Factors Influencing Client Experience with a Community-Based Intervention for Adult Depression in Vietnam

by

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Bachelor of Arts (Psychology), University of British Columbia, 2016

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Science

in the
Master of Science Program
Faculty of Health Sciences

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SIMON FRASER UNIVERSITY
Summer 2023

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Abstract

This thesis identifies key factors influencing client experiences and participation with a community-based self-supported management (SSM) intervention for adult depression in Vietnam. Using qualitative methods, an in-depth understanding of client feedback on the intervention was gained, key factors that influence patient experience(s) with the intervention were identified. and the ways in which client feedback can be incorporated and implemented in subsequent iterations of the intervention was determined. Clients highlighted the key factors contributing to the success of the intervention. While equipping them with the skills and knowledge to address their depression, satisfaction was enhanced by social collaborators who excelled at establishing meaningful relationships. Future adaptations should carefully consider the critical role of relationship-building and trust formation, which may be impeded by a transition to online delivery. Moving forward, interventions should encompass a holistic approach that addresses the broader context in order to promote lasting positive outcomes for clients.

Keywords: patient experience; task shifting; depression in Vietnam; low- and middle-income countries

Acknowledgements

I would like to express my deepest gratitude to all those who have supported and guided me throughout my journey in completing this master's thesis. Their unwavering encouragement, expertise, and assistance have been invaluable in shaping this research project.

First and foremost, I am profoundly grateful to my thesis advisor, Dr. John O'Neil, for his exceptional guidance, wisdom, and patience. His expertise in the field, insightful feedback, and constant encouragement have been instrumental in refining my research questions, improving my methodology, and shaping the overall direction of this thesis. I am truly indebted to Dr. O'Neil for his unwavering support. I would like to extend my sincere appreciation to the members of my thesis committee, Dr. William Small and Dr. Vu Cong Nguyen for their valuable insights, constructive feedback, and expert evaluation of my work. Their contributions have played a crucial role in enhancing the quality and depth of this research.

I am deeply grateful to the faculty and staff of Simon Fraser University for providing an academic environment that fostered my intellectual growth and nurtured my passion for knowledge. Their dedication to education and their commitment to excellence have inspired me throughout this journey. I would like to acknowledge the support and amazing work done by the research teams of MAC-FI and IRIS-DSV projects, especially our colleagues at The Institute of Population, Health, and Development (PHAD) who conducted all of the interviews used as part of this thesis work in-person in Vietnam. The entire research teams' discussions, feedback, and camaraderie have been instrumental in shaping my ideas and refining my research approach.

My heartfelt appreciation goes to my partner Andy, my cats Dewey and Rudy, and my extended family for their support, companionship, and encouragement. Their continued patience and understanding have been a source of strength throughout this academic endeavor. Lastly, I want to express my deepest gratitude to all the participants and individuals who generously shared their time, experiences, and knowledge as part of our research team's ongoing work in Vietnam. Without their contributions, this study would

not have been possible, and their willingness to be a part of this project is greatly appreciated. Cảm ơn nhiều lắm!

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List of Acronyms

ASW	Antidepressant Skills Workbook
CBT	Cognitive behavioral therapy
CHW	Community Health Worker
CIHR	Canadian Institutes of Health Research
DSM-V	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
GCC	Grand Challenges Canada
ICD-10	International Classification of Diseases, Tenth Revision
IRIS-DSV	Implementation Research to Improve Scale-Up of Depression Services in Vietnam
LMICs	Low- and middle-income countries
MAC-FI	Mental Health in Adults and Children – Frugal Innovations
MOLISA	Ministry of Labour, Invalids and Social Affairs
PHAD	Institute of Population, Health, and Development
PHQ-9	Patient Health Questionnaire 9
RCT	Randomized control trial
SSM	Self Supported Management
SC	Social Collaborator
SFU	Simon Fraser University

SRQ-20	Self Reporting Questionnaire
WHO	World Health Organization

Introduction

This thesis will describe the barriers and facilitators to a meaningful client experience of a task-shifting self-supported management (SSM) intervention for depression in Vietnam, through semi-structured interviews with clients and providers of the intervention. The aim of this work is to describe and identify the key factors that influence client experience(s) and participation with the SSM intervention. The goals are to develop an in-depth understanding of client feedback on the intervention; to identify the key factors that influence client experience(s) with the intervention; and to explore how client feedback can be incorporated and implemented as part of the scale-up of the intervention.

This thesis is situated within ongoing work evaluating the effectiveness and the scaling-up of an SSM intervention for adult depression in community-based settings in Vietnam. The *Mental Health in Adults and Children – Frugal Innovations* (MAC-FI) study, funded by Grand Challenges Canada (April 2016-March 2019) demonstrated the effectiveness of the SSM intervention in Vietnam through a randomized control trial across 8 provinces. Clients were referred to lay community health workers, known as social collaborators, who guided them using the Antidepressant Skills Workbook (ASW), based on the principles of CBT. SSM is defined by "access to a self-management guide (workbook or website) plus encouragement and coaching by health care provider, family member, or other supporter" (1). The second study, *Implementation Research to Improve Scale-Up of Depression Services in Vietnam* (IRIS-DSV), funded by CIHR (2019-2023) aimed to explore the factors that influence the implementation and scale-up of this intervention across additional provinces in Vietnam. A total of 113 interviews with 40 clients, 41 providers and 32 key stakeholders regarding their experiences with the SSM have been completed to date. Task-shifting interventions are defined as mental health interventions being provided by non-mental health professionals who have received training specific to the interventions being delivered (2). Currently, there are various interchangeable terms for these 'lay health workers' and work detailing their roles in international settings in existing literature, but only one specific to the 'social

collaborator' role unique to Vietnam, and their capacity in the delivery of mental health services (3,4). While there is a large body of literature on task shifting and the role and motivations of its providers, there is little that explores the client experience with these interventions. To align with the overall project's goal of assessing scale-up, client voices and on the acceptability of task-shifting interventions for mental health, and specifically depression, in Vietnam should be explored and prioritized to ensure future adaptation of the intervention is informed by client feedback.

1.1. Mental health in LMICs

The global burden of mental illness is significant, accounting for 32.4% of years lived with disability and 13.0% of disability-adjusted life-years, according to recent research from 2017 (5). Depression, the most common mental illness, affects over 300 million people globally and is a major contributor to the global burden of disease. It increases the risk of suicide and is the top contributor to global disability (6). This problem is particularly pronounced in low- and middle-income countries (LMICs) where 90% of those in need of mental health treatment don't have access to resources (7). To address this, the World Health Organization (WHO) launched the Mental Health Action Plan 2013-2020, in response to the Sustainable Development Goals, with the aim of promoting mental health and well-being for all ages (8,9). Countries facing natural disasters, war and conflict, economic recession, domestic and partner violence, and poverty are particularly affected by mental health issues (10,11). The WHO projects that by 2030, depression will be the leading cause of disability, surpassing cardiovascular disease, traffic accidents, chronic pulmonary disease, and HIV/AIDS (7).

There are also various social and economic factors that contribute to the burden of mental health, including poverty, gender, urbanization, internal migration, and lifestyle changes (12). LMICs often lack the resources to effectively implement mental health policies and programs, making access to mental health care difficult for citizens (13). Those with mental illness in LMICs often face discrimination and may be stigmatized, mistreated or abused, negatively affecting their willingness to seek appropriate care and adhere to treatments (13).

In some LMICs, mental illnesses, such as depression, can be interpreted as "karma" or divine punishment caused by an individual's behavior (13). The stigma faced by people with mental health conditions can also extend to their family members, who may hide the illness from the community, preventing them from seeking support and treatment for their loved one. People recovering from mental illness can also face discrimination from the community, which can cause relapse (14). Shame and fear often prevent people with mental health conditions from discussing their experiences, hindering their recovery and limiting their access to mental health services. This increases the risk of depression, anxiety, and even suicidal thoughts (13).

The shortage of funding for mental health care is a major issue in LMICs where less than 50% of mental conditions are treated and the majority of countries do not have a dedicated budget for mental health (13). The limited mental health expenditure in LMICs is often inadequate for the type of care and treatment needed, and the reliance on donor agencies and out-of-pocket payments for healthcare finance makes it difficult to estimate total expenditure. This lack of funding exacerbates the already inadequate health systems in LMICs and creates a heavy burden on those suffering from mental illness, who often present late to mental health services with more serious conditions. As a result, they will require more intensive and expensive hospital-based treatments, which are already in short supply due to the shortage of mental health care providers (13).

1.2. Prevalence of depression and the burden of illness in Vietnam

With 92 million inhabitants, Vietnam is the 14th most populous country globally (4). With a per capita GDP of $1,596, it is classified as a low- to middle-income country (5). Vietnam has seen significant progress in improving the economic and social well-being of its people, with the World Bank praising its "spectacular success" in poverty reduction and economic growth over the past 15 years (5). However, as the government prioritized infrastructure projects most directly connected to economic development during the country's shift to an industrial economy, social services and healthcare – including mental health –received limited investment (6, 7). Despite overall economic growth, access to healthcare has become increasingly difficult as the population grows

and demand for services increases, with some parts of the system being privatized and receiving less government subsidies (8).

Similar to other LMICs, Vietnam is experiencing a significant shortage in mental health professionals: a study examining the prevalence of psychiatrists, nurses and psychosocial care providers (which includes psychologists and social workers) in 144 LMICs showed that Vietnam had the largest shortage of psychiatrists and psychosocial care providers, with 1.70 psychiatrists and 11.52 psychosocial care providers per 100,000 of the population (15). Vuong (2011) found there were 2.1 mental health nurses per 100,000, compared to 81.9 per 100,000 across all healthcare fields (16). A separate study found the rate of mental health professionals in the population to be 0.63 psychiatrists, 0.3 psychiatric nurses, and 0.06 psychologists per 100,000 – among the lowest in Southeast Asia (17).

A national epidemiological survey of 10 common mental disorders conducted between 2001–2003 found that the 10 disorders combined had a prevalence of approximately 14.9% of the population; from this result, it is estimated that approximate 12 million people require mental health services. Depression is the second most prevalent of the 10 disorders, affecting an estimated 2.8% of the population (16).

A nationwide study surveying 14–25 year-olds in Vietnam in 2005 showed that "32% of them experienced sad feelings about their life in general, 25% felt so sad or helpless that they could no longer engage in their normal activities and found it difficult to function, and 21% felt disappointed about their future, 0.5% reported to have made a suicide attempt and 2.8% tried to deliberately injure or harm themselves" (16). A 2010 survey of 4,981 Vietnamese adults using a self-reporting questionnaire (SRQ-20) found 19.2% of the sample to be probable sufferers of mental health disorders, with females having a higher prevalence than men (18).

1.3. Mental health care in Vietnam

Mental health policy was identified as one of the main targets of the National Health Target Program since 1998, with the goal of improving mental health systems by "increasing and strengthening community-based mental health care" (19). Since 2002, depression has been included in the national initiative for non-communicable disease prevention and control for the period 2002–2010, aiming at reducing depressive clients, and suicides related to or stemming from depression (20).

