Sociocultural challenges to screening for perinatal suicide risk by lay health workers in southern Viet Nam

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Abstract

Sociocultural challenges to screening for perinatal suicide risk by lay health workers in southern Viet Nam

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This qualitative study examined sociocultural factors influencing the discussion of suicide and suicide risk by lay health workers during perinatal depression screening. As part of a collaborative care model pilot study, this study centers perspectives of lay health workers from My Khanh and Tan Thoi communes in the southern Mekong delta region of Viet Nam.8 focus group discussions and 7 interviews were conducted with Commune Health Center (CHC) staff and pregnant or postpartum women. Focus group discussions and interviews were audio recorded, translated, and transcribed for thematic analysis. Four major themes were discussed: the avoidance of the term “death” in screening language, the disruption of social harmony, the establishment of trust between lay health workers with both perinatal women and their families, and adequate training to increase confidence in screening.

INTRODUCTION

Globally, mental disorders rank among the leading causes of disease burden.[1] In a 2017 report, the WHO estimated over 322 million people living with depression and depressive disorders accounting for 7.5% of all YLD, ranking as the single largest contributor non-fatal health loss.[2] As these numbers and the concern for mental health care continue to increase globally, nearly 30% of cases occur in the South-East Asia Region, over 80% of disease burden occurs disproportionately in low- and middle- income countries (LMICs), and also affect women more than men.[2]

Women are particularly vulnerable to depressive disorders during the perinatal period, defined as the period during or up to one year after pregnancy. During the perinatal period, suicide has been identified as a leading cause of maternal mortality and accounts for up to 20% of postpartum deaths.[3,4] Common perinatal mental disorders have also been identified as more prevalent in LMICs and are associated with negative health effects not only on mothers but also on infant health outcomes.[5-8]

Perinatal Depression in Vietnamese Women

In Viet Nam, depressive symptomology was found to be present in every 1 of 3 perinatal women.[9] Of these women, 19% exhibited suicidal ideation. Risk factors for perinatal mental disorders have been identified within the Vietnamese context, including rural residence, socioeconomically disadvantaged backgrounds, exposure to intimate partner violence, and quality of interpersonal relationships.[10,11]As such, perinatal mental disorders may be described as "manifestations of disorder in a woman's overall social, cultural, and economic situation" and there is a need for perinatal mental health interventions to incorporate a woman's broader context to inform effective prevention and treatment.[12]

Commune Health Centers and Collaborative Care

While effective treatment for perinatal depression through evidence-based psychosocial interventions and medications exist, challenges to care include lack of mental health specialists and lack of sufficient training and capacity at the local health care level to recognize and treat depression. To address these challenges, both task-shifting and culturally specific adaptations to treatment have been identified as effective ways to improving depression screening accuracy and acceptability at the community level.[13-15] In Viet Nam, Commune Health Centers (CHCs) serve as the main public sources of primary health care at the community level. Each CHC is also served by local community health workers, also known in this study as collaborators. Collaborators serve as community liaisons between the public health system and families in their respective communes, providing a range of services from population health such as vaccinations and nutrition education to prenatal and pediatric care.

Me Vui Ve, Nha Hanh Phuc

This qualitative study is a part of the Me Vui Ve, Nha Hanh Phuc project, a participatory pilot study focused on developing, implementing, and evaluating the efficacy of a collaborative care model for perinatal mental health services in Can Tho, Viet Nam. This pilot project is a collaboration between the University of Washington Department of Psychiatry and Behavioral Sciences and Global Health and the Can Tho University of Medicine and Pharmacy (CTUMP).

This pilot intervention sought to utilize existing health system infrastructure, adapted to incorporate collaborators to identify cases and deliver effective treatment for perinatal depression. Their diverse connections to the community and existing relationship with the CHC supported by evidence of effective task-shifted depression interventions for lay health workers presented significant potential for effective perinatal depression screening at the community level.

Based on preliminary data, collaborators were trained to use a common Vietnamese translated and adapted version of the PHQ-9 depression symptom scale. While collaborators were trained in this screening process, collaborators did not, however, feel comfortable asking the last question of the screening survey discussing suicide risk to women in the commune.

While previous studies have explored perceptions of perinatal depression and its risk factors in Viet Nam, this study gives special attention to the perspectives, attitudes, and experiences of collaborators specifically around the discussion of suicide risk during depression screening to inform the collaborative care training process of community health workers. This research was guided specifically by the following questions: 1) What sociocultural factors influence difficulties experienced by collaborators when discussing suicide risk with Vietnamese parous women? and 2) How do these factors hinder or facilitate discussion of suicide risk to provide effective perinatal depression screening?

