is reported. With approximately 40 to 50 observed variables, the resulting ratio of roughly six to seven observations per variable exceeds the minimum recommended for factor analysis and regression [15]. Administrative level was self-reported on a three-category item (central; provincial; service-delivery level, comprising centres and health stations). The achieved structure was central 37 (12.1%), provincial 118 (38.6%) and service-delivery level 151 (49.3%). For the central comparison between planning and implementing roles, the central and provincial strata were combined into a management group (155, 50.7%) and compared with the service-delivery group (151, 49.3%). Since the two upper strata were covered by a near-census and the service-delivery stratum was selected rather than randomised, the design yields structural representation of the policy chain rather than probability-based estimates for the national health

workforce; sampling error is eliminated at the two strata that carry the study's central comparison.

Further sample characteristics: gender 109 men (35.6%) and 197 women (64.4%); principal field of training public health 164 (53.6%), journalism 41 (13.4%), public relations 6 (2.0%), other 95 (31.0%); access to PR training never 101 (33.0%), once or twice 123 (40.2%), three times or more 82 (26.8%); age under 38 years 100 (32.7%), 38 to 43 years 103 (33.7%), 44 years and above 103 (33.7%).

The instrument measured six dimensions of government PR capacity, each with ten items rated on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Items were generated deductively from the theoretical requirements set out in Table 1 and reviewed by the research supervisors before administration. Two negatively worded items were reverse-scored before scale construction. Internal consistency was acceptable to high for all six scales (α = .895 to .971; reported in Table 2). Values above .95 indicate a degree of item redundancy within scales [16, p.54] and are addressed in the limitations. Because the scales were theory-derived rather than exploratory, no exploratory factor analysis was performed; confirmatory validation is left to subsequent work.

3.2. In-depth interviews

Twenty-seven semi-structured interviews were conducted with policymakers, communication officers, journalists and senior public health practitioners drawn from the Ministry of Health portal, the Medical Publishing House, provincial Centres for Disease Control, tertiary hospitals, the Department of Animal Health, and health and general news organisations. Transcripts were analysed thematically: an initial inductive coding pass generated candidate themes, which were then organised against the six capacity dimensions. Coding continued until no new themes emerged. The procedure follows the qualitative content-analysis sequence set out for Vietnamese communication research, in which coding serves theory building rather than theory testing, and credibility is established through independent coding and the discussion of divergent readings rather than through a reliability coefficient [17]. Quotations are identified by an anonymised code indicating interview number, gender and organisational type.

3.3. Research ethics

Participation was voluntary and anonymous. Consent was obtained twice: each official agreed to take part when contacted individually, before receiving the questionnaire, and the questionnaire itself opened with an explicit consent item that had to be answered before proceeding; interviewees gave informed consent to be recorded and to the use of anonymised quotations. No personally identifying information is reported. The author is an official of the Office of the Ministry of Health; this position facilitated access to respondents and also constitutes a potential source of bias, which is discussed in the limitations.

4. Results and Discussion

4.1. The PR Capacity Gap: Strong Institutional Transparency, Limited Frontline Competence

Table 2 presents the mean scores for the six dimensions among the 306 surveyed officials. Transparency and accountability received the highest mean

(4.04/5), while individual communication capacity received the lowest (3.48/5) with the greatest dispersion (SD = 0.87). The 0.56-point difference reflects a structural imbalance between communication provisions operating at the institutional level and the competence of the officials who deliver them.

Table 2. Scale reliability and mean scores for six capacity dimensions (N = 306)

Capacity dimension	Items	Cronbach's α	Mean	SD	Rank
Transparency and accountability	10	.971	4.04	0.79	1
Spokesperson and press relations	10	.917	3.86	0.68	2
Coordination and governance	10	.958	3.74	0.78	3
Digital communication capacity	10	.949	3.72	0.80	4
Feedback and dialogue	10	.895	3.67	0.67	5
Individual communication capacity	10	.951	3.48	0.87	6

Source: Author's analysis of survey data

Read against the framework, the pattern is theoretically interpretable. The two requirements derived from the two-way symmetrical model split sharply: transparency, which can be delivered by regulation and by central publication, ranks first; feedback and dialogue, which requires an interlocutor at the point of contact with citizens, ranks fifth. The CERC requirements that can be centralised -a designated spokesperson and coordinated messaging -rank second and third. The requirement that cannot be centralised, individual competence, ranks last. In other words, Vietnam's health communication system satisfies those theoretical requirements that an institution can meet by rule, and falls short on those that depend on the capability of the individual official.

Independent-samples t-tests comparing officials at management levels (central and provincial, n = 155) with those at the service-delivery level (n = 151) confirm that the deficit is concentrated at the point of contact with the public (Table 3). The largest gap is in editing messages for specific audiences (0.60 points, $p < .001$), followed by confidence in speaking and dialogue (0.56, $p < .001$). Notably, the two groups do not differ in keeping professional knowledge up to date ($p = .113$), indicating a deficit in communication skill rather than in subject-matter knowledge.

