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A Comprehensive and Community Mental Health Approach

A case-study on Cambodia's rural zones

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Fait à Louvain-la-Neuve le 10 août 2024,

Par Jeanne Khleang-Piel

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Table of Contents

Introduction

Contextualization of the thesis' topic

« There is no health without mental health » (Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A., 2007). This quote means that mental health is part of public health and should no longer be underestimated (Prince, M., et al., 2007). Indeed, mental health disorders accounts for 14% of « the global burden of disease », mainly because of the disabling and persisting effects of frequent mental health disorders, such as depression, psychoses, and substance use-related (Prince, M., et al., 2007; Tambyah, R., Olcoń, K., Allan, J., Destry, P., & Astell-Burt, T., 2022). This results from a poor consideration of the direct relationship between mental health diseases and health diseases, meaning that there is comorbidity between mental health and communicable and non-communicable diseases (Prince, M., et al., 2007). In other words, « many chronic diseases [and disabilities] create a psychological burden », which means that they might be bridges to poor mental health conditions (Prince, M., et al., 2007). Moreover, this is even more alarming in the Low-and-Middle-Income countries (LMICs), as mental health is still not acknowledged as priority (Prince, M., et al., 2007).

Additionally, poor consideration of mental health influences the acheivement of the Millennium Development Goals, « such as promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, and reversal of the spread of HIV/AIDS. » (Prince, M., et al., 2007). Besides, when an individual lives with mental health issues, all levels of their daily life is affected, as for their professional life, study life and social life (Tambyah, R., et al., 2022). They also present intellectual and functional limitations which are correlated with some factors such as « poor health and social outcomes, frequent presentations to hospital, long inpatient admissions, and an ongoing need for support from community-based mental health services » (Tambyah, R., et al., 2022). In addition, reports have showed that individuals experiencing serious mental condition are home-isolated, meaning about spending 75% to 80% of their day « sleeping, resting, or doing nothing than the general population », given that the outside world provokes « loneliness and depressed moods » (Townley, G., Eugene, B., Klein, L., McCormick, B., Gretchen, S., & Salzer, M. S., 2022).

Then, mental health neglect is also caused by stigma towards people with mental health issues. Indeed, WHO refers stigma to « mark of shame, disgrace or disapproval that results in an individual being rejected, discriminated against and excluding from participating in a number of different areas of society » (Javed, A., Lee, C., Zakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., ... & Azeem, M. W., 2021)

Therefore, this context highlights how essential are awareness raising and mental health policies as they will enable a more efficient work between public and community health (Prince, M., et al., 2007). Here, the sense of community differs from the Occidental meaning of it, it is not about the notions of solidarity nor community identity, it is more related to how Eisenbruch defines it as such « Community is a compound of group, villages, communes where people live together in the same environment, same tradition, culture and customs » (Prigent, 2016).

Consequently, all these elements on mental health and how it has affected our current world development are the reasons why mental health is a relevant thesis' topic. Mental health matter needs to be explored thoroughly, especially in LMICs where mental health issues pose a serious burden on the population living there (Javed, A., et al., 2021).

Research question

The topic's thesis contextualization has demonstrated that mental health neglect is a worldwide burden, especially in the LMICs where mental health is not recognized and with a minimal support. This shows that LMICs are in an urgent need of mental health poligices guidelines and services that must be culturally appropriate to their users, but also accessible and affordable. It is essential that those services benefit the community and as the way Eisenbruch means it. Which is why the community mental health approach appears to be a great facet to explore with the aim of addressing mental health neglect.

Thus, the following research question is: *What are the different challenges and lessons learnt from a comprehensive and community mental health approach regarding mental healthcare services in Cambodia's rural areas?*

Thesis editorial plan

Therefore, to tackle the research question, the thesis will be organized into five sections: literature review, case-study, methodology, results, and discussion.

To begin with, a literature review will be conducted, and it will enlighten us about the mental health situation in LMICs and the community mental health. Then, to grasp more about the thesis' topic, it seems that a case-study was crucial to narrow the research to a specific geographical zone, here Cambodia. Following that, the methodology will be detailed with a focus on qualitative analysis. Ultimately, the results section will unveil relevant elements of answer that will be explored.

1) Literature review

To approach the research question, it is important to explore the different dimensions that it implies. To do so, a literature review based on scientific articles and WHO reports will be mobilized. The following parts will be divided into two main chapters such as the mental health situation within the Low-and-Middle-Income Countries (LMICs), and Community Mental Health (CMH).

1. Mental health situation in LMICs

According to some experts, good health entails positive mental wellbeing (Barry, M. M., Clarke, A. M., Jenkins, R., & Patel, V., 2013), this is why mental health is a significant concern that needs to be addressed, particularly in the Low-and-Middle-Income Countries (LMICs) (Alloh, F. T., Regmi, P., Onche, I., van Teijlingen, E., & Trenoweth, S., 2018). Moreover, there is clear evidence that mental health is intimately related to development considering that social and economic factors impacting human development are linked with mental health, and since poor mental health will impair longevity, creativity and general well-being (WHO, 2004). Hence, in LMICs where infrastructures are poorly developed, labor force and material resources are insufficient, and where human rights practices are not guaranteed, it makes it even more challenging to promote mental health (WHO, 2004).