METHODS

Setting

This study was conducted in My Khanh and Tan Thoi communes located in the Phong Dien district of Can Tho city, the largest city in the southern Mekong delta region of Viet Nam. The larger Can Tho city has a population of 1.2 million people. Within Can Tho city, the population of Phong Dien district is approximately 98,400 people, 90% of whom reside in rural settings and 10% of whom reside in urban settings.[16]

Focus group discussions and individual interviews were held both in-person at My Khanh and Tân Thới CHCs and by phone.

Sample

Participants included CHC staff comprised of lay health workers, doctors, pharmacists, nurses, and midwives as well as women residing in My Khanh and Tan Thoi communes who were pregnant or had recently given birth. Participants were selected using convenient sampling by CTUMP partners based on existing partnerships and so that FGDs and interviews were representative of lay health workers and women in the Can Tho region.

Focus group discussions (FGDs) and individual interviews took place from March 2020 to August 2021. All FGDs and interviews were facilitated in Vietnamese by CTUMP research team members and were audio recorded.

FGDs and interviews took place both before and after CHC staff training for the Thinking Healthy Program. For this study, all FGDs and interviews were reviewed for thematic analysis, however, topics related to sociocultural context and discussion of suicide risk during screening were given particular focus.

Data Analysis

Following data collection, audio recordings were transcribed and translated into bilingual transcripts for analysis. Using both inductive and deductive coding, a collaborative codebook was created. Three transcripts were individually and separately, the compared with the remaining coded transcripts to ensure agreement. All coding and transcripts were reviewed with special attention given to codes and categories related to discussion of suicide risk during screening and sociocultural context. Dedoose coding software was used for coding between UW and CTUMP research team members and subsequent thematic content analysis.

RESULTS

Four major themes were identified: the avoidance of the term "death" in screening language, the disruption of social harmony, the establishment of trust between lay health workers with both perinatal women and their families, and adequate training to increase confidence in screening.

Avoidance of the term "death" in screening language

When discussing the final question of the PHQ-9, which asks interviewees about thoughts of death or self-harm, collaborators generally expressed reluctance or refusal to using the term "death" when speaking to women.

> *"10: Don't use the word death. […] Don't use the word death. 10: Yes, it's right. 8: Leave out the word dead because it's too heavy."*

> *"8: It is difficult because it relates to death. […] 8: I think we should abstain and avoid […] 8: Do not mention about this. We should talk a little about this and give them some advice. We should not ask this question."*

> *"4: If you ask, you must avoid the work death. 9: Use another word"*

> *"I don't dare to mention "death". […] I will ask carefully and avoid asking about "death"."*

Collaborators feared that using the term "death" directly with women would worsen their condition. If women were happy and not depressed, collaborators worried that mentioning "death" would cause women to then feel sad. However, if women were depressed, collaborators worried that mentioning "death" would in turn cause women to think of death and develop a desire to commit suicide.

> *"11: Sometimes depressed people do not have that thought in their minds. Asking may suggest them to think of it. Moreover, we are medical staff, we feel embarrassed to say that word. 1b: Why? 11: The reason is that we don't want people to think about it."*

"8: She was not treated badly by their family so she will be sad if you ask her"

"11: This question can be asked mild or moderate depression but not severe one because severe depression might commit suicide after being asked."

Disruption of social harmony

Discussing thoughts of death and self-harm directly with women was also perceived as a disruption to social harmony between collaborators, women, and women's families. Participants described feeling worried about being viewed or treated negatively by family.

"8: I dare not ask people. They will beat me if I ask them such a question."

"This question is hard to ask because we should as softly so that they can share. If we ask frankly, people will think we are scrutinizing them"

"4: they will be very annoyed with us […] if they have that problem, they will get annoyed with us."

"I can ask but I am afraid that the family will say "Mrs. 4 is crazy? Why does she suddenly ask my daughter-in-law such a weird question? She asks impolitely and not scientifically". So I don't dare to ask."

If women presented happy and did not show symptoms of depression, participants felt the question was not necessary should be avoided to prevent introducing negativity.

"3: When you asked this question, you only asked when person was sad. If people were not sad, you did not need to ask."

"If we suspect they are depressed we should not ask this question."

"4: yes, we have to assess that person. If she is normal, I will not ask this question."

"3: We could not ask the question number 9 immediately, but had to go around at first. 10: Whether they were sad or wanted to hurt themselves. Dr1: Like Mr.2 said, you would skip the number 9 if they didn't have any of 8 former questions. 2: If they were happy, that would be no need to keep asking. Number 9 is like a conclusion."

"8: I think we should abstain and avoid. If women look good, we should not ask this question."

Establishing trust between lay health workers, women, and their families

Fostering mutual relationships between collaborators, women, and women's families was important to facilitate openness and trust when discussing suicide risk. Participants often described interacting with women's husbands and their mothers-in-law first during home visits before meeting directly with women.