Table 3. Differences in individual communication capacity by administrative level

Item (individual communication capacity)	Management (n = 155)	Grassroots (n = 151)	Difference	Sig.
Editing messages for specific audiences	3.79	3.19	0.60	< .001

Item (individual communication capacity)	Management (n = 155)	Grassroots (n = 151)	Difference	Sig.
Confidence in speaking and dialogue with the public	3.54	2.98	0.56	< .001
Writing and presenting to an audience	3.74	3.26	0.48	< .001
Individual capacity is effectively utilised	3.77	3.31	0.46	< .001
Handling public reactions quickly	3.57	3.15	0.43	.000
Keeping professional knowledge up to date	3.94	3.76	0.18	.113 (n.s.)

Source: Author's analysis of survey data

4.2. Two determinants: administrative level and PR training

The multiple regression model shows that the two factors with the clearest association with individual PR capacity are administrative level and the frequency of specialised PR training. Full results are reported in Table 4. The model is statistically significant, $R^2 = .080$, adjusted $R^2 = .074$, $F(2, 303) = 13.19$, $p < .001$, Durbin–Watson = 1.83. Working at the service-delivery level is associated with a reduction of 0.333 points in individual capacity ($\beta = -0.192$, $p = .001$), while each step up in training frequency is associated with an increase of 0.205 points ($\beta = 0.182$, $p = .001$).

The explanatory power of the model is modest: the two predictors account for 8% of the variance, which means that most of the variation in self-assessed capacity is attributable to factors not measured here, such as budget, delegated authority, or workload. The model therefore identifies two actionable levers; it does not provide a complete account of what determines PR capacity.

Table 4. Multiple regression predicting individual communication capacity (N = 306)

Predictor	B	SE	β	t	Sig.
(Constant)	3.250	0.144	—	22.506	< .001
Grassroots level (vs management)	−0.333	0.096	−0.192	−3.455	.001
Frequency of PR training	0.205	0.063	0.182	3.274	.001

Source: Author's analysis of survey data

One-way analysis of variance indicates that specialised training is associated with individual capacity (M = 3.29 for untrained, 3.46 for occasionally trained, 3.76 for regularly trained; $F(2, 303) = 7.18$, $p = .001$) but not with the regulation-based dimensions of coordination and governance ($p = .630$) or transparency and accountability ($p = .840$), nor with spokesperson capacity ($p = .947$), digital capacity ($p = .699$) or feedback and dialogue ($p = .372$). The implication is that training

changes what individuals can do, whereas the institutional dimensions are determined by rules and resources and are unaffected by training. Because the design is cross-sectional, this association cannot be interpreted causally; officials who are more confident communicators may also be those selected for training.

4.3. Gender Differences in Communication Confidence

Women accounted for 64.4% of the survey sample, consistent with the workforce composition of service-delivery health units. A t-test shows a significant raw difference in overall individual capacity between men (M = 3.65) and women (M = 3.39), t(304) = 2.50, p = .013. However, men are unevenly distributed across levels, accounting for 51.7% of provincial respondents but only 25.2% of service-delivery respondents, so the raw difference may reflect position rather than gender.

Following the reviewer's recommendation, the difference was re-tested with administrative level and training frequency entered as controls. The gender coefficient for overall individual capacity becomes non-significant (B = 0.149, p = .145): the apparent gender gap in general capacity is largely an artefact of where men and women work. The single item measuring confidence in speaking and dialogue with the public behaves differently: here the gender coefficient remains significant after controls (B = 0.475, p < .001; Table 5), as do level and training. The two groups do not differ in keeping professional knowledge up to date (p = .902).

Table 5. Regression predicting confidence in public speaking, with controls (N = 304)

Predictor	B	SE	β	t	Sig.
(Constant)	2.833	0.189	—	14.970	< .001
Male	0.475	0.131	0.202	3.638	< .001
Grassroots level	−0.412	0.125	−0.182	−3.281	.001
Frequency of PR training	0.240	0.080	0.166	2.999	.003

Source: Author's analysis of survey data

The revised finding is therefore narrower but better founded than the original: there is no general gender gap in PR capacity once position is accounted for, but there is a specific and robust gap in confidence in speaking publicly. Read through the two-way symmetrical model, this matters because dialogue with citizens is performed overwhelmingly by women at the service-delivery level, that is, by the group reporting the least confidence in precisely the act their role requires. The finding concerns self-reported confidence and cannot distinguish between differences in confidence, differences in opportunity to speak, and differences in socialisation around public speech.

4.4. Practitioners' Accounts of the Capacity Gap

The interview data offer a consistent explanation for the quantitative pattern, and converge on three mechanisms.

The first is the loss of dedicated communication staff. Following administrative restructuring, provincial Health Communication and Education Centres were merged into Centres for Disease Control, and communication duties were absorbed

by clinical and preventive-medicine staff. A provincial CDC officer reported that communication personnel are now largely working on a part-time basis, with few dedicated staff, which affects the depth and sustainability of the work (I-05, male, provincial CDC). A second provincial respondent noted that officers responsible for communication are frequently reassigned, so the work is repeatedly interrupted, and that available funding is insufficient to produce high-quality multimedia material (I-04, female, provincial CDC).