Indeed, 85% of the global population resides in LMICs where more than 80% of people with mental disorder live, and the main mental health disorders are depressive disorders, schizophrenia, bipolar disorder, and alcohol use disorders (Bolton, P., West, J., Whitney, C., Jordans, M. J. D., Bass, J., Thornicroft, G., Murray, L., Snider, L., Eaton, J., Collins, P. Y., Ventevogel, P., Smith, S., Stein, D. J., Petersen, I., Silove, D., Ugo, V., Mahoney, J., El Chammay, R., Contreras, C., Eustache, E., … Raviola, G.; Alloh, F. T., et al., 2018 & Arjadi, R., Nauta, M. H., Chowdhary, N., & Bockting, C. L. H., 2015; Alfredssona, M., San Sebastian, M. & Jeghannathan, B., 2017; Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F., 2017).

In addition, 75-90% of those requiring medical care are not getting appropriate or any treatment at all (Alloh, F. T., et al., 2018). By lacking proper care, people living with mental illnesses may be isolated at home or at an institutional establishment by their family and as a result, they encounter obstacles to live a proper life as they have more difficulties to attend school or to secure a job which can result in intensified marginalization, inadequate education, and lower employment prospects (Bolton P., et al., 2023).

Moreover, the general rate of people living with mental disorders are consequent, as World Health Organization (WHO) asserted that above 450 million individuals are dealing with a mental health condition, for instance depression alone affects 300 million individuals worldwide (Alloh, F. T., et al., 2018). Besides, untreated mental health conditions result in high suicide rates, making suicide the second leading cause of mortality among 15 to 29-year-olds as over 800 000 individuals commit suicide annually (Alloh, F. T., et al., 2018).

Given all these facts stated above, WHO has initiated « The mental health action plan 2013-2020 » in order to focus on mental health as a priority and to reach the targets aimed by the Sustainable Development Goals (SDGs) that were designed to ensure balanced lifestyles and improve overall health and happiness for all individuals (Alloh, F. T., et al., 2018). Yet, mental health remains an unaddressed matter in public health within LMICs as they are struggling to deliver mental health services that meet their populations' needs (Barry, M. M., et al., 2013; Rathod, S., 2017).

Furthermore, to tackle the lack of consideration regarding individuals with mental health issues in LMICs, it has become necessary to integrate mental health into the primary health care (Alloh, F. T., et al., 2018). In fact, in LMICs, health care facilities, in general, are limited and they are even more deficient for mental health care, given that most mental health facilities are mainly located in urban areas (Alloh, F. T., et al., 2018). This integration will enable a better and early intervention for mental health problems before going further into intensive interventions (Alloh, F. T., et al., 2018). Besides that, the primary care providers and the existing community health workers need to be trained on the multipipe facets related to mental health and mental conditions (Alloh, F. T., et al., 2018).

Lastly, another crucial point in this neglect matter concerns the poor implementation and execution of national policies and laws for mental health (Alloh, F. T., et al., 2018). Besides,

these policies and laws do not comply with human rights and exclude family from treatment process (Alloh, F. T., et al., 2018).

Therefore, to grasp the situation, the following sections will discuss the various reasons contributing to mental health neglect in the LMICs. But before addressing the mental health neglect, it will explore the reasons of such rate of mental health disorders within LMICs, which is why we chose to focus the thesis' topic on this geographical zone.

a. Exploring the reasons of higher occurrence of serious mental health conditions in LMICs

According to experts, LMICs' populations appear to be more affected by mental health problems as they are more prone to environmental disasters, warfare, economic decline, disease outbreaks and food scarcity (Alloh, F. T., et al., 2018; Rathod, S., 2017). While those factors intensify the prevalence of emotional and psychological ailments within the impacted communities, the governments rather opt to reallocate the resources to other sectors than mental health, an area that is already financially challenged (Arjadi, R., 2015; Rathod, S., 2017). The prevalence of serious mental health conditions in LMICs is also compounded by socioeconomic factors such as poverty, inequality, unemployment, poor education, urban development, domestic migration, low social status, financial hardships, and gender discrimination (WHO, 2004; Alloh, F. T., et al., 2018; Rathod, S., 2017). Furthermore, the mental health neglect can also result from low self-esteem, lack of security and loneliness (WHO, 2004).

Another reason is demographic factors that intensify the prevalence of severe mental health conditions, such as a considerable part of the population being in the younger age group, which increases the occurrence of major mental disorders including, for example, schizophrenia:

> « 21.5% of the population in Pakistan are in the age range of 15 to 24 years'; similarly, 47.1% of Saudi nationals and 41% of the total population in the Kingdom of Saudi Arabia (KSA) are below 24 years of age. » (Rathod, S., 2017)

Then, an additional factor is domestic violence and abuse towards women and girls which aggravate mental health issues among them (Alloh, F. T., et al., 2018). Following such incidents, they may suffer from depression, post-traumatic stress disorder (PTSD), anxiety, and substance

abuse (Alloh, F. T., et al., 2018). In fact, these types of violence and abuse appear to be the main cause of mortality and morbidity within the reproductive-age women in many nations (Alloh, F. T., et al., 2018). For instance, in Ethiopia, 70% of women have experienced physical or sexual violence from a significant other (Alloh, F. T., et al., 2018). Besides, it is estimated that one-third of women worldwide have experienced sexual assault (Alloh, F. T., et al., 2018). Despite the alarming rates, such incidents are scarcely documented in LMICs due to the culture of silence to avoid shame from the community, and it is also due to victims' fear of stigma and discrimination, along with the patriarchal essence of the press, legislative and legal systems (Alloh, F. T., et al., 2018).