Mental health services in Vietnam are provided as part of a four-tier system according to the administrative tiers of government: at the central, provincial, district and commune levels[1]. The primary point of entry into the system of care often is initiated at the commune health station (18,21). Except for upper- and upper middle–class individuals in the two major cities (Ho Chi Minh City and Hanoi), access to mental health services is provided through a network of 27 provincial psychiatric hospitals distributed across the 64 provinces or through mental health departments in district-level general hospitals (22). These facilities focus mainly on schizophrenia, bipolar disorder, and epilepsy but not depression. Although epilepsy is a neurological disorder, it is often (as is the case in Vietnam) treated in mental health care settings by psychiatrists, as clients with epilepsy often have considerable psychiatric comorbidity, and require training, planning of services and treatment similar to clients with mental health disorders (23). Vuong (2011) reported that "depression care in primary care was essentially nonexistent and available older generation medications (e.g., tricyclics) were the primary treatment option for depression" (16).

Treatment through formal mental health systems in Vietnam utilizes the DSM-V and the ICD-10 as the basis for diagnosis and medication, much like Western settings. However, unlike in Western mental health systems, the Vietnamese system focuses largely on "severe, visible mental health issues such as schizophrenia, while issues like depression are often marginalized" (21).

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[1] Each commune represents approximately 10,000 individuals.

Several determinants play a crucial role in shaping mental health in Vietnam. Despite the lack of research specifically addressing these determinants, many of the factors contributing to mental health disorders in other populations are present in Vietnam. Wars and violent conflicts, which the country has experienced multiple times, can have direct and indirect impacts on mental health and healthy social structures (24). The shift from a planned to a market economy since 1986's *doimoi* reforms has brought significant social changes and increased pressure on families and support systems (24). This has also widened access to health and social services gaps, particularly for marginalized groups and increased drug and alcohol use (16). Studies in other low and middle-income countries show a high burden of mental health disorders during rapid political, economic, and social transitions (25,26). Economic change in Vietnam may also contribute to mental health problems in youth through increased family stress and interference with effective child-rearing practices (27,28). Mental illness and poverty have a cyclical relationship, with better mental health interventions leading to improved economic outcomes (29).

Although the correlation between mental illness, poverty, and lack of employment has not been studied in Vietnam, disability and poverty have been linked (30). Mental illnesses, including disabilities, also negatively affect education, which is a predictor of future economic stability (28). Mental health also affects general health, including non-communicable and communicable diseases, as well as intentional and unintentional injuries (31). Untreated mental illness impacts families, with a link found between maternal common mental disorders and child underweight and illness (32). Disruptive behavior in children can interfere with normal development and predict adult mental health problems like depression and suicide (33,34). Children's problems also affect their parents' mental health and functioning (35,36). The shortage of mental health resources in Vietnam, combined with the burden of mental health issues throughout life, highlights the need for more support. Improving the availability of psychosocial care from non-specialist providers can directly improve care and quality of life, and may have indirect positive socioeconomic outcomes, such as reducing absenteeism and reducing comorbidity. This shows that low-cost interventions like the proposed innovation could have far-reaching, transformative impacts.

1.4. Task-shifting for treatment of depression

The shortage of human resources for health has been identified by the World Health Organization (WHO) as a major constraint in health system delivery (37). Access to mental health care in LMICs has been found to be inadequate (38–41). Many LMIC governments report a lack of mental health care provision (38,40). The impact of mental health needs is expected to increase due to causes such as centralization of services, policy prioritization, stigmatization, cost-cutting, lack of affordable interventions and education for potential mental health professionals (42–45). Barriers to treating individuals with mental illnesses include a shortage of skilled and trained staff, unequal and inadequate resource distribution, limited community awareness of mental health, poverty and social deprivation, and stigma associated with psychiatric illness (46). Task-shifting is defined as moving tasks "to health workers with shorter training and fewer qualifications" from highly qualified health workers (47). Scaling up evidence-based services and task-shifting mental health interventions to non-specialists have been suggested as key strategies for closing the treatment gap (48).

In LMICs, various organizations, including governmental, private, and non-governmental, utilize community health workers (CHWs) in their service delivery, including in clinics, schools, and communities. Nurses, social workers, and CHWs may also take on follow-up or educational/promotional roles (49–51) Lay health workers have been involved in supporting carers, befriending, ensuring adherence, and delivering simple mental health interventions (52,53). John, Powers, and McLachlan (2012) recognized several key benefits of task shifting, such as fostering collaboration, utilizing community resources, and providing ongoing supervision, which influence awareness gains, social bonding, building trust, and developing skills and understanding within the community, resulting in intervention buy-in, overall effectiveness, sustainability, improvement of mental health symptoms, and local empowerment (54). Strong therapeutic relationships and trust between providers and clients have been found to enhance self-esteem and mood (55). The skills of openness, communication, and a nonjudgmental attitude, consistent with the humanistic approach to psychological

healing, along with the core concepts of psychological intervention identified by Rogers (1959), based in understanding, empathy, and congruence, are key to this approach; humanistic theory, often the foundation for many psychological models used by highly trained professionals, can also serve as a solid base for nonprofessional interventionists (54,56)

There are also several challenges to task-shifting interventions, including the costs and sustainability of continued implementation and scale-up to larger populations (54). Some instances of task shifting interventions that were unsuccessful attributed insufficient training, or lack of local buy-in. In other cases, subjects found gaining awareness and understanding of mental health was a factor contributing to decreased isolation and self-blame (50,54,57–61). Through our research team's ongoing work on the SSM intervention, we can attest to similar challenges being identified through our own experiences, as well as similar sentiments shared by CHWs and other project stakeholders through interviews. Further reflections on the benefits and challenges of task-shifting will be explored in subsequent chapters.

Chapter 2. Methods

2.1. Previous work

Dating back to 2009, our research team has an extensive history of collaborating with the Vietnamese government to provide technical advice in the mental healthcare and social sectors, which have led to influence on mental health policy through the National directives (Project 1215, Project 32). Our initial intervention project "The "*Feasibility Study in Preparation for Randomized Trial of Enhanced Primary Mental Health Care Implementation*" (CIHR December 2016-November 2018) demonstrated very promising results and proof of concept for the proposed full-scale intervention to train primary health care workers in Vietnam to screen and deliver an intervention to reduce adult depression. The feasibility study demonstrated that training health workers to screen for depression and offer a SSM intervention in primary care is a highly feasible, acceptable, and an appropriate 'frugal innovation' that fills a critical gap in mental health services in Vietnam. The feasibility study indicated success in regard to the study design, the ability to recruit participants, the acceptability of the study to healthcare professionals and clients and the ability to measure outcomes. The study demonstrated the feasibility of engaging with local stakeholders and obtaining buy-in from all levels of government and with healthcare workers in the community health centers.

***Mental Health in Adults and Children – Frugal Innovations* (MAC-FI) and *Implementation Research to Improve Scale-Up of Depression Services in Vietnam* (IRIS-DSV)**

The MAC-FI project (GCC April 2016-March 2019) was a randomized controlled trial (RCT) that demonstrated the effectiveness of a SSM intervention where people are provided an "Skills Workbook" and supported by local community-based social collaborators and social workers from the Ministry of Labour, Invalids and Social Affairs (MOLISA). The research team demonstrated in an RCT that an in-person SSM intervention was effective in reducing depression symptoms (62,63).

The RCT used a cluster-randomized modified stepped wedge trial design and included 376 adults in 32 communes in eight provinces across Vietnam. Eligible participants scored > 7 on the SRQ-20 depression scale. The SRQ-20 (Self-Reporting Questionnaire-20) is primarily used as a screening tool for mental health disorders. It was developed by the World Health Organization (WHO) as a brief instrument to identify individuals who may be experiencing common mental health problems in community settings, particularly in low-resource settings. The SRQ-20 consists of 20 questions that assess various psychological symptoms and distress. It covers a range of domains such as depressive symptoms, anxiety, somatic complaints, and social dysfunction. Each question is scored dichotomously (yes/no) based on the presence or absence of the symptom. The purpose of the SRQ-20 is to identify individuals who may require further assessment or intervention for mental health concerns, often used as a screening tool by healthcare professionals, community workers, and researchers to quickly identify individuals who may be experiencing significant psychological distress. However, it does not provide a formal diagnosis of specific mental health disorders, instead serving as an initial screening tool to flag individuals who may benefit from further evaluation or referral to a mental health professional for a comprehensive diagnostic assessment.

As part of the SSM intervention, social collaborators provided individual coaching on the use of the ASW in the participants' homes over a two-month period. The number of social collaborators involved varied depending on the size of the commune, with six to ten collaborators per commune. The coaching sessions were scheduled every two weeks, during which the social collaborator discussed the participant's progress, reviewed the concepts covered in the ASW, and assisted in creating a plan for the following two weeks. The control group received enhanced treatment as usual, which included the standard treatment provided in primary care settings along with an adapted leaflet based on the "Understanding Depression" pamphlet by Beyond Blue (www.beyondblue.org). This leaflet provided participants with information about depression, its symptoms, risk factors, and approaches to care. Due to limited resources and low recognition of depression in primary care in Vietnam, the treatment as usual

typically involved minimal or no treatment following screening. Participants in the control group, except those with severe depression or suicidal ideation, were not referred to secondary care at this stage but were free to seek additional services on their own if desired.

At 2 months, 26.4% of the intervention group and 42.3% of the delayed group (control) had SRQ-20 scores > 7. The adjusted odds ratio of having depression between the intervention and control was 0.42 ($p < 0.0001$), 95% CI (0.28, 0.63). Receiving the intervention thus reduces the odds of having depression by 58% after 2 months of treatment (64).As a follow-up to MAC-FI, the *Implementation Research to Improve Scale-Up of Depression Services in Vietnam (IRIS-DSV)* project (CIHR 2019-in progress), is a five-year, qualitative implementation study to address 3 study objectives: 1) Conducting interviews with clients to retrospectively assess the acceptability of the intervention and demand-side barriers and drivers to participation and adherence and with providers to identify barriers and drivers to maintaining fidelity and the need for adaptation; 2) Conducting interviews with community organizations, managers and policy makers to assess the factors impacting scale-up in real time, and; 3) Engaging stakeholders, through meetings, workshops, and targeted communications processes, to provide ongoing evidence to support implementation and scale-up of the intervention. The 81 interviews conducted with clients and providers were analyzed to identify the factors influencing effective scale-up of the SSM. The goal of IRIS-DSV is to provide robust evidence to ensure that the SSM intervention can be successfully implemented and scaled-up so as to achieve maximum public health impact in the long term to allow for scale-up within Vietnam and beyond.

2.2. Current thesis work

This work is based on secondary data analysis of qualitative semi structured interviews conducted from November 2018 to May 2019 in Vietnam with clients and providers of the SSM intervention (which have been transcribed verbatim and translated into English), as part of the IRIS-DSV project. The interviews were conducted using a convenience sample by PHAD team members in Vietnamese and have been translated to

English by either a translation service or PHAD members who did not take part in the interview itself. However, the quality of translation was not ideal, and transcripts have been further corrected by English-speaking members of the research team to ensure legibility.

Interviews with clients (n=40) focused on the acceptability of the intervention, the provider and the materials; and factors influencing participation and adherence. A PHAD team member invited clients to participate in a qualitative interview using the *Patient Recruitment Script* by either telephone or email, based on client preference. Recruitment was done through commune health staff, who generated a list of possible clients – participants were randomly selected from this list. If a client declined to participate, another client was selected using the same method.