"4: I will have a conversation with her, then ask her, ask her family. Firstly, I have to ask other family members because she will not tell me. Firstly, I ask about family health, and then probe the family whether the pregnant woman is happy or worried, whether she has interest during pregnancy, works normally or feels sad about work."

"6: She rarely talks to me. She only talks to her husband. I just ask her husband or her mother in law"

"11. When we approach a pregnant woman, but there are some certain difficulties, we will not meet her directly, we will meet her mother or mother in law or her siblings instead so that we can have information about her."

"7: It depends on the way that we talk, we interact with their family, many daughters-in-law who their families must call out, talk with us."

While in some cases, family members could help collaborators facilitate screening with women, in other cases, family was also described as a barrier to direct discussion with women.

"*7: Daughter-in-law told me she is preferred to go to some hospital but the mother-in-law did not like it. So when I visited I could not ask anything"*

"if there's some conflict in the family, we can see the sadness from the mother during pregnancy. now we can approach them but we cannot talk deeply to them"

In order to establish trust, participants recognized the need for sympathy and empathy towards women and their families, considering both social and economic causes that may be impacting their mental health.

"*10: Besides, to the way of my thinking, we have to put our feet in their shoes so that we can truly understand their situation. That's called 'empathy'. 2: In my opinion, empathy is simply the combination of understanding their stories and sympathizing for them.***"**

"*many women, people are depressed but people come in contact with me, they are normal, but only when they are alone, they will have symptoms of depression, then those things that we won't be able to detect at first and that is what we have to be contact many times and we have knowledge which makes they have sympathy and share their stories, their difficulties. must have sympathy. One more thing, I think we should put ourselves in that woman'shoes so that we can understand and share with them."*

Adequate training and education to increase collaborator confidence

Lastly, participants recognized education and training as key resources for successful screening. Collaborators described feeling more confident and better informed following the training and attributed their confidence and comfort with screening to a better awareness and understanding of symptoms of perinatal depression and its treatment.

"So, I feel that I am braver than before. When I went to each household before, I only spoke a little, but now when I go to each household, I have a lot of information to talk, and to advice, corresponding to each household. I can't go only one time, but I have to go back for the second and third time. As a result, this program [..] is very effective and meaningful for both the collaborators and the local people. Because the people […]are not either trained nor go to school to understand. But thanks to my studying, I can explain and discuss things so that people can understand and avoid those diseases."

"5: Personally I think, we would never know what depression exactly was without the training, and neither did the women. That may be a difficulty when we ask them what their problems were, what they had to face with. After this course, I have a deeper insight about this disease and when I returned my area, it did help a lot for detecting depression. First, it helps reduce the amount of women suffering from depression. Second, it could limit the arguments of depressed women. Then we can encourage and help them to avoid the negative thoughts. Moreover, there is a strong bond between the collaborators and the women community, especially the pregnant ones who would not confide their problems to anyone but the collaborators."

DISCUSSION

This study set out to explore sociocultural factors influencing the discussion of suicide risk during perinatal depression screening by analyzing perceptions and attitudes of lay health workers training under a collaborative care model for perinatal mental health care. Findings show that cultural perceptions of "death" in screening language, disruption of social harmony, fostering interpersonal relationships of trust, and adequate education all affected collaborator comfort and willingness to ask women about feelings of death or causing harm to oneself.

The use of the term "death" presented a significant barrier to discussion of suicide risk, prompting most collaborators to avoid asking women about thoughts of death entirely. Regardless of how collaborators interpreted the condition of women being screened, "death" was seen as socially unacceptable to speak of. Findings suggest that future training should dedicate specific focus to the cultural context surrounding death when reviewing screening language.

The findings of this study also emphasized the role of family dynamics and interpersonal relationships during screening, particularly with husbands and mothers in-law. In addition to the well-being and perspectives of women being screened collaborators also took into consideration that of their husbands and mothers-in law. As a result, gaining trust from all family members aided collaborators in gaining more trust and openness with women as well. In Viet Nam, cultural norms rooted in Confucian values of harmony, filial piety, and a patriarchal society all reinforce the social order that facilitate the significant roles of the husband and mother-in-law during perinatal depression screening for women. Thus, incorporating family engagement and navigating interpersonal relationships with family into training can support collaborator comfort in discussing suicide and suicide risk with women more openly.

While collaborators maintain a unique and effective position to conduct perinatal depression screening as part of the collaborative care model, considering the underlying social and cultural context that facilitate family dynamics, interpersonal relationships, and attitudes towards screening language are key to addressing collaborator confidence around the discussion of suicide risk.

Limitations

This study may not be generalizable to other regions due to a limited sample. Perspectives were limited to two semi-rural communes, which may not be representative of urban populations in Viet Nam. In addition, perspectives were limited to a small sample size. Despite these limitations, results may still provide informative and nuanced insights for other perinatal depression screening interventions that utilize lay health workers in Viet Nam.

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