A final factor is the cultural beliefs system which includes religious and institutional prejudices towards women and particular communities that worsen the burden of illness in these subgroups (Rathod, S., 2017). Besides, stigma, cultural and faith-based characteristics of mental disorders that impact the support-seeking conduct make it harder to access mental health services as many people rather turn to spiritual healers due to their lack of trust in standard therapeutic practices (Rathod, S., 2017). Hence, individuals who need to be treated for their mental health conditions end with no medical treatment (Rathod, S., 2017).

b. The treatment gap

As for the LMICs situation, there is a huge inequality in the distribution of specialized human resources as one single country (the United States of America) has more psychiatrists than the most populated nations (India and China) and a whole continent (Africa) all gathered (Patel, V., & Thornicroft, G., 2009). In fact, most individuals with mental disorders have no access to adequate mental health care services and consequently receive no specialized treatments, this phenomenon is commonly acknowledged as the « Treatment gap » (Kale, R., 2002; Thornicroft, G., Deb, T., & Henderson, C.,2016; Kohn, R., et al.., 2004). This phenomenon is described as « the difference between the number of individuals in need of mental health care and those who actually receive treatment » (Subramaniam, M., Abdin, E., Vaingankar, J.A., Shafie, S., Chu, H. C., Tai, W. M., Tan, K.B., Verma, S., Heng, D., & Chong, S.A., 2020:1415).

Indeed, the treatment gap is largely caused by a reluctance to seek help, influenced by various factors (Thirunavukarasu M., 2011; Kohn, R., et al., 2004; Subramaniam, M. et al., 2020):

- many individuals lack adequate understanding about their mental health conditions to seek appropriate care,
- some prefer to manage their challenges independently, avoiding professional guidance,
- failure to recognize of mental health issues exacerbates the problem,
- fear of stigma and discrimination also deters individuals from seeking support,
- financial limitations can impede access to mental health services for some,
- accessibility and transportation issues pose another barrier to treatment,
- poor infrastructures and workforce deficit affects both quality and quantity of mental health services.

On top of that, the workforce and the financial support supplied by the Ministries of health (MoH) for mental health care remain clearly insufficient to address that large treatment gap (Lund, C., Tomlinson, M., De Silva, M., Fekadu, A., Shidhaye, R., Jordans, M., ... & Patel, V., 2012).

Therefore, "Integrating mental health services into primary health care is an efficient way of closing the mental health treatment gap in LMICs, particularly in the rural communities." (Javed, A., 2021).

c. Understanding the factors behind the neglect of mental health

There are various parameters that can explain the low consideration of mental health in LMICs. The first factor is about the stigma and the discrimination that represent a major barrier for the individuals with mental illnesses as they are often stigmatized, excluded, and even mistreated (Alloh, F. T., et al., 2018; Bolton P., et al., 2023). For instance, 70% of individuals affected by mental illness face stigma and discrimination in the UK, but this rate is even higher in LMICs (Alloh, F. T., et al., 2018). This is caused by limited awareness and lack of understanding about mental health and mental illness which result in the proliferation of stereotypes — associating mental illness with danger, incompetence, or blaming the individual for their condition — within the population by encouraging discriminatory behaviors including avoidance, coercion, and segregation (Alloh, F. T., et al., 2018). Moreover, in some LMICs, psychiatric disorders are viewed as *karma* which are understood as divine or universal punishment for past sins (Alloh, F. T., et al., 2018). This kind of belief intensifies marginalization and encourages individuals with mental illness, and their families, to conceal their condition from the community, which

impedes their access to support, care and treatment (Alloh, F. T., et al., 2018). Furthermore, many individuals suffering from mental illness are reluctant to discuss their experiences, which also prevents them from accessing mental health services and hence, hinders their recovery and escalates their risk of depression, anxiety, or even suicidal thoughts (Alloh, F. T., et al., 2018).

The second factor is the cultural biases, as in LMICs, they have a detrimental effect on mental health, especially when it comes to stereotypical expressions such as « Man up! » or « Just face it » which prevent people from sharing about their mental and emotional issues (Alloh, F. T., et al., 2018). As a result, in LMICs, mental health conditions are only acknowledged when people demonstrate physical symptoms of mental health distress (Alloh, F. T., et al., 2018).

The third factor regards the quality of care namely treating patients with respect, compassion and dignity (Alloh, F. T., et al., 2018). Indeed, inhumane treatments within mental health facilities have been reported which leads to lack of trust in psychiatric assistance (Alloh, F. T., et al., 2018). Besides, it was also noted that the patients' relatives are often excluded from the decision-making procedure regarding the patients' mental health status (Alloh, F. T., et al., 2018). This issue highlights the need to offer proper and adequate mental health services and follow-ups in order to treat properly and with dignity people with mental disorders (Alloh, F. T., et al., 2018).