All clients were asked questions regarding their experiences with the screening and referral processes. If the client completed the intervention, they were asked about their experiences using the SSM materials, their relationship with the SSM provider, and perceived benefits of participating in the intervention. For clients who did not complete the intervention, they were asked their reasons for non-adherence and cessation. (See Appendix 1: Patient Interview Schedule).

41 providers were also interviewed from among 393 social workers and social collaborators trained to deliver the SSM intervention. The results of these interviews describe the social collaborators roles and functions and have been published elsewhere (4). However, these interviews were also coded for commentary on the client experience and this data was reviewed as well for this thesis.

The interview guide was developed from a first draft led by SFU researchers and finalized by significant contributions from PHAD, focusing on the participant's experiences around the SSM intervention. In most cases, participants were willing to share with interviewers when asked about the situations surrounding and contributing to their mental state. In that vein, interviewers were very consistent in asking participants about their current situation, how they were feeling, prompting about specific client conditions if the interviewer was familiar with the participant. PHAD interviewers took

the lead in asking questions about participant overall wellbeing, self-reported mental health, and family conditions. They often provided suggestions and advised the participants during the interview, such as how to keep up their progress, how further participation in community events would be helpful, and even commiserated with and shared advice about participants' difficult family situations. The interview guides were followed but also a significant number of details about participants' personal lives and circumstances were able to be gathered through the unstructured conversations between interviewer and interviewee. This allowed the development of the client profiles in Chapter 3.

Qualitative descriptive methods and thematic analysis were used to examine the key informant interviews. All interview transcripts were entered into NVivo for coding. A coding framework and corresponding themes were developed deductively, based on the findings from the MAC-FI study and the literature, and through inductive analysis, to identify the contextual barriers to and drivers of the SSM model's sustainability in its real-life cultural and social context. Two team members (HL and LC) independently read, re-read, and coded the translated interview transcripts. Key codes were identified and captured in a coding guide. Through an iterative process involving numerous rounds of discussion and consultation amongst the team members, the codes were identified, categorized, and collapsed into larger themes, which were then discussed and agreed upon by the team. To enhance rigor and trustworthiness, an interrater reliability test was performed, and the coding process was documented in detail.

All procedures were approved by research ethics boards at Simon Fraser University in Vancouver, Canada [#2016s0604 and 2018s0340] and PHAD in Hanoi, Vietnam [2016/PHAD/MAC-FI-AD-01-01 and 2019/PHAD/IRIS-01]. Funding for the MAC-FI study was provided by Grand Challenges Canada and funding for the IRIS study was provided by the Canadian Institutes of Health Research.

2.3. Limitations

Due to travel and research limitations that arose in response to COVID-19, we were unable to conduct follow-up interviews to delve into themes that emerged that that we wanted to explore further. By the time COVID-19 restrictions eased in Vietnam and Canada, the research team determined that too much time had passed since clients had participated in the original MAC-FI intervention and that subsequent follow up interviews following our preliminary analysis of the data would not be possible. During the analysis of the initial client and provider interviews, HL and LC had noticed that even in the original set of interviews, clients often had difficulties recalling their time and experiences with participating in the SSM due to the time that had passed since they had been part of the intervention. Because of this, follow-up interviews may not have provided additional insights from clients if conducted in 2021. Local village health centers and representatives were also inundated by COVID-19 management so that the research team came to the decision that it would not be appropriate to reach out for further support with conducting additional interviews.

Another limitation was the quality of the translation of interview transcripts from Vietnamese to English. There were notable instances of grammatical error in the translations across the interviews. We (HL and LC) mitigated this by reaching out to PHAD team members who are bilingual in Vietnamese and English and asked them for clarification on specific passages of interest, comparing their answers to our own interpretation of the text.

The key themes and findings identified through qualitative analysis are outlined in the following chapter.

Chapter 3. Results

3.1. Client demographics

Of 45 total clients interviewed, 4 clients identified as male and 41 identified as female. One client did not report age. Clients ranged between 24 to 67 years of age. Of those who shared their occupations or were currently working, these included: farmer, teacher, housewife, construction workers, freelance work, amongst others.

3.2. Client profiles

These profiles are constructed from the participant interviews. They are identified using pseudonyms, sex, and their home provinces.

Client A (F, Ben Tre)

Client A has a husband who is illiterate. She has a daughter who is not currently working. Her daughter must help her to read the workbook. She finds it difficult to focus and feels like "she wants to die in crowded places". She used to be able to go to the market but now feels it is too overwhelming. She joined the program to get better, but her husband discouraged her from participating.

Client B (F, Ben Tre)

Client B moved to her current village when she got married at the age of 18. Client B is a caretaker for her husband who is ill and requires the use of a wheelchair. She struggled to balance this with her job at the market selling soy milk. Before attending the interview, she finished selling her wares for the day and dropped off her husband at the hospital, as he had had a stroke 10 days ago. She previously had support and help from her daughter, but since she recently got married, all of the responsibilities have fallen to Client B. She struggles with her vision and can't read the workbook without her glasses. Although she did not remember many aspects of the intervention due to the busy

nature of her life and shared that it was difficult to find time to read it because of her responsibilities, she reported feeling satisfied with the experience and has recommended it to other people in her life experiencing depression.

Client C (F, Thanh Hoa) Client C is a 57-year-old farmer who sells scrap iron, with three children in their teenage years. Her husband works in another province to support the family financially, while Client C looks after their children and the family farm. She finds herself worrying about the future and reported often only sleeping around 2 hours a night. Her children are busy with their studies, so she does not ask them for help when reading the workbook, although she would have appreciated their assistance. After taking part in the SSM program, she gained a better understanding of depression as an illness, and reported that both her quality of sleep, as well as her relationship with her husband, had improved.

Client D (F, Thanh Hoa)

Client D is a recent widow and the breadwinner of her extended family, which includes her children and her elderly cousins. She and her family often face financial struggles, which leads her to continue to work even in her own old age. Despite this, she is proud that her children are able to rely on her. Client D has been living with heart problems for a significant period of time and feels her health is slowly failing. While her feelings of stress and despair are not new, she laments no longer being able to share her struggles with her husband, who was her strongest support. She began participating in the SSM intervention soon after her husband's death and shared with interviewers that she found it very helpful that the workbook taught her about managing her health and disease prevention, and that she particularly enjoyed reading the advice on diet and exercise. While Client D was satisfied with the care by the social collaborators and the content of the intervention, she cannot find hopes for a better future due to her increasingly poor health and worsening financial situation. Client D feels a significant contributor to her difficulties is the lack of support she receives from the government.

Client E (F, Quang Ninh)

48-year-old Client E lost her husband four years ago to a sudden cancer diagnosis; her mother-in-law passed away soon after in the following months. Her son was 2 years old at the time of her husband's passing, and she was suddenly put in the position of needing to become a breadwinner to her ill mother-in-law, her stepchildren and young son. Her stepchildren began to treat her poorly after their father's death, and she found herself unable to tell her mother-in-law that her son had passed, instead telling her he was away for business. Client E still mourns her husband, sharing that she often holds her son and cries. After losing two family members and being left alone with young dependents, she fell into a deep depression and did not feel as if she could continue on. She received support from social collaborators, who reached out to her and continued regular visits to her home following the conclusion of the SSM intervention period. The social collaborators encouraged her to join her local women's union, and she was able to make friends and receive the social support she had been severely lacking. At the time of the interview, she had moved in with her parents, her child was enrolled in kindergarten, and she relied on seasonal work to make ends meet. She receives support from the local ward and district, as well as the Seniors and Buddhist Associations whom she often joined for prayers.

Client F (F, Da Nang)

Client F began working as a tailor to support her two children, ages 5 and 8, following the death of her husband a year ago. He died after struggling with hepatitis for over a year, which was not diagnosed until it was too late. While her husband used to support her at home, she became the primary caregiver of her mother who is partially paralyzed. Her social collaborator had reached out to her, calling her repeatedly and asking her to join the program after hearing of her husband's passing. Client F shared that she enjoyed reading the ASW and found it helpful in guiding her to manage her feelings. However, she found that she barely had any free time at the end of the day after tending to her other responsibilities and wasn't able to use it consistently. At the time of the interview, she was considering joining the Women's Union to build connections in her community and expressed hopes to find a better-paying job so she can comfortably support her family.

Client E (M, Khanh Hoa)

Client E lost his job recently and insisted with interviewers that his depression was a condition of his spirit, directly related to his unemployment. His three children are in university, and he is proud of being able to raise them into reliable adults. Client E told interviewers that due to his age, his vision was poor, and he was frustrated trying to read the workbook for a long period of time. He did not find the instructions of the workbook or the support of the social collaborators to be helpful, instead claiming to have overcome his depression through reminding himself that he had to live up to the responsibilities of being the breadwinner of his family and wanting to see his children continue to be happy.

Client F (M, Thai Nguyen)

Client F is 45 years old and works as a freelancer. His only child is his 4-year-old son, who was born with congenital heart disease and brain complications and has undergone several surgeries. His son also lives with cerebral palsy and his mobility is limited to lying in his bed for most of the day. For years, Client F was unable to quiet his mind of his anxieties and feared he could never be a good enough father. He felt many aspects of the intervention to be helpful to his life, especially when social collaborators came to visit him and give him encouragement and advice. Client F is now attending regular counselling sessions and feels he's made significant progress.

Client H (F, Thai Nguyen)

Upon sitting down to speak with interviewers, 40-year-old Client H shared that she came to the interview without letting anyone know, upon fears that her family and neighbors would not understand her condition. She struggled to understand her adult son, who suddenly stopped working and became withdrawn. During this, Client H experienced stress and depression and cried every night in private while putting on a brave face in front of her community. Client H thinks her son's behavior may be related to his father's death – her husband was killed 6 years ago in a traffic accident. She also worried about her daughter who wanted her support while she filed for divorce from her husband. Both she and her daughter struggle with high blood pressure and experience frequent fainting

episodes that require hospitalization. Client H quietly began to take part in the intervention, attending sessions at the local health center. Since completing the program, she now works as a manager of a restaurant, where she employs her son. She feels grateful to the program and the social collaborators that supported her, and dreams of one day building houses for her children.

Client G (M, Long An)

27-year-old Client G is an inquisitive man who loves to read foreign books and worked as a farmer before his anxiety made it difficult for him to live a functional life. After taking part in the intervention and meeting the social collaborators, Client G was motivated to consult with various physicians and was able to find a psychologist through the internet at a reasonable cost. In addition to his treatment, he also spends his time going to the Buddhist temple, reading scriptures, and watching Buddhist videos online. He was very grateful to the social collaborators and the program itself, believing that it helped him greatly in turning his life around for the better. At the time of the interview, Client G had passed his college exams and began studying psychology.

3.3. Provider Demographics

In total, 47 providers were interviewed. 10 identified as male and 37 identified as female. Their ages range from 37 to 73 years old, discounting 16 individuals who did not provide their age. They identified themselves as social workers, village heads, commune collaborators, district health workers, and other specialties detailed in Appendix 1.