The second is a mismatch between professional background and communication tasks. A senior official in the animal health sector described a workforce composed entirely of veterinary specialists with no systematic training in communication skills, and no staff able to use professional design software (I-12, male, senior official, animal health agency). The same respondent described the absence of joint messaging on zoonotic risk: each sector communicates according to its own assessment, so that the health sector may communicate intensively about a risk the animal health sector judges to be low -a direct failure of the CERC requirement of message consistency.

The third is the absence of listening infrastructure. An officer at the Ministry's own information portal confirmed that automated analytics and social listening tools are not in use for monitoring public opinion (I-02, male, ministry information portal), while a provincial respondent described monitoring social media manually each day in the absence of any formal mechanism (I-04, female, provincial CDC). A respondent from a government portal warned that AI-generated content now outpaces the verification capacity of many agencies, particularly at local level (I-10, female, government portal). This evidence explains why feedback and dialogue ranks fifth despite high scores on transparency: the system is equipped to speak but not to listen, which leaves the symmetrical model only half realised. The consequence is well documented in the Vietnamese setting: where official agencies are slow to supply clear and reliable information, misinformation immediately fills the vacuum that the public is seeking to have filled [18].

A counter-case is instructive. A tertiary hospital respondent described a programme of 53 online consultation sessions with specialists and a weekly podcast series, reporting that direct dialogue between clinicians and the public reduced anxiety and strengthened trust in policy (I-06, male, tertiary hospital). Where dedicated capacity and budget exist, symmetrical practice is achievable; the constraint is resourcing, not willingness.

5. Implications for Strengthening Government PR Capacity

Taken together, the findings point in the same direction: the priority is not to produce more information, but to strengthen the capacity of those who deliver it. Three implications follow, each tied to a specific finding.

First, the health communication network should be consolidated in line with the two-tier local government model in operation since 1 July 2025. With the district tier no longer in place, dedicated communication focal points should be designated at provincial Centres for Disease Control and at commune health stations, matching the three levels actually observed in this study. This responds to the finding that the

capacity deficit is concentrated at the service-delivery level (Table 3) and to interview evidence that the dissolution of dedicated units is its proximate cause.

Second, PR training for implementation personnel should be institutionalised as a regular activity. The regression and ANOVA results show that training is associated with individual capacity but not with the institutional dimensions, so training should be targeted at the operational skills where the gap is largest: message editing for specific audiences, public speaking, and handling public reactions. Given the finding in Section 4.3, programmes should explicitly build speaking confidence among service-delivery staff, the majority of whom are women.

Third, the health sector should strengthen information governance in the digital environment. The interview evidence indicates that neither the Ministry's portal nor provincial units currently operate social listening tools. A shared monitoring capability, available to all levels rather than procured unit by unit, would address the listening deficit identified in Section 4.4 and would move the system from multi-platform presence towards evidence-based communication management.

6. Limitations

Four limitations qualify these findings. First, the capacity measures are self-reports and index perceived rather than demonstrated competence; they are not validated against observed performance. Second, while the central and provincial strata were covered by a near-census of mandated units, the selection of service-delivery units was not randomised, so the findings describe the structure of the system rather than supporting probability-based estimates for the national health workforce. Third, Cronbach's alpha exceeds .95 for three of the six scales, indicating item redundancy; shortened scales should be developed and confirmatory factor analysis conducted in future work. Fourth, the cross-sectional design permits no causal inference, and the author's position within the Ministry may have influenced both access and responses. Officials were invited individually rather than sampled at random, so self-selection cannot be excluded; and because administrative level was self-reported, the service-delivery group should be read as implementing units generally rather than commune stations exclusively. Future research should combine self-report with independent assessment of communication outputs and with evidence from the citizens these officials address.

7. Conclusion

This study examined the public relations capacity gap in Vietnam's health policy communication system from the perspective of government public relations. The evidence indicates that institutional provisions -transparency, coordinated messaging and a designated spokesperson regime -are comparatively well established, while the operational capacity of officials at the point of contact with citizens lags behind. Message editing, public speaking and public dialogue received the lowest scores and are associated with administrative level and access to PR training. Once position is controlled, the gender difference in general capacity disappears, but a specific gap in speaking confidence remains.

Framed theoretically, the system meets those requirements of the two-way symmetrical and CERC models that can be satisfied by regulation, and falls short on those that depend on individual competence and on the capacity to listen. The

experience of COVID-19 and the continuing attention to Influenza A/H5N1 indicate that health communication shapes the extent to which the public accepts and follows epidemiological measures. The concept of the infodemic, set out in the World Health Organization's 2020 guidance [19] and developed by Eysenbach [12], underlines that misinformation can spread as rapidly as the disease itself, making communication governance an integral part of public health response. Investment in the operational PR capacity of service-delivery personnel is therefore not peripheral to epidemic preparedness but constitutive of it.

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