Limited financial resources, both for public funding of mental health care and the patient's personal financial budget, are another cause of mental health neglect (Bolton P., 2023). In fact, in LMICs, less than 50% of the mentally-ill receive treatments and many countries do not allocate specific funds for mental health care as less than 2$ allocated for each individual mental health conditions annually (Alloh, F. T., et al., 2018; Rathod, S., 2017). In fact, in many LMICs, mental health receives less than 1% of health budget allocations (Rathod, S., 2017). For instance, in India, 4.6% of GDB is directed to health, which represents 0.22$ per person, while only 0.06% is dedicated to mental health (Rathod, S., 2017). Furthermore, this underfunding happens since the main funds for mental health come from personal expenditures, taxes, social insurance, and private insurances (Rathod, S., 2017; Alloh, F. T., et al., 2018). For this reason, it is essential to establish standards for the optimal budgets distribution in order to optimize the funds allocation for both general healthcare and mental health services (Rathod, S., 2017).

Another considerable challenge is stigma, as it « manifests at the levels of the individual (intrapersonal), society (interpersonal) and health system (Javed, A., 2021). The self-stigma is when the discriminatory beliefs are emotionally internalized and therefore accepting the mental health stereotypes which results in excluding themselves from the community and feeling marginalized » (Javed, A., 2021). Besides, self-stigma can be increased by the health system itself due to the staff 's inadequate behaviors (Javed, A., 2021). Whereas the societal stigma is a consequence of an absence of knowledge on mental health topics but also limited contact with people with mental health issues (Javed, A., 2021). Additionally, when the family does not give the needed support due to stigmatization of mental health illness, it can result in a completely neglected individual living with mental health diseases (Javed, A., 2021). However, to limit/end stigma, there are various LMICs who focus on the implementation of governmental anti-stigma interventions based on developing mental health knowledge and behaviors toward people living with mental health condition (Javed, A., 2021). Indeed, « Anti-stigma awareness programs are often based on two key messages, normalization paradigm (people with MHDs are similar to other people) and medicalization (MHDs are treatable) » (Javed, A., 2021).

Then, another factor is the « mental health gap » meaning the « limited availability of mental health services is often characterized by a disproportionate number between patients and mental health professionals » (Arjadi, R., 2015). In fact, there is a lack of availability and expertise of the workforce which is essential in order to have sufficient manpower to fulfill populations' mental health treatment requirements (Bruckner, T. A., Scheffler, R. M., Shen, G., Yoon, J., Chisholm, D., Morris, J., ... & Saxena, S., 2011). Indeed, this highlights a significant shortage of mental health specialists (Petersen, I., Ssebunnya, J., Bhana, A., Baillie, K., & MhaPP Research Program., 2011). Therefore, experts have encouraged LMICs to enhance their mental health manpower by strengthen the workforce competences and efficiency with different strategies such as « shared competencies, task-shifting, substitution between health professions, and multiple tasks performed by a particular category of providers » (Bruckner, T. A., 2011). In addition, in LMICs, primary healthcare workforce delivers inadequate mental health support which leads to the necessity of having qualified mental health specialists such as psychiatrists, nurses, and psychosocial experts (Bruckner, T. A., 2011; Bolton P., 2023). Therefore, on one hand, they will be able to support patients with demanding specialized treatment, and on the other hand, they will act as a reference who provides training, guidance, and oversight to non-specialists (Bruckner, T. A., 2011; Bolton P., 2023). In this perspective, it is crucial to expand

their mental health workforce, especially regarding competent professionals for effective mental health services delivery (Bruckner, T. A., 2011).

Moreover, the insufficient relevant data on mental health systems in LMICs presents a significant challenge to workforce, especially regarding planning efforts, as it makes it impossible to gauge the disparity between the required mental health manpower and the available workforce (Bruckner, T. A., 2011). Therefore, it calls for a comprehensive approach from LMICs governments to tackle the major mental health limitations: scarcity, inequity and inefficiency (Bruckner, T. A., 2011).

The following factor concerns the coverage of mental health services. Indeed, the widespread mental health facilities across different regions considerably impacts the accessibility and effectiveness of mental health care, as it mainly provides treatments in urban areas whereas in the remote rural areas, or with limited transportation infrastructure, there are limited mental health services (Rathod, S., 2017; Bruckner, T. A., 2011). Given such circumstances, it may be challenging for some individuals to regularly return to a health facility for their essential treatments and interventions (Rathod, S., 2017; Bruckner, T. A., 2011).

Finally, one last reason is legislation and policies, as in many LMICs, there are no appropriate and profitable mental health policies and laws to coordinate their mental health initiatives and services (Rathod, S., 2017). One good example of that is PRIME which is a « Program for Improving Mental Health Care » that targets to find what works best for treating mental health neglect in countries like Ethiopia, India, Nepal, South Africa, and Uganda (Rathod, S., 2017). To do so, the theory of change is mobilized to establish integrated mental health care plans for specific districts within the mentioned countries (Rathod, S., 2017). However, even if PRIME has showed relevant outcomes, it is suggested that engaging local communities by getting their feedback and support could improve the program effectiveness (Rathod, S., 2017).

Conclusion

To conclude, the mental health situation within the LMICs is alarming and needs to be addressed with strategies that will reprioritize mental health and the individuals living with mental illnesses. This current neglect must be resolved to guarantee good health and positive

well-being. One way to resolve this is through mental health policies, but in order to do so, mental health topics must be on the agenda to ensure proper mental health services and care.

Consequently, the lessons learnt from the past chapter is that it is crucial to increase the number of qualified mental health professionals in order to combat treatment gap, and lastly, the necessity to develop mental health awareness campaigns to achieve better understanding of mental health issues, and thus, limit the spread of stereotypes.