3.4. Provider Profiles

The following are provided as examples of social collaborator profiles where they describe working with clients and share their stories:

Provider A (F, Da Nang)

Provider A is a social collaborator who sees multiple clients in her locality. She shares that many people in her community have complex living situations, including her client H who works cutting banana leaves and is raising 4 children, 2 of which are too young to be in school. Client H is the primary caretaker for her husband who lives with untreated mental illness and depressive episodes, of which the latest led him to be sedated and transported to hospital. Client H did not have any time to read the workbook in her own time, so Provider A would visit her frequently to provide encouragement and advice. While she finds the workbook to contain helpful material, Provider A believes that meeting with a client and having a conversation in person is more effective than leaving them with a workbook to read in their own free time.

Provider B (M, Ben Tre)

Provider B shared a story of one of his cases where he was dispatched to treat a woman with depression. When she was initially approached about the program, she was alert, happy and interested in participating. After a period, her condition deteriorated and Provider B visited her home to speak with her husband and daughter. While her husband was supportive of her continuing to receive treatment, he confided in Provider B that he hadn't been able to sleep for days, now having to care for his wife and 18-year-old daughter. Their daughter used to take on caregiving duties for her mother but recently started behaving more rebelliously. His wife had previously run out of the house in the middle of the night, forgotten where she was and was subsequently hospitalized. The husband reported he could not stop working, but often had to take time off from work to care for both his wife and daughter, putting the family further and further into debt. Provider B showed concern for the husband, noting that the stress would soon likely affect his health as well.

Provider C (M, Long An)

Provider C described his encounter with a client from their initial meeting throughout their time together. His client had previously been evaluated at the local commune health center and been assigned to Provider C. The client worked as a farmer to support his wife

and 2 children. His wife and son were ill, and his daughter acted as her caretaker, while also looking after him and her sibling and taking on all of the household duties. The client expressed great stress and anxieties around his farmwork, his children, and their health, which kept him up most nights. Provider C approached the daughter to ask if she had been reading the workbook to her father, to which she replied she was too busy looking after the rest of her family to find time. Because the client had poor vision, he was unable to read the workbook himself and relied on his daughter to guide him through the intervention.

Provider D and Provider E (both M, Quang Ninh)

Provider D and Provider E both works as social collaborators in Quang Ninh and were interviewed together. They shared some of the common contributors toward depression they noticed within their communities. Such contributors included: the loss of relatives, concurrent health conditions (such as heart problems or diabetes), domestic abuse, loss of jobs and income, and bankruptcy. Provider D identified family disputes over land and property as a common issue, which have become more regular occurrences in his community in the latest years. Provider E noted that new mothers who had recently given birth often presented as the severest cases in his community, and one of the high-risk groups he keeps an eye out for.

3.5. Key Themes

Overall, clients generally reported positive experiences with the SSM intervention as delivered by the social collaborators.

> **Q: Why did you decide to join the program?**
>
> A: [To] reduce [my] stress, and the stress on family, work, and job as participating in the program. I participate in this program, I feel relaxed. For depressed clients like me, I feel it is good. It teaches me how to relax and get out of depression. Very good.
>
> **Client I, Ben Tre**

In the following sections, key themes identified throughout the client and provider interviews will be explored in detail.

3.5.1. Benefits

Client-provider relationship building

Clients largely reported they were able to build social rapport with their providers. Most of the feedback through client interviews was focused on the providers, rather than the intervention itself. Access to health care and social support are both necessary according to the WHO. As such, it makes sense to provide an intervention such as the SSM through providers who can provide regular social interactions with clients, in addition to providing guidance through the self-led evidence-based intervention. A strong provider was identified by clients as someone who takes the time to get to know the client, their families, their communities as well as their living conditions and life circumstances. Due to the nature of the client-provider relationship and the fact that individuals with depression can be hesitant to socialize, it is up to the providers to take the lead in establishing a positive initial interaction and a relationship through friendliness and openness. Ideal traits of providers include enthusiasm, motivation, and strong interpersonal skills.

> At first, I was bothered [and] did not want to talk… I wanted to avoid [the provider], but seeing her [visit] many times, she was patient. If she [visits] in the early morning but [I am unavailable], she will come late at night. After [seeing] that, I began to talk with her. **(Client J, Quang Nam)**

Another important quality is persistence, especially through initial rejections by clients. One key theme that outlined successful client-provider relationships was the importance of providers having consistency and building trust with clients over time.

> I have to dedicate [time] and be subtle when visiting a client… [especially] if you meet their family. You could make some [jokes] or have lunch with them. And then when their family [goes] out, [leaving] you and [the client], you could start to talk to them. They will be more open and won't be embarrassed. **(Provider F, Quang Nam)**

Providers shared how it was often difficult and required multiple approaches before clients agreed to participate in the interventions. After gaining trust and becoming more familiar with the providers, clients were able to slowly open up more and confide in them. This is completely different from the traditional hospital model, which is meant to be a short-term solution to only the most serious of cases of depression and psychiatric conditions where there is no relationship building involved between healthcare providers and clients and all the focus is on treating the physiological condition. The organic relationship building between clients and providers is a benefit of the model used for the SSM. However, our findings also showed that a successful intervention requires a significant amount of effort from providers, who were often not compensated for the extra time and labor spent in reaching out to clients, which raises concerns around the sustainability of this model.

Family, community, and connections

Clients and providers identified strong collaborators as being members of the communities in which they work. Because they live amongst the community and often hold existing jobs as commune health workers and/or community representatives, they have existing relationships with the clients of the SSM. They may have a history of previously working with them as part of other local health initiatives and may be on friendly terms, or at least familiar with the client and their life circumstances. This is also sustainable because the providers have less of a distance to travel (identified as a key challenge, described further below). Providers working in their home communities have the benefit of existing connections, so they are not building trust from the ground up.

> Q: [Did] you already know these [social] collaborators?
>
> A: [Yes, because we are] from the same village and hamlet, we know each other.
>
> **Client K, Khanh Hoa**

> Q: The first time you met them, did they come to you or [the] clinic?

A: I came to their house, not only because I'm the [social] collaborator, but also because I'm the head of the village, so I understand and know all the [family] situations in the village. So [if anyone] needs to talk to [me], I will [go] to their house to meet them and talk.

Provider G, Da Nang

Beyond introducing and guiding the client through the SSM intervention, often providers spend their home visits conversing and getting to know the client. Several providers discussed the importance of approaching a client with sensitivity so to avoid embarrassment and rejection from the client's side.

Q: When you approached the client at first, did you find any difficulties and advantages?

A: There are some difficulties. Although I [visited] many times, they are afraid, do not talk [to me or] speak directly on their problem. I also try to ask [about] their health and family. I support them but not directly speak to the problem [of depression]. If [my initial] approach is not done correctly, they will resist, and it will be difficult for me to work with them.

Provider H, Ben Tre

Q: How do you improve the [client-provider] relationship?

A: Usually, I make acquaintance with them, and [share] a little bit about myself. Then I [discuss] social matters I read in the newspapers. Gradually they will [become] friendly with me and tell their stories. Sometimes they talk and cry. I [give] advice and then find [solutions], inviting them to join in the women's union meetings… they [become] friendly with me.

Provider I, Ben Tre

Q: Do you feel [clients were] satisfied with the program? If possible, we want to expand the program to other areas.

A: While going to visit clients [at their homes], I keep regular company with and encourage them to open up about [their concerns]. After that, I mobilize, encourage, [and] sympathize with their sadness and then slowly calm them down, so they gradually no longer worry or feel melancholy. When I do [my] job by slowly [and gently] advising them, the conversation progresses well.

Provider J, Ben Tre

The recommendations and suggestions of the social collaborators also extend beyond workbook activities. Providers encouraged clients to engage with groups and activities in the community such as the local Women's Union. In addition to guiding clients to build local connections, providers also spent time with clients on a social level outside of official SSM related visits.

> Q: What characteristics and advantages do you think this program have, and what do you think this program need to improve?
>
> A: The [SSM] program gave us a chance for us to gather and discuss. [The providers] visit and talk with us, showing the ways to relax. It is so fun. She came to me and gave me advice every time I cried. She helped me all the time, [even when] I thought it was too hard for me to bring up my children and also have to handle negative thinking. I [feel] better because of them.
>
> **Client L, Da Nang**

> Q: Did he guide you to do activities?
>
> A: Before, I did not do anything, [only] staying at home whenever I was sick. But I joined the Inter-Generation Club, so [now] I go to gymnastics every afternoon and then cook in the evening.
>
> **Client N, Thanh Hoa**

> It is more fun to join [local] activities. Because in the past, I worked [providing] social activities for the Youth [and] Women's Unions. When I fell down, everyone encouraged me to stand up. **(Client M, Quang Ninh)**

Advice and guidance shared by the providers are carefully tailored to the client and their personal needs. This includes socializing, goal setting and employment support.

> Q: So why do you want to continue [with the intervention] after feeling [initial] hesitation?
>
> A: Some days later, I thought I should participate, and I went for coffee with [Provider], then did some exercise in [the] morning.
>
> Q: [Provider] supported you in using this book… when she explained how did you feel?

A: She did not instruct too much, just told me [to] sing karaoke, exercise, drink coffee and play football [with friends].

Client O, Quang Nam

At first, [I visited] every 15 days… At first, I talked to them when we were exercising, then I went to their home and introduced the [workbook]. [Then] I met them every 2 or 3 days and slowly created a good relationship with them. **(Provider P, Da Nang)**

There were instances where providers shared using their existing connections to help their clients, as in this case where a social collaborator helped a client find employment:

Q: Is there any livelihood support here?

A: There is little support, especially [for] poor households.

Q: Do social collaborators also help people find jobs?

A: [One] social collaborator is in a group who makes fishing-nets and gave [a client] a job.

Provider K, Da Nang

Providers guided clients beyond using the workbook and participation in the SSM to help them gain employment, build connections, and sometimes even become friends with clients, meeting up with them for social activities outside of their designated duties as a provider of the intervention.

There are families with sick family members, money problems or [other] troubles that lead to negative social [outcomes]. I also [identify families] that are losing money, or [getting] a divorce, which leads to depression so I [reach out and] support them. **(Provider L, Quang Nam)**

The first time I [visited], they cried very much [and] I supported them. That is my pleasure [to do so]. I contacted a person who had a stroke. She fell into depression but didn't want contact anyone, because of feeling inferior. There are also the [elderly] or those who have lost marriages, or those who are stuck in debt. But [in talking to them], they are gradually relieved, and feel less discouraged. I approach and confide with such [people] – when they see me, they are very happy because there is no one else to talk to. **(Provider N, Ben Tre)**

3.5.2. Challenges

Avoidance

Though all clients who were enrolled in the MAC-FI study had initially provided consent to participate, not all were receptive of engaging with the SSM and providers once it was underway. Some clients actively ignored or avoided the providers when they received visits, and some were dismissive and did not want to participate once approached by providers. Despite this, several providers confided that some clients just needed persistent engagement for them to open up.

> Q: When you first contact the client, are there any advantages or disadvantages [as a social collaborator]?
>
> A: Many [households] are welcoming… I talk to them about this program [and] they try to understand and [are] supportive, but there are many houses that [don't] understand so they get annoyed.
>
> Q: So, they get annoyed even when you ask them questions?
>
> A: Yes.
>
> **Provider P, Quang Nam**

> Q: Do you find it difficult to approach clients? Do you find [that the] client has hesitation or… doesn't want to join the program?
>
> A: It's nothing but hesitation. [I attempt to visit] only a few times, but too many people don't have time to receive me. I'm also shy.
>
> **Provider O, Long An**

Providers also shared that one of the strategies they used to gain the trust of clients is first gaining the support of family members. While some families did not want to engage with social collaborators due to stigma, many were happy to welcome the social collaborators, encouraging their family member with depression to participate:

> Q: What difficulties did you experience during the process of project implementation?

A: For example, [clients] avoid me… they do not want to see and talk with anyone at first, so I have to encourage their family, then [I will] gradually contact them. It is difficult to see [the client] immediately.

Provider Q, Quang Ninh

Q: What could you do when you [encountered] a difficult case?

A: I encouraged clients and clients' families.

Q: What can we do to increase their awareness of depression?

A: If their [condition is serious], they need help from their family members… When we guided them, we told them that there are many activities [they can try and] have fun. If they were too sad, we showed them how to [develop routines], for example: wake up [early], clean the house and do physical exercise [every day]. I would recommend 30 minutes for exercise, but if that's not possible we can [aim for] 20 minutes. Often, they didn't want to, so we have to create motivation… their family members have to join them to let them get used to these activities.

Provider R, Da Nang

Clients' responsibilities

One of the main challenges that providers identified was how difficult it was to find the right time to engage with clients. Both clients and providers expressed that many clients were busy with work, supporting their families and children, as well as meeting basic needs (of which failure to do so was often identified as contributing to their depression).

Q: Do you remember any skills [from the workbook]?

A: It has been a long time, and I'm also too busy with my job at the market.

Q: You have to look [after] your husband, and sell soy milk at the same time?

A: Yes, I have to do it all by myself. My daughter got married.

Client O, Ben Tre

This posed a challenge to both the clients and providers, as providers expressed struggling because they needed to work around client schedules in order to find them at an opportune time. Sometimes providers had to visit a client multiple times before they were available to engage with them, and providers were not compensated for additional transportation costs.

Q: After you show them the [workbook], how many times did you visit them?

A: Based on the client their schedule, also their work [hours] and mine, I have to make it work for both of us…

Q: So, is it hard for you to [go] to each person's houses like that?

A: Yes… I have to choose a time that would work for both of us.

Provider S, Da Nang

Clients' existing conditions

Many clients shared how they live with concurrent medical conditions, often physical, in addition to suffering from depression. These conditions ranged from ones that caused significant long-term pain and mobility issues, to ones that could be remediated but were left untreated, such as poor eyesight leading to clients being unable to read the workbook. Often this left clients dependent on help from providers and their family members in order to participate in the intervention.

Q: Did the [social] collaborator tell you to make [notes] about what you did daily? Like how many times you go outside?

A: Yes, I did wake up early and do some exercise, but then my legs hurt so I went home.

Q: So, you went home?

A: I couldn't go because of my leg.

Client P, Da Nang

Q: Were you forgetful before?

A: I am forgetful… I often have headaches, so I don't remember much. Sometimes when talking to my children, I cannot hear anything if they speak in a low voice.

Client Q, Thanh Hoa

Q: Can you read this book yourself?

A: No.

Q: Can your daughter read it [for you]?

A: Recently, she [hasn't].

Q: Is she busy?

A: Yes.

Q: Did your husband read it [for] you?

A: No, he is illiterate.

Client R, Ben Tre

Stigma and lack of acceptance

Stigma was identified by both clients and providers as a barrier to participation in the SSM intervention, although it was more frequently brought up by providers. Providers shared how clients dropped out of the intervention or were hesitant to open up to them because of the negative associations around depression.

Q: What has been [your] experience of this province? Is it… difficult to recruit clients?

A: In this [locality], when we find a client, that client is assigned a [social] collaborator. [Social collaborators] consult with the client following the PHQ-9 assessment, but that client [does not] want to accept that she has depression because she is scared that people around her [will] know about her [disease]. For example, a client… dropped out the program because she [didn't] want to share that she has depression.

Provider T, Ben Tre

Q: What do you think about the people who don't accept [their diagnosis]?

A: They think they are healthy. When I asked them [about their depression], they said they are absolutely healthy, that nothing is difficult [for] them, and [it was] unnecessary to take the intervention. I think their struggle is economic [in nature], but they don't understand my [perspective], and don't like to share [their] problems with me. I'm a health medicine staff in the hamlet, but I don't belong to a lot of community programs. This program also has no economic support, so when I talked about [finances] , people do not like [this and] do not contact me.

Provider U, Ben Tre

Q: And with regards to the difficulties and clients avoiding you: at first, they'd already agreed to meet, but why [might] they avoid seeing you?

A: From my point of view, maybe they were afraid of being interviewed. Many clients might think that I would [schedule an] interview with them to swear at them because they are crazy…

Provider V, Da Nang

Some of these negative effects could be mitigated by building trust over time (as outlined in previous sections), and "softening" the language around the initial approach.

Q: [Is there anything] clients don't understand when they first learn about depression? How do they react?

A: They just think that we judge them, [so] we don't say that they [have] depression.

Q: Then how do you say it?

A: I just say, today we have some doctors coming to talk and give us advice, but I [don't] say that they [have] depression. I wouldn't dare to.

Q: So, you introduce them to the program first and you don't [mention] depression?

A: I [don't] say anything about that. I'm afraid that they would not feel good, and they wouldn't [attend].

Provider W, Quang Nam

Despite the stigma, clients shared how they were fortunate to have support in their communities, especially from the providers who were amiable, sociable, and encouraged them to establish relationships with local associations and clubs. While it seems that stigma was a barrier for some clients, those who did and were able to build social connections with the help of providers reported feeling welcomed by their community.

Chapter 4. Discussion

Most clients reported being overall satisfied with the intervention delivered by social collaborators. They shared their gratefulness for the program, both for the workbook demonstrating useful skills and guidance, and for the care and support offered to them by the social collaborators who came to their homes and provided interpersonal connections. Participants eagerly offered insights into their daily lives with interviewers, sharing struggles and hopefulness alike. For client and provider demographics, the majority of both identified as female, and were mainly older (age 50 and over). This can be reflective of the average person who is drawn to working as social collaborator and/or community health worker – older women who are retired, eager to remain active and take on a positive role in their communities. It is also reflective of the client demographic of individuals who might be experiencing depression, living in areas outside of large cities, who would be willing to participate in an intervention such as the SSM.

4.1. Immediate needs of clients

Through interviews with both clients and providers, both groups identified depression as being firmly linked to their life circumstances. Countries facing economic recession, domestic and partner violence and poverty are more heavily burdened with mental health issues than those without. People living in LMICs such as Vietnam are exposed to a constellation of stressors that make them vulnerable to developing psychological symptoms and/or mental disorders (53,66,67). This is reflected in what clients and providers chose to share with us about their lives.

While the inclusion criteria of participating in the RCT required clients to be literate, some clients shared that they were unable to read the workbook due to vision loss or deterioration related to old age. These clients often required the help of social collaborators or often younger family members to guide them through the workbook, which meant that they could not read it without assistance. For such elderly clients, it is likely heavily burdensome to travel to the nearest optometrist office or clinic, undergo

vision testing, receive a prescription, and purchase glasses so that they may read documents such as workbook if they are used to functioning without glasses and do not often read. Similarly, a physical challenge identified by elderly clients was chronic mobility struggles. When invited by social collaborators to join neighborhood meetings or local union gatherings to strengthen social connections, they were unable to accept due to struggles leaving their home. Many clients reported feeling responsible for their nuclear and extended family members, as the primary breadwinner and/or caregivers to their children or elderly relatives. As is common in Asian countries, many Vietnamese follow Confucian ideals of filial piety, where the assumption is that it is the duty of children to care for their parents as they age, particularly the responsibility of the eldest male child, although often the day-to-day care falls to the female family members (68). The clients in this cohort reflect this reality, as several women shared that they were widowed, now responsible for the care of both her and her late husbands' elderly parents, in addition to their children and other extended family. Loss and grief are also prominent themes found within client stories, with many having experienced the death of a family member or spouse. The resulting burden was reported to be particularly heavy as they now took on the caregiving roles they had before the passing of their husbands, as well as falling into the role of primary breadwinner.

Another struggle for clients was financial difficulties and under- or unemployment. In the United States, a single episode of major depressive disorder is associated with an average of over 5 weeks of lost productivity per worker, resulting in an annual capital loss to employers of $36 billion (69). Costs extend to impairment in everyday situations. Psychiatric disorders account for over 50% of the days that individuals report that they could not perform their usual tasks when queried about physical or mental health (70,71). Mental disorders are more impairing than common chronic medical disorders, with particularly greater impairment in the domains of home, social, and close-relationship functioning (72). Clients often identified difficulties with finding stable sources of income, the resulting stress was a significant contribution to their depression, and their depression made it challenging for them to find better work, with these corresponding issues feeding into a vicious cycle.

4.2. Situating and contextualizing depression

> "Poverty is the basic problem that patients present with. Most of them (85%) lack even food, proper shelter and clothes. Women are not allowed to go to work for cultural reasons, forcing the family to live in penury. All suffer from stress. Most patients suffer from depression, anxiety, schizophrenia, which are rooted in the lack of primary needs such as food. Many lack a secure home to live in". (73)

As reflected by shared client experiences, both physical and mental illnesses stem from and lead to continued poverty - they are chronic, disabling, and all consuming. The "economic, social, and environmental conditions into which a person is conceived, born, reared, educated, eats, sleeps, lives, works, and receives health and social care" have a cumulative effect across a lifetime (74). Kessler et al. (1994) reported a higher lifetime and 12-month incidence of depressive, anxiety, and substance use disorders among low-income individuals (75); more recently, Kessler et al. (2003) found a higher 12-month incidence of major depressive disorder among those living in or near poverty (76). Rates of depression, anxiety, and suicide have been found repeatedly to correlate negatively with income (29,77–79) and employment (29,80). Those with the lowest incomes in a community suffer 1.5 to 3 times more frequently from depression, anxiety and other common mental illnesses than those with the highest incomes (29).

Several longitudinal studies have specifically examined the relationship between depression and socioeconomic status and concluded that the causal direction runs from socioeconomic status to depression. Iceland and Bauman (2004) found that income poverty is more strongly associated with some hardship measures, such as food insecurity, difficulty paying bills, and possession of consumer durables, and less strongly associated with others, including housing and neighborhood problems (81). The premise that material hardship may mediate the income–mental-health relationship is based on neomaterial approach in social epidemiology (82). In the neomaterial tradition, material hardship measures could have a negative impact on mental health through a direct effect of lack of nutrition, exposure to unhealthy housing conditions, or deterioration in other basic living conditions (83).

Addressing the mental health of participants cannot be done in a silo separate from acknowledging their socioeconomic status and life circumstances. Similarly, success in the SSM from client perspectives may be strongly tied to not only the intervention itself, but the encouragement, advice and support provided by social collaborators. As Holland (2018) said, “mental distress is often individualized and disconnected from social, political and economic conditions” (84). Public-health crises such as the COVID-19 pandemic tend to disproportionately affect those living in poverty (85). They may worsen mental health on average, and particularly among the poor. First, income and employment losses because of morbidity can be large, which in turn can reduce mental health through the mechanisms described above. In addition, the exposure to trauma, increased worries and uncertainty, and worsened physical health will tend to impair mental health, in turn reducing income and employment (86).