2. Community Mental Health

This section will be mainly based on the « Guidance on community mental health services » issued by WHO in 2012, this chapter will lay out an overview on Community Mental Health by defining it and exploring its approach through different dimensions: services and workforce.

a. Defining Community Mental Health

When it comes to Community Mental Health, there is a wide range of factors that needs to be considered (Thornicroft, G., et al., 2016). Indeed, Community Mental Health entails a population-focused approach, patients' socio-economic consideration, prevention strategies at both individual and population levels, a systemic view of services delivery, an open access and team-based services, a long-term and life-course perspective, an emphasis on cost-effectiveness and commitment to social justice and addressing the needs of underserved populations (Thornicroft, G., et al., 2016).

In addition, according to the Guidance on Community Mental Health services, issued by WHO (2021) and the perspectives given by the Word of Psychiatry (Thornicroft, G., et al., 2016), the key components and principles of Community Mental Health care are:

- Recovery-oriented perspective: this perspective emphasizes on acknowledging individuals' abilities, decisions, potential, autonomy, and aspirations without putting aside their limitations and disabilities. It also crucial to support people in having or reclaiming meaning or purpose in life through services that are designed to boost positive identity, self-management, and pursuit of esteemed social roles.
- Community involvement: community mental health care involves active engagement with the broader community which includes not only reducing adversity but also optimizing the strengths of families, social networks, and organizations to back mental health initiatives.
- Integration of evidence-based medicine and ethics: this approach is based on evidence-based practices with ethical matters by guaranteeing that interventions are rooted in scientific evidence and honoring individuals' rights to understand their illnesses and have a role in decision-making processes.

- Patient perspective: in order to provide effective care, it is essential to prioritize their perspectives such as sociocultural beliefs, knowledge about mental illness, and patients' perceptions of treatments that are available for them.
- Care provider factors: this relates to knowledge, skills, motivation, availability, empathy, and communication abilities, by understanding their critical role in delivering quality mental health care.
- Healthcare facility, organizational and evaluation factors: this includes assessing the accessibility of medications and equipment, the availability of qualified workforce, the consistency and thorough provision of care, coordination among different stakeholders, and the utilization of information systems to enhance service delivery efficiency.
- Policy maker roles: in an effort to deliver mental health care within communities, it is necessary to analyze and consider the legislative framework surrounding mental health and resource allocation to mental health services and programs.

To wrap up, community mental health care works to boost mental well-being in local communities by meeting specific needs, empowering individuals, nurturing community networks, and providing evidence-based, recovery-focused services (Thornicroft, G., et al., 2016 & WHO, 2021). Each of these aspects are essential in boosting mental health care within local communities, highlighting the importance of a comprehensive approach to meet the diverse needs of individuals and to promote mental wellness (Thornicroft, G., et al., 2016 & WHO, 2021).

b. Community mental health services

There is a clear imperative to establish a network of community mental health services as these services offer better accessibility and responsiveness to patients' needs while also minimizing the risk of neglect and human rights violations compared to psychiatric hospitals (Martin, J. P., 2013). Therefore, the aim of community mental health facilities is to provide assistance within a community-based setting that is close to individual’s home rather than in institutionalized environment (WHO, 2021). In addition, the types of assistance provided by these centers are determined by their size and environment, but also depends on the broader national healthcare system (WHO, 2021). Most of them offers consultation services that deliver various types of care such as counselling, medication and therapy (WHO, 2021).

Besides, in their efforts to value their patients' roles within their communities, these services are actively committed to ensure their patients' social integration and active engagement in community life, especially through accessing employment, learning prospects, and social and recreational activities (WHO, 2021). Moreover, these centers aspire to reduce power imbalances between mental health professionals and patients (WHO, 2021). Hence, through these community mental health services, continuity of care, support and cooperation are guaranteed as they are community and right based, and additionally these services acknowledge the relevance of support extending beyond medical care. (WHO, 2021).

In other words, community mental health services refer to a care framework in which the patient's community, not a concrete establishment like a hospital, operates as the primary provider of care[1] for people with a mental condition (Ayano, G., 2018).

In fact, the urgent need for countries to develop such network is exacerbated by the scarcity of mental health services in many countries as these community-based services play a crucial role in communities for receiving and treating individuals with mental illness (Martin, 2013).

Therefore, to achieve well-developed community networks it is crucial to ensure that the rights of the individuals they serve are honored, and that they have access to « the highest attainable standard of health » (WHO, 2021). These networks must be established on common characteristics such as (WHO, 2021):

- A dedicated and consistent political effort to reform the mental health care system, by implementing a human rights and recovery-oriented approach.

[1] "Primary Health Care Providers are general healthcare providers working in non-specialized healthcare settings. They form the basis of healthcare systems in most countries. In HICs they are usually physicians, physician In "In many LMICs most Primary Health Care Providers are non-physicians with more limited primary care training. Most Primary Health Care Providers focus on physical health. Our experience is that LMIC Primary Health Care Providers are usually uncomfortable managing mental health conditions. This is due to existing workloads, lack of training, and the greater time required to treat these conditions. Also, psychological counseling skills are different from the typical advice-giving counseling skills of Primary Health Care Providers. Their training typically consists of history taking via closed questions followed by diagnosis and specific disease-focused treatments, requiring fewer visits. Under the C4 Framework we propose building on these existing strengths with management duties assigned to other workers with the requisite training. Primary Health Care Providers remain at the center of patient management, as they do for other health-related issues, since they are usually the most highly trained available care providers and the primary source of pharmacologic treatments. They are also best placed to deal with mental and physical comorbidity (World Health Organization, 2015a, 2018f). Integration of mental health services within primary health care is achievable in LMICs" retrieved from (Bolton, P., et al., 2023).