While those who participated in the SSM intervention were those who scored high enough on quantitative, validated measures of depression, it is through the qualitative interviews that we were able to gain insight into where it may be stemming from. Kottai (2020)‘s work following social workers in Kerala, India, found that psychosocial care (in the form of family psychoeducation, peer support meetings, home care, etc.) is “reduced to a supplementary effort to ensure medicine compliance… [resulting in] overmedicalization of poverty not only labels everyday sadness as a treatable disorder, but also deflects attention from severe mental disorders which are most responsive to psychopharmaceuticals”. There is a risk of taking away mental health resources from severe mental disorders when they are used to “treat natural reactions to traumatic life contexts by framing them as anxiety and depression” (73). Kottai (2020) shares a case where women in Kerala reported being depressed because they were being subjected to domestic violence by their husbands or mothers-in-law, and rather than addressing the structural violence they were experiencing day to day, they were ignored and prescribed medicine by social workers (73). By easing some everyday burdens of clients through holistic interventions and acknowledging clients’ realities and the challenges they face, less severe cases of depression may be alleviated.

4.3. The SSM model: reflections on task-shifting

Both participants and social collaborators shared their satisfaction with the relationship built between them, showing how participants found their support invaluable while social collaborators also found happiness and fulfillment in their roles. Most social collaborators were already working in their communities as village health workers, helping to raise awareness and visiting homes to encourage people to visit their local health center (detailed in Appendix 1).

The task shifting model met all the conditions identified by Kazdin (2013) when rating successful novel interventions for mental health (71):

Table 1: Kazdin (2013)'s criteria for successful novel mental health interventions

Reach	Capacity to reach individuals not usually served or well served by traditional service delivery models. Scalability: Capacity to be applied on a large scale or larger scale than traditional service delivery.
Affordability	Relatively low cost compared to that of the usual model, which relies on individual treatment by highly trained (master's, doctoral degree) professionals.
Expansion of nonprofessional workforce	Increases the number of providers who can deliver interventions.
Expansion of settings where interventions are provided	Brings interventions to locales and everyday settings where people in need are likely to participate or attend already.
Feasibility and flexibility of intervention delivery	Ensures that the interventions can be implemented and adapted to varied local conditions to reach diverse groups in need.

Of the participants, male users were underrepresented in the sample overall. Men often exhibit fewer mental health help-seeking behaviors compared to women, creating a concerning disparity in accessing appropriate support and treatment (87). Traditional masculine ideals, such as the emphasis on strength, independence, and self-reliance, contribute to the reluctance of men to acknowledge their mental health needs and seek assistance (88,89). Moreover, the stigma surrounding mental health in many societies

perpetuates the notion that seeking help is a sign of weakness. This stigma, combined with societal pressures to conform to masculine norms, can create a barrier for men in seeking mental health care (90). As a consequence, men may experience higher rates of undiagnosed and untreated mental health conditions, potentially leading to long-term negative outcomes for their overall well-being (91).

As observed in other examples of task-shifting approaches from around the world and specifically LMICs, the community health workers form the soul of the model, showing extraordinary empathy and compassion, filling multiple roles often out of necessity and undercompensated. Nading (2013) followed community health workers working as part of dengue prevention campaigns in Nicaragua and observed:

> "[CHWs] visit patients' homes and provide drugs, wheelchairs, groceries, books, school fees, and clothes to those who are needy, sit with patients and family members, and listen to their stories. They also help in nursing tasks and train caregivers in the same. The backgrounds of volunteers are cross-cutting: shopkeepers, taxi-drivers, school- children, and police donate to palliative clinics and serve the community... [they] see health with two sets of eyes: both "like a state," with bureaucratic and technical rigidity, and like a concerned neighbor, with compassionate flexibility (92)".

Successful social collaborators are those who have strong interpersonal skills, as building the connection with participants was identified as one of the most significant factors in a successful ongoing relationship with clients, which influenced adherence to the programs they promote and improved client outcomes. Meas (2016) writes that community health workers are "social actors within the communities that they serve… [with] social and psychological lives that influence health policy and programs, whether intended or unintended." More than administrators of biomedical interventions, they engage in "serious social and emotional labor (93). Maes further argues for the importance of advocating and working toward policies that are aimed towards creating secure employment opportunities for CHWs with appropriate compensation (93).

Despite the rise of task shifting as a viable alternative to many traditionally administered health interventions, there are several criticisms about task shifting for mental health. Task-shifting has the danger of becoming merely "task dumping of stigmatized health

care activities on persons who have less power to refuse these jobs (94)". Local people, trained by professionals in biomedical models for task-shifting mental health practices, can experience a disruption of their selves as they feel incompetent to address issues from an expert's vantage point (73). Kohrt and Griffith (2015) illustrate in their description of a study in Uganda, where task-shifting to identify psychosocial disability backfired as it increased numbers of referrals and the consequent burden on mental health specialists (94). Community health workers volunteering in HIV/AIDS prevention in Ethiopia also reported distress, shame and disappointment in what they perceived as not being able to improve the lives of clients no matter how much time and effort the put in, with one CHW reporting experiencing sleep problems when I wake up [in the middle of the night] I think about what [my clients] tell me in the day about their problems…" (93).

One of the common challenges shared by the health workers across interventions was the lack of appropriate compensation. Providers shared in interviews both how they were happy to go above and beyond to reach clients, saying it was a natural expectation of their role as social collaborators within their communities, while also reporting struggling with the lack of support and funding at an organizational level. Cultural customs, such as clients expecting gifts during home visits, were followed by social collaborators but they were not reimbursed for these purchases, nor for the extra hours spent trying to reach clients who were not initially responsive and required multiple visits. While they found pride in and valued their roles as social collaborators, providers were firm in their requests to be compensated fairly and proportional to their hours worked. Similarly, Nading (2013) found similar concerns among *brigadistas* (health workers) in Nicaragua, who "questioned the expectation that she would take to the streets voluntarily… The government wants the people to [help], to work, for the love of the party, and it's not like that . . . love doesn't give anyone anything to eat. Love isn't there in your stomach" (92). Volunteer CHWs in Ethiopia were similarly told that sacrifice and mental satisfaction was the greatest reward, while local officials praised their selflessness and service to the nation was appreciated, without offering proper compensation (93). Similarly, in Nepal, female community health workers were not paid because in the Buddhist culture, their service itself was believed to be *dharma*, or spiritual merit, which was seen as sufficient and appropriate for their work. There is also often challenges for CHWs to find further

opportunities for employment: Maes (2016) found that several of the volunteer CHWs in Ethiopia had signed up for the program in hopes for further advancement and well-paid career options in the healthcare field, but these opportunities never become available and remained out of reach for those without proper training and education of traditional healthcare workers (93). While CHWs were presented as noble, selfless and happy with their service, they were often anxious about their own economic situations, reporting earnings under $1 USD/day and experiencing food insecurity, and signs of common mental disorders (93). While we did not inquire about providers' financial, emotional and mental well-being as part of this research, because they often reside in and are part of the communities in which they serve, it is likely that they share somewhat similar socio-economic situations as clients who did share difficulties. Without proper compensation and higher-level support overseeing their work, the social collaborator model is unsustainable, no matter how spiritually rewarding it may be. As Kazdin (2013) argues, "in any given application, task shifting requires coordination among government agencies, nongovernment organizations, professional organizations, and local governments… [Task shifting when] implemented in developing countries where infrastructures (e.g., from local and national government, accrediting organizations) might be more amenable to change or at least rapid change (71). Kohrt and Griffith (2015) stress the need for "relational dialogue, creating spaces for learning and facilitating therapeutic alliance at various levels" (94). Hands-on and continuous training and opportunities for professional development is crucial for the success and well-being of community health workers and volunteers.

These findings from the literature align with what social collaborators shared with us through IRIS-DSV interviews and are further discussed in Chau et al. (2020) which identifies key factors to successful implementation, scale-up, and sustainability of the SSM model delivered by social collaborators: training and supportive supervision, regulation defining scope of work and remuneration, and policy support from government (4). Social collaborators working with the project team as part of the SSM reported finding significant fulfillment in their work with clients, and valued the time spent together and the bonds they formed. However, most social collaborators struggled with lack of sufficient compensation for the amount of time and effort they needed to connect

with effectively, which was underestimated by the research team. It seems to be a consistent pattern in LMICs, where task-shifting is found to be helpful to clients and clients and fulfilling for the health workers, yet the model is not viable due to the lack of support and is unable to continue. Echoing the findings above in the task shifting literature and considering the value clients expressed they found with the social collaborator-led SSM model, there is value in pursuing this model further with stronger funding for more in-depth and continuous training, compensation for time, gifts, and travel for social collaborators, and more opportunities for professional development.

Chapter 5. Conclusion

5.1. Findings

The SSM intervention has been shown to be successful with adults experiencing depression in Vietnam through an RCT (64). Considering the lack of available traditional avenues to access mental health support and treatment in Vietnam, this intervention is a practical alternative for individuals in need of treatment, particularly for those living outside of urban areas and considered low-income. When interviewed by research team members about their experiences, participants reported their overall satisfaction with the SSM intervention as delivered by social collaborators (4). Many participants discussed the life circumstances that led them to participating in the intervention, and commonly expressed that their experiences with depression were closely tied to their overall physical, financial, and psychosocial well-being. Many either themselves suffered or lived with loved ones that suffered from illness, disability, unemployment and feelings of hopelessness and despair.

These clients did not have access to other forms of mental health treatment, either because these services were not available to them, or that they themselves chose not to seek out treatment. This is one of the ways in which the SSM excels, in that it is community-based and administered by trusted members of the community. The social collaborators meet the clients in their homes instead of clients venturing to the local health center, or beyond to larger urban areas where the only accessible psychiatric health facilities might be located. Inconvenience and inaccessibility have been identified as a significant barrier to seeking and receiving mental health treatment in LMICs. 50% of clients who were interviewed as part of the MAC-FI study were noted to be living in rural areas. Most clients were in their 50s or older, and many shared in their interviews that they had troubles with physical mobility and vision. It is likely many clients would require help from able-bodied family members, neighbors, or friends if they need to reach a hospital outside of an easily communicable distance and read materials related to their treatment. Several older adults shared that they required support from their spouse or

children to read the workbook and help them understand certain concepts, yet at the same time shared that they were either embarrassed or hesitant to ask for help, because their family members were already swamped with their own responsibilities. Even though the intervention is designed to be used individually outside of scheduled time with social collaborators, the reality is that many individuals needed help in order to access it.

Participants shared their overall satisfaction and gratitude with social collaborators, identifying them as one of the key aspects that they enjoyed about the SSM intervention. Across several visits, participants came to accept the social collaborators as friends, confidants, and were able to share their troubles with them. One of the main benefits of having social collaborators administer the SSM was the ability to get personalized advice and support. Successful personalized healthcare involves home-based supported self-care (95). As opposed to a participant making their way through the workbook on their own, social collaborators were there with them throughout the whole process, and participants were able to share their personal struggles and thoughts with a trained provider who was then able to provide feedback and support. While the workbook is more general and designed to be able to support adults going through depression, having someone to talk to and give specific support was considered a strong benefit of the model. Through this, participants are able to identify what works specifically for their own journeys and social collaborators provide not only guidance with the intervention but also social support and friendship. Many providers shared how they visited participants more than the suggested number of visits (for which they were compensated), going out of their way to meet with clients in their own time, and engaging in social visits that involved more than just discussing the SSM. For example, some providers regularly went out for morning coffee or for exercise with their participants, visited and socialized with participants' families and invited them to join community organizations and unions. From the interviews it seemed providers were happy to do this, and it came from a genuine desire to connect with clients. Due to their regular training as social collaborators (not provided as part of this project), it seems that they were able to take their regular approach of connecting with clients and apply to their work as part of the SSM.

Many clients seemed to benefit greatly from having a friend or someone to talk to that they could trust. This trust was not always easy to develop – some clients admitted to hiding from providers when they initially made visits to their home or refusing to answer their phone calls. Providers often expressed having struggles with gaining access to clients, sharing that often they had to try multiple times to speak with clients, having to make several attempts at phone calls, in person visits or both. Unfortunately, providers shared that this model is ultimately unsustainable because they were not compensated for extra time spent trying to meet with clients which often took several tries. Providers held other responsibilities as social collaborators outside of administering the SSM intervention alone, and the extra burden of being unable to reach clients easily or having clients purposefully avoid them was seen as particularly stressful. At the same time, working as local healthcare workers and representatives allowed successful providers to identify those in their communities to reach out to, and clients reported feeling appreciative, touched, and even surprised that providers went to such lengths to reach them, feeling they truly cared for them and their well-being. Over multiple visits, both clients and providers reported their relationship developing and trust being built. It can be argued that it is because of the persistence of providers that clients felt comfortable sharing their circumstances with them and being able to confide in them. A successful client-provider relationship takes time and effort on the part of both parties.

Once clients were able to establish trust with providers, they were able to share their specific concerns and struggles and in turn, providers were able to provide advice and support specific to what clients were going through. For example, one client who struggled with unemployment was referred to a job by a provider whose acquaintance was hiring for their business. Another client who struggled with marital issues and loneliness was invited to join women's union meetings to build connections and develop social support within her community. While this is one of the goals outlined in the SSM workbook, without the support of providers who knew their community well and facilitated these connections, it would likely have just been a thought exercise instead. Several clients identified their provider as a friend – they built a lasting relationship even after the conclusion of the intervention period. When asked what makes a successful provider, many shared sociability and personality as one of the key aspects that allowed

them to make strong connections with clients. These providers described themselves as sociable, friendly and easy to talk to – key attributes that they either learned on the job as a community health worker, or as an attribute that led them to seek out a people-facing occupation. Providers shared how they happily invited clients out for coffee, exercise, and other social outings. Several providers also discussed how establishing a good relationship with family members was significant in getting clients to trust them, and also for family to help support the client with their depression and with using the intervention.

A common challenge expressed by both clients and providers was the difficulty for clients to adhere to using the intervention regularly. Many clients shared with interviewers that they hadn't been able to find time to use the workbook, or that they had only flipped through the book several times; some clients admitted they had forgotten what they'd learned or about the intervention itself altogether. While a few clients expressed that they simply felt unmotivated or had no desire to try the SSM intervention, a large number said it was because they simply could not find the time due to their existing obligations and responsibilities. Those who were employed at the time of the interview often worked busy schedules and still had responsibilities at home, while clients who were not employed often acted as homemakers or the primary caregiver to underage, elderly, or ill family members. In fact, many clients identified their obligations as one of the struggles that contributed to their depressive symptoms. As highlighted in the Client Profiles section, clients shared their stories and many were strife with loss and grief, financial struggles, familial conflict, and instability. Likewise, the providers recognized this and encouraged them to resolve their issues with their families, helped them find employment and build social connections. Clients expressed their depression as ultimately related to the challenges in their lives – unfortunately these challenges often hindered them from seeking help or being able to continue with the intervention.

5.2. Transitioning the SSM + social collaborator model to mHealth

The SSM model as administered by social collaborators was a success, proven to be effective through the RCT as well as from qualitative feedback through interviews with clients and providers. Through the interviews we identified the benefits which come

from the development of the client-provider connection, as well as the challenges that come from a lack of provider supports when needed. These challenges experienced by social collaborators are significant, especially due to lack of funding for the SSM model to continue. Priorities have shifted since the initial implementation of the RCT, with the Government of Vietnam now focusing on children and youths, and specifically on individuals with autism and schizophrenia. As it currently stands at time of writing, it is unlikely that there will be funding allocated to support the social collaborator led SSM intervention in the upcoming years. Due to the unsustainability of the SSM social collaborator model in its current form in Vietnam, the research team is currently in the process of pivoting the intervention to be delivered through mHealth.

"mHealth" stands for "mobile health" and refers to the utilization of wireless technology in medical care delivery (96). mHealth interventions offer support to behavior through a range of features including delivering educational material, supportive and positive text messages, and goal selection. The mobile features' content is customized to particular populations and the intervention may be combined with other treatments. Evidence supports the effectiveness of mHealth interventions in treating health conditions (97,98) and it has been successfully used for clinical assessment and education in medicine and public health (99,100). Meta-analysis studies of mHealth clinical interventions for quitting smoking, weight loss, and diabetes control show that these interventions are cost-effective and have a positive impact (101–105). These studies indicate a growing trend of mHealth interventions being utilized in various health settings across different cultures.

Using mobile devices, people are able to access services in their own environment without having to contend with stigma or other related barriers (106). However, some findings show that mHealth interventions are used less and less as time passes without regular contact and prompts with the participant, if the information is static, or relies on the participants' initiative to access, use declines within a week or two (107). The future of the SSM intervention should be developed while keeping in mind that there is a significant benefit in having a sense of hope, a sense of community, and relationship with the social collaborator. It may be difficult to simulate in a mobile app; however, one of

the benefits of having a mobile intervention is the convenience. Many clients reported that they were unable to meet with the social collaborators, who likewise mentioned that they struggled with being let into client's homes, with gaining initial contact, and being able to meet at a time that worked for both social collaborator and clients. If clients are able to communicate with a social worker through the app, it may work closer to a mobile messaging service, in which messages can be sent and replied to at one's convenience. There are also options to set up a scheduled video call or live chats as according to their preference.

While initially we had concerns that there would be hesitance from participants to interact with social collaborators as part of the SSM because of the social and physical proximity of the social collaborators to the client's communities and the potential stigma, it seems that clients are overall happy with having a social collaborator that knows them and the situations they are in. In some cases, clients were contacted directly by providers who underwent the training and thought of them as someone who fit the program. This was possible because of the expertise of the social collaborators, who are well versed in the situations of people in their communities and make it their priority to reach out to those who may be in need of help. This can help to reach clients who do not seek help themselves, whether it is because they don't know what's available or simply because they are not ready or able to reach out for support at that point in their life.

This work, based on the findings of interviews with SSM participants and social collaborators administrating the intervention, argues that the success of the SSM is closely linked to the client-provider relationship. One of the key aspects to success is the careful and intentional relationship building across a number of visits. The interpersonal and relational skills of the social collaborators are also very significant. Thus, it may be difficult to replicate in an mHealth context. The advantages that come from mHealth – such as convenience and reach, contrast the main themes of success of the SSM such as the importance of connections to community and trust building. While social collaborators had difficulties reaching clients at their homes and be welcomed in to talk, mobile apps can be accessed at any time and at the client's discretion. While the mobile app allows for privacy which protects clients from experiencing potential stigma, the

participants, and social collaborators both expressed the value of family involvement and support. Social collaborators interacted with participants outside of providing the SSM intervention, often sharing their personal contact information and reaching out to spend time with participants socially, such as sharing coffee or inviting them to community association meetings. While the interviews showed that social collaborators were not being compensated enough and this required much personal sacrifices from the collaborators that would almost certainly lead to burnout and is unsustainable, both participants and social collaborators seemed to treasure these extra acts of social and emotional labor. It gave participants the social support and companionship that provided them with comfort, along with the SSM that taught them evidence-based techniques to manage their depression. Outside of changing their life circumstances which is beyond the scope of any targeted intervention of this kind, this is a very holistic treatment approach. These are important considerations when developing the VMood mobile app, the successor to the MAC-FI model.

Language and cultural relevancy are both essential to the success of adapting programs for use in a new country; when programs are developed without taking into consideration the needs of clients, they will be difficult for clients to learn misused, and underutilized (108). Beliefs about the etiology of mental health conditions and cultural norms around acceptable treatments can vary greatly depending on region (71).

5.3. Moving forward

The objective of global mental health proponents should focus on integrating mental health care and prevention into primary care systems. To achieve this, national mental health policies should be developed while considering the perspectives and involvement of clients, if feasible, during the design and implementation of interventions. However, in LMICs, the provision of mental health care services has been consistently inadequate and primarily concentrated in urban areas. While inadequate provision of basic health care services in LMICs, the situation is even more dire when it comes to

mental health care. The low priority of individuals suffering from mental illnesses requires immediate attention and a shift in priority at the policy level (13).

The relationship between mental health and physical health cannot be overlooked, as it plays a crucial role in the effective treatment and management of various health conditions. For instance, Alloh et al. (2018) notes that diabetes management is significantly impacted by mental health, with daily management challenges often leading to depression and even thoughts of suicide, while people living with diabetes are known to have higher rates of mental illness (13). Furthermore, the co-occurrence of mental illness and diabetes leads to poorer health outcomes for individuals with both conditions (109,110). In order to prioritize mental health treatment and care, it is important to encourage the integration of mental health services into primary healthcare in LMICs. This will allow for early diagnosis and intervention, and if necessary, a referral can be made to a specialist mental healthcare facility.

Additionally, it is crucial to train existing community health workers and primary care providers on various mental health issues. For instance, a project in southern Nepal used UK healthcare workers who volunteered to train auxiliary nurse midwives on a range of mental health topics (111). Similarly, in Nigeria, a theory of change was implemented to integrate mental health into primary health care services by training healthcare workers and finding community champions for mental health within the community (112). These initiatives demonstrate the potential of integrating mental health into primary healthcare, and they can help reduce the burden of mental health worker shortages in LMICs.

The importance of a well-structured and effectively implemented national policy on mental health cannot be overstated. Despite the fact that a majority of WHO member states have a dedicated mental health policy or plan, and even mental health legislation in place, the reality is that many of these policies and laws are not properly executed. This can be attributed to the fact that the implementation of these policies often lacks the active participation of policymakers, and the involvement of family members in the treatment process of individuals with mental illness is not always adequately considered,

particularly in LMICs (113) . In Nigeria, mental health is not even included in the general health strategy and plan and there is no specific budget allocated for mental health, with 4% of the health budget being directed to neuropsychiatric facilities (112). In contrast, despite the existence of a national health plan for mental health in Nepal, implementation remains poorly executed (111). This lack of prioritization and proper implementation of mental health policies is a major concern that should be addressed (13).

In order to ensure the sustained effort and success in addressing mental health, it is imperative that national policies on mental health be developed with clear strategies in place to ensure effective implementation. Moreover, these policies include the active participation of policymakers and the full involvement of family members in the treatment process of individuals with mental illness.