- The conception of new policies, laws, and budgets, in conjunction with increased resources fundings, which reflects a political will to better the situation.
- The establishment of community-based mental health services, which are inter-related and connected with various stakeholders from different sectors including social services, healthcare, employment, judiciary, and others.

To summarize, the determinants that set the foundation of community mental health services are very different from the ones setting public mental health:

> « 1) treatment based not on diagnosis but on the overall situation of the person; 2) shared experience with peers; and 3) empowerment, inviting the person to become involved in decisions concerning his/her treatment and service use as well as decisions that concern the functioning of the organization; 4) establishment of more egalitarian relationships between service users and treating professionals; and 5) rootedness of the organization within the community. MCHO are grouped at the provincial level according to their functions, their ideological affinity, and or their particular mandate, but there is no national classification of community organizations as yet. » (Grenier, G., et al., 2014).

Basically, the principal aim of community mental health services is to ensure that a wide range of them are easily available for each community member (Ayano, G., 2018). They consist of

> « day centers, CBR[2] services, hospital diversion programs, specialist CMH[3] programs, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families and other support services. » (Ayano, G., 2018).

Additionally, community mental health services help to overcome various challenges regarding mental health within LMICs (Ayano, G., 2018). First, they play an essential role in community inclusion of the individuals with mental conditions (Ayano, G., 2018). Secondly, they ensure a direct care delivery by improving the access to care at community level (Ayano, G., 2018). Thirdly, community-based mental health care enhances accessibility to mental health services within rural areas as many people cannot access public network services (Ayano, G., 2018). This leads to physical and mental health improvements and hence, improve quality of life

[2] « Community Based Rehabilitation »
[3] « Community Mental Health »

(Ayano, G., 2018). As well as, it helps to promote acceptance, and to lessen social stigma and human rights violations (Ayano, G., 2018). Moreover, through early identification and treatment, it also helps to prevent chronic conditions and physical health complications (Ayano, G., 2018).

Effectively, the community mental health services were not developed to oppose or replace the public mental health system, but rather to complement with it (Grenier, G., et al., 2014). Thus, these services can be situated within clinics or other service buildings, or even at home (Bolton, P., et al., 2023).

Furthermore, literature says that community mental health services have been proved to be beneficial to their users as it positively contributes to their recovery since it enables a better self-esteem (Grenier, G., Fleury, M. J., 2014). This happens through the establishment of a social networks, the learning of new abilities, the individual's ability to act on their social environment and to better advocate for their rights which helps to alleviate (self-)stigma (Grenier, G., Fleury, M. J., 2014).

Consequently, community mental health services need to be considered as part of a comprehensive and integrated network of services and systems that must embody the diversity and complexity of everyone's needs (WHO, 2021). To achieve that purpose, it is fundamental that all services are accessible and available to the general population, including the ones with mental health disorders and psychosocial limitations (WHO, 2021).

c. Community mental health workforce

According to literature, Community Health Workers (CHWs) have been essential actors in delivering mental health interventions to address a range of mental conditions, such as « depression, anxiety, psychological trauma, and disruptive behavior disorders. » (Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S., 2018). They represent the main treatment providers for individuals facing mental health disorders given that community health workers play a key role in providing effective mental health services delivery which produce positive mental health outcomes (Barnett, M. L., et al., 2018). Indeed, they succeed in addressing global and national inequalities in care for underprivileged populations and communities (Barnett, M. L., et al., 2018).

Then, in an effort to gap the mental health experts' shortage, and to successfully integrate mental health into primary health care, task-shifting appears to be one great strategy, especially in delivering Evidenced-Based Therapy (EBT)[4] (Armstrong, G., Kermode, M., Raja, S. et al., 2011). Task-shifting consists of « using non-specialists or paraprofessionals (lay counselors) with little to no prior mental health training or experience to deliver care, under supervision » (Dorsey, S., Gray, C. L., Wasonga, A. I., Amanya, C., Weiner, B. J., Belden, C. M., ... & Whetten, K., 2020). In other words, task-shifting refers to « The process of redistributing mental health services from mental health professionals to non-specialist health workers » and it has showed to improve clinical outcomes for common mental, neurological and substance abuse disorders (MNSDs) (Alfredssona, M., et al., 2017).

In fact, it has demonstrated effective results in mental health interventions (Dorsey, S., et al., 2020). As shown in a study conducted by Petersen et al. (2011), community mental health workers are ideally positioned to dispense psychological interventions to people with common mental conditions because of their proximity within the community. Additionally, the community mental health workers find « the supportive counseling and problem solving » training they acquired to be very beneficial in taking care of their patients, especially during home-visits (Petersen, I., et al., 2011). Indeed, following several studies, those trainings consist of three main objectives, identification, management and awareness of common mental disorders, which will enable the community mental health workers to properly treat their patients and refer them to the adequate specialists in order to effectively help the patients (Armstrong, G. et al., 2011; Petersen, I., et al., 2011). Moreover this facilitates the access to mental health services as some individuals are reluctant to do it by themselves (Petersen, I., et al., 2011).

Ultimately, the training provided to community mental health workers has helped to reduce stigma when it comes to treat people with mental disorders as they gained mental health literacy (Petersen, I., et al., 2011).

[4] « a treatment that has been scientifically tested and subjected to clinical judgment and determined to be appropriate for the treatment of a given individual, population, or problem area » (Sorensen, J. L., Hettema, J. E., & Larios, S., 2009).

In fact, mental health literacy is described as « knowledge and beliefs about mental disorders which aid their recognition, management or prevention » and has various factors that need to be considered, such as

> « (a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments avail- able, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis » (Jorm, A. F.,2012).

Additionally, within the range of community mental health workers, there are psychosocial workers with two main functions (Bolton, P., et al., 2023; Petersen, I., et al., 2011). On one hand, they actively promote mental health and well-being by offering preventative measures and coping plans to people facing distress and difficult life events (Bolton, P., et al., 2023; Petersen, I., et al., 2011). On the other hand, they help to acknowledge and facilitate referrals for individuals requiring mental health support. (Bolton, P., et al., 2023; Petersen, I., et al., 2011). Therefore, to provide adequate care to the people in need, they have to be aware of the services accessible within their communities for individuals navigating distressing situations (such as legal aid, housing assistance, and protection services) and to offer referral guidance as necessary (Bolton, P., et al., 2023).

Besides their dual responsibility, psychosocial workers have other functions, such as educating community about mental health with the aim to reduce stigma and to promote understanding and appropriate call for mental health services (Bolton, P., et al., 2023). Additionally, with the purpose of empowering people to address stressors, the psychosocial workers will provide them supportive communication and practical support during acute crises (Bolton, P., et al., 2023). Besides mental health support, psychosocial workers also provide social support and other necessary assistance (Bolton, P., et al., 2023). They will also refer people in need of any health services to Primary Health Care Providers (Bolton, P., et al., 2023). Furthermore, to assist individuals with chronic mental health conditions and their caretakers, they will carry-out community visits to guarantee « medication adherence, self-care, and social support » (Bolton, P., et al., 2023).

Finally, another major strategy used by community mental health workers is the creation of self-help groups (Levy, L.H., 2000; Segal, S. P., Silverman, C. J., & Temkin, T. L., 2010; Petersen, I., et al., 2011). They were originally born from a sense of frustration with the existing health care system and are referred as « consumer-operated programs » (Levy, L.H., 2000; Segal, S. P., et al., 2010). They are defined as « mutual-help groups of *people in the same boat* and as ready-made social support systems in specific domains of problems » (Levy, L.H., 2000).

Besides, these groups are different from being around relatives as their members refer to each other as

> « peers, [and] each acting as both a provider and a recipient of help, focused on their common problem or condition. […] These are directly generated from the community and are beneficial to it as it needs low expense for their members, and it has no hierarchy as it encourages them to be more empowering as they are the ones in charge. [This last part demonstrates that] there is a positive effect of an empowering participation experience on recovery […] suggesting that people who are more involved in the organizational operations […] tend to benefit more from participation. » (Levy, L.H., 2000; Segal, S. P., et al., 2010).

Conclusion

Ultimately, community mental health appears to be an effective approach in responding to the different challenges that lay behind mental health neglect in LMICs. It promotes a person-centered strategy by providing them the proper and personalized medical assistance they need by revaluing their role within their community, facilitating mental health services, and by educating their communities to mental health literacy. Additionally, it contributes to increase mental health workforce with the task-shifting strategy as it helps to educate community mental health workers about mental health conditions. Besides, it also helps to lessen stigma and discrimination regarding the mental illnesses. Another major benefit from this community approach is that individuals with mental health conditions are treated within a human-rights-based structures. Hence, community mental health approach can be an interesting tool to bridge the existing gaps regarding mental health in LMICs.

2) Case-study: The Cambodian experience of mental health

Considering the general context regarding mental health in LMICs, it will be interesting to narrow the focus on one specific geographical area of the study — here, Cambodia — which will enable a more thorough perspective. Through this case-study, it will be easier to grasp the thesis' themes — mental health neglect in LMICs and community mental health — as it provides a concrete contextualization of the matters. Therefore, this chapter will firstly tackle Cambodia's history background, and then, the country's mental health situation by addressing the barriers and the challenges regarding of Cambodia's mental health care, as of funding, infrastructures, services, and workforce, but also the cultural beliefs around mental health.

1. Cambodia's historical background

After 25 years of disorder, brutality and turmoil, Cambodia tends to sustain and to prosper (Parry, S., 2020; Dubois, V., Tonglet, R., Hoyois, P., Sunbaunat, K., Roussaux, J-P. & Hauff, E., 2004). Indeed, after the French colonial period, Cambodia was caught up in the Vietnam war (Van de Put, W. A., & Eisenbruch, M., 2002; Alfredssona, M., et al., 2017). This implication had weakened the country allowing room for a strategic coup d'état orchestrated by the U.S. in 1970, Prince Norodom Sihanouk, the reigning king at that time, was deposed by Lon Nol, the Prime Minister (Van de Put, W. A., et al., 2002). This event leaded the country into a five-year civil war with 10% of the Cambodia's population killed and mostly due to the U.S. bombings (Van de Put, W. A., et al., 2002). Thus, 1975, the communist opposition known as the Khmer Rouge, led by Pol Pot, took over and lasted for almost 4 years, they were enlisting numerous young individuals since 1960s, (Maddock, et al., 2023; Van de Put, W.A., et al., 2002).

Pol Pot had shattered the traditional Cambodian life into a huge forced-labor camp, with transforming policies aimed to remodel the Cambodian traditional society into a communist one by dismantling religion, education, family that were the core of the Cambodian society (Van de Put, W. A., et al., 2002). It was only in 1979, that Vietnamese troops put an end to the Khmer Rouge, but low intensity warfare prevailed throughout the '80s (Van de Put, W. A., et al., 2002). At the beginning of the '90s, the situation started to stabilize as Cambodia attempted to rebuild its identity under the UN assistance (Ozano et al., 2018). The Khmer Rouge regime has caused a social impact and a cultural disconnection since the dismantling of the nuclear

family scheme has severely affected the current households with physical and mental damages (Ozano et al., 2018; Van de Put, W.A., et al., 2002; Maddock, A., Best, P., Ean, N., Armour, C., Ramstrand, N., 2023).

Then, regarding human casualties, through warfare, Cambodia saw « A million and a half [of its inhabitants] died due to starvation and sickness, half a million were eliminated in the name of agrarian revolution [i.e., the Pol Pot regime] and about two million people were internally displaced between 1975 and 1978] » (Jeghannathan, B., Gunnar, K. & Parameshvara D., 2015).

Furthermore, under the ongoing conflicts, and mainly due to the Pol Pot regime, the healthcare system has been destroyed including the medical facilities and equipment (DMHSA, 2023). Additionally, there were less than 50 out of 600 doctors who survived the Pol Pot period and among them, there were no mental health specialists left (Van Hoof, J., Rato, S. & Sennef, C., 2020; DMHSA, 2023; Parry, S. et al., 2020). It was not until 1979, after the fall of the Pol Pot administration, that the rehabilitation of the healthcare system was back on the agenda (DMHSA, 2023). Nevertheless, back then, there were no existing mental health training nor services (DMHSA, 2023). It was only in 1992 that the first mental health program was presented by the Ministry of Health (MoH), it was done through a sub-committee who was in charge of facilitating, developing and implementing mental health activities as a necessary component within the global service delivery (DMHSA, 2023). Some years later, in 2012, the Department of Mental Health and Substance Abuse (DMHSA) was created to enable mental health to be incorporated into the national public health system (DMHSA, 2023). Their three main project sections are mental health, substance abuse and harm reduction, and their roles all imply areas associated with mental health and substance abuse which consist of designing policies and action plans regarding, database management, services and programs assessment, conducting studies, partnership with the ministerial, institutional, national, regional and international stakeholders involved, staff training and development, events planning (DMHSA, 2023).

2. Mental health context: psychosocial issues and trauma experiences

Even though, Cambodian people share a common experience of the genocide, they usually tend to avoid talking about it and they develop symptoms like sleeping disorders, nightmares, overthinking, unable to concentrate and gloominess (Van de Put, W. A., et al., 2002). In addition, as trauma is persistent and multidimensional, it becomes a part of their daily life (Van de Put, W. A., et al., 2002).

As a result, many are unable to participate in the daily life as they are at loss for how to deal with their poor mental health including grief and trauma, those in such conditions are looked down as *crazy* (Van de Put, W. A., et al., 2002). Therefore, some are stuck in a psychological distress (Van de Put, W. A., et al., 2002). And on top of that, it is the most mentally vulnerable who face many barriers in terms of healthcare access, and are being discriminated and stigmatized (Maddock, A., Best, P., Ean, N., Armour, C., Ramstrand, N., 2023; Van de Put, W. A., et al., 2002).

In Cambodia, there is a high rate of poor mental health which is due to everyday burdens such as poverty, scarcity, financial worry, family concerns, domestic violence, and alcoholism addiction (Dubois, V. et al., 2014; Van de Put, W.A., et al., 2002; Maddock, A., Best, P., Ean, N., Armour, C., Ramstrand, N., 2023). Indeed, there is a high rate of MNSDs in Cambodia (Jeghannathan, B., et al., 2015). Moreover, in 2017, it was reported by WHO that 10.7% of Cambodia's inhabitants — namely, 1,6 million — experienced different types of mental disorders and the most frequent being depression, anxiety, and schizophrenia (DMHSA, 2023).

Additionally, regarding the suicide rates, in 2019, it was represented by 4.9 per 100, 000 individuals (DMHSA, 2023). Besides, evidence also shows that 34.2% of drugs consumers live with a mental health condition (DMHSA, 2023). In fact, data demonstrated that there is a recurring co-morbidity between substance abuse and mental health disorders (DMHSA, 2023).

Furthermore, findings reveal that a high co-morbidity exists between individuals living with disabilities and mental health issues, implying that disabled people experience important mental health distress and unaddressed PTSD (Maddock, A., et al., 2023). Besides, healthcare services are physically difficult to access by individuals with disabilities, mainly because of scarcity of

public transportation, distance, poor quality of the roads and facilities limitations as their location is far to reach (National Institute of Statistics, Ministry of Planning, 2022).

3. Mental healthcare funding and infrastructures

As stated above, Cambodia has a consequent mental disease rates