It is important to acknowledge that while governmental support and resource allocation play a crucial role in the provision of mental health services in LMICs, the need for a shift in societal attitudes towards mental illness is just as crucial for improved health outcomes for the people who struggle with them. Unfortunately, social behaviors and attitudes towards mental illness, such as stigma, discrimination, and lack of empathy, often contribute to and exacerbate the problem of mental illness. Until these attitudes and behaviors change, it will be difficult for individuals with mental illness to seek help and access mental health services without fear of judgment or discrimination. It is only through the development of a more empathetic, accepting, and non-discriminatory society that the priority of mental health and access to mental health services can be fully realized.

Chapter 6. References

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Appendix A. Provider role descriptions

Role of Social Collaborator	**Description of Role (1-2 sentences)**	Reference
Population Collaborator	Population Collaborators are responsible for assisting the Head of the commune health station to develop a plan and organize the implementation of the target program on population and family planning in the commune. For detail, the full-time Population Collaborators, an officer of the Commune Health Station, directly propagate, mobilize and advise on population and family planning and provide condoms and oral contraceptives to each household.	CIRCULARS number 05/2008/Ministry of Health
Village Health Worker	Village Health Worker is responsible for primary care: (1) Propagating and educating health in the community, (2) Detect, participate in monitoring and reporting on situation of epidemics, communicable diseases, non-communicable diseases, social diseases and food-borne diseases in villages, (3) Propagate and encourage pregnant women to go to commune health stations to register for pregnancy management, antenatal care and health facilities for childbirth; management of miscarriage for pregnant women who	CIRCULARS number 07/2013/Ministry of Health

	cannot promptly come to medical examination and treatment establishments for childbirth	
Commune Collaborator	same with Village Health Worker, but maybe in difference interview in difference places, they used difference words	
Population and Health Collaborator	See: Population Collaborator	
Village Heads	(1) Organize village conferences, (2) collaborate with other departments in village to solving the legitimate recommendations and aspirations of the people in the village	CIRCULARS number 09/2017/MINISTRY OF HOME AFFAIRS
Health Commune Collaborator	same with village health worker	
Woman Village Planner	multiple tasks between Population Collaborator and Women's Union Association of the People's Committee of the Commune Member	
District Health Worker	same with Population Collaborator but in district level	
Women's Union Association of the People's Committee of the Commune Member	The purpose of the association is for equality and development of women. They are responsible for propagandizing, educating, campaigning and guiding women in implementing the	

	Party's guidelines, the State's policies and laws.	

Appendix B. Patient Interview Schedule

Implementation Research to Improve Scale-Up of Depression Services in Vietnam (IRIS-DSV)

Patient Interview Schedule [Version 2, August 15, 2018]

[Researcher to introduce and complete informed consent form with participant]

1. Introduction to study:

Hello. Thank you for taking the time to participate in this interview for the Implementation Research to Improve Scale-Up of Depression Services in Vietnam (IRIS-DSV) study. The researchers on this team also conducted the Mental Health in Adults and Children – Frugal Innovations (MAC-FI) study. The MAC-FI study tested whether the Supported Self-Management intervention (from hereon in referred to as "SSM") helped people with symptoms of depression to feel better. Now, we are conducting the IRIS-DSV study to help us understand how to make sure the SSM intervention works best for people in Vietnamese communities. You were asked to participate in the IRIS-DSV study because you participated in the MAC-FI study. This interview will help us understand several things related to the SSM program. First, it will help us to understand what you liked about the SSM, what you did not like, and what could be improved. Second, it will help us to understand any differences in interest and use of the SSM by different types of people, including men and women, and people who live in urban areas and rural areas.

We will be engaging in similar discussions with other patients and providers from the MAC-FI study in both urban and rural locations so we can better understand these differences. We will also be conducting interviews with experts in the field of mental health in Vietnam in order to understand how the SSM could be implemented on a larger scale. Overall, these interview discussions will help us to better understand how the SSM can work best for people with symptoms of depression in Vietnam and how to improve it so we can make sure it is available to everyone who needs it in the future.

During the interview, which will take approximately 30-60 minutes, I will ask you questions and invite you to share your opinions openly. There are no right or wrong answers, and your experiences are important. We are here to learn from you.

As we discussed when you signed the consent form, we will record this interview so that we can capture all of your responses. [Researcher #2 Name] will also be taking notes. These notes will not contain your name or information that could be used to identify you. We will remove your name and any information that could potentially be used to identify you when we transcribe the recording and in any material we share about our findings. The notes and completed transcriptions will be stored in RADAR, SFU's online repository, for future use in open access initiatives.

Finally, your participation in this interview is totally voluntary and you are welcome to stop at any time. There will be no negative consequences if you decide to stop before the interview is over, or if you decide you would rather not answer any of the questions.

Do you have any questions?

2. Warm up and ice-breaker:

- How long have you lived in this commune?
- What is your job or main occupation? [If patient seems shy or nervous, interviewer to ask polite probing questions about job or other occupation, e.g., student, stay-at-home parent, etc., to put patient at ease]

3. Determining patient category (e.g., participated in intervention, began intervention but did not complete, or was referred but did not participate)

- As we talked about earlier, you were invited to take part in this interview because you were previously referred to the SSM intervention. Can you please tell me whether you participated in SSM?
- If yes, did you complete the full two months of SSM?

4. Experience with screening, referral and initial uptake of SSM

For all patients:

Experience with screening process:	With the help of a health worker, you completed a questionnaire that helped to identify that you were experiencing symptoms of depression. Based on what you remember, how did you find the experience of completing this questionnaire? [Probing questions: Did you understand what the screening was for? Did the healthcare worker explain what the results meant to you? How did you feel about this experience?]
Experience with referral process:	After completing the questionnaire and discussing the results with the health worker, you were referred to take part in the SSM intervention. Based on what you remember, can you tell me about this experience? [Probing questions: Did the health worker do a good job of explaining what SSM was? Did the health worker answer any questions you had about SSM?]

For patients who DID NOT participate in SSM:

Uptake of SSM	Why did you decide not to participate in SSM?

For patients who DID participate in SSM:

Uptake of SSM	Why did you decide to participate in SSM?

5. Experience with SSM intervention

For patients who DID participate [Interviewer to bring copy of Antidepressant Skills Workbook for participants' reference and to refresh memory]:

SSM Materials	Can you tell us about your experience using the Antidepressant Skills Workbook? What did you like about it? What did you not like about it? What, if anything, could make it better?
Relationship with provider	Who supported you in using SSM [Probing questions: Was it a social worker or a social collaborator? A woman or a man?] Could you tell us about your experience working with them? What did you like about it? What did you not like about it? What, if anything, could make it better?
Perceived benefits	Did participating in SSM help you to feel better? If so, what changes did you notice? What aspects of SSM were particularly helpful/ unhelpful? Would you recommend SSM to a friend or family member experiencing depression?

For patients who STOPPED participating in SSM after initial uptake

Reasons for non-adherence	Why did you decide not to continue SSM? [Probing questions: Was it the materials? The relationship with the provider? Other factors?] If you had the option now, would you decide to complete SSM?

For patients who DID NOT participate in SSM [Interviewer to describe the SSM intervention and show the Antidepressant Skills Workbook to refresh memory]:

Impression of SSM intervention	Based on what you know about SSM, if you were referred, today would you participate? Why or why not? [Probing questions: Is the material easy to use?

Does your relationship with your provider support this? Other factors?]

6. Other Comments

- Do you have any other comments or suggestions you would like to share about your experience with screening, referral, or using the SSM intervention?

Thank you for participating in this interview. Your answers have been very helpful. We appreciate the time that you have taken out of your schedule to share your experiences and opinions with us. Do you have any questions related to the study?

Thank you for your time.

Appendix C. Provider Interview Schedule

Implementation Research to Improve Scale-Up of Depression Services in Vietnam (IRIS-DSV)

Provider Interview Schedule [Version 2, August 15, 2018]

[Researcher to introduce and complete informed consent form with participant]

1. Introduction to study:

Hello. Thank you for taking the time to participate in this interview for the IRIS-DSV study. As you know, the researchers on this team also conducted the MAC-FI study. The MAC-FI study tested the effectiveness of Supported Self-Management for helping people with symptoms of depression. Now, the IRIS-DSV study will help us understand more about how to make sure the SSM intervention works best for people in Vietnamese communities. You were asked to participate in the IRIS-DSV study because you participated in the MAC-FI study. This interview will help us understand several things related to the Supported Self-Management program. First, it will help us to understand what you liked about SSM, what you didn't like, and what could be improved. Second, it will help us to understand any differences in interest and use of SSM by different types of people, including men and women and people who live in urban areas and rural areas.

We will be conducting similar discussion with patients and other providers from the MAC-FI study in both urban and rural locations so we can understand these differences. We will also be conducting interviews with experts in the field of mental health in Vietnam in order to understand how the SSM could be implemented on a larger scale. Overall, these interview discussions will help us to better understand how SSM can work best for people with symptoms of depression in Vietnam and how to improve it so we can make sure it is available to everyone who needs it in the future.

During the interview, which will take approximately 30-60 minutes, I will ask you questions and invite you to share your opinions openly. There are no right or wrong answers and your experiences are important. We are here to learn from you.

As we discussed when you signed the consent form, we will record this interview so that we can capture all of your responses. [Researcher #2 Name] will also be taking notes. These notes will not contain your name or information that could be used to identify you. We will remove your name and any information that could potentially be used to identify you when we transcribe the recording and in any material we share about our findings. The notes and completed transcriptions will be stored in RADAR, SFU's online repository, for future use in open access initiatives.

Finally, your participation in this interview is totally voluntary and you are welcome to stop at any time. There will be no negative consequences if you decide to stop before the interview is over, or if you decide you would rather not answer any of the questions.

Do you have any questions?

2. Warm up and ice-breaker:

- Could you tell me a bit about your job as a social worker/ social collaborator? [Probing questions: How long have you been doing this job? Could you tell me about your main tasks?]
- Approximately how many patients have you worked with to deliver SSM?

3. SSM Intervention Delivery

We've brought a copy of the workbook with us in order to refresh your memory. You can refer to this throughout the interview.

[Interviewer to give copy of Antidepressant Skills Workbook to participant]

Referral of patients to SSM	Please describe the process of patients being referred to you for SSM by a health worker. What works well about this process? What, if any, challenges exist?
Introducing SSM	Please describe how you introduce SSM to patients. How do you describe the program to them? What works well about this process? What, if any, challenges have you encountered?
Using SSM workbook	Please describe the process of using the Antidepressant Skills Workbook (ASW) with patients. Do you give the workbook to every patient you work with? (If no, why not?) How do patients usually respond to being given the workbook? If they are hesitant, do you encourage them to use it? (If yes, how? If no, why not?)
Patients guided through SSM	Please describe the process of guiding patients through the SSM intervention. In general, how often do you meet with the patient? How do you provide support to patients? What has worked well in this process? What if any challenges have you encountered?

4. Need for adaption

ASW workbook	Based on your experience in supporting patients to use the ASW, what works well about the book? What, if anything, would you change?
Provider-patient relationship	Based on your experience guiding patients through SSM, what works well about this process? What, if anything, would you change?

Other	Based on your experience with SSM, are there any other aspects that work well or that you think should be changed?

5. Other Comments

- Do you have any other comments or suggestions you would like to share about your experience delivering the SSM intervention?

Thank you for participating in this interview. Your answers have been very helpful. We appreciate the time that you have taken out of your schedule to share your experiences and opinions with us. Do you have any questions related to the study?

Thank you for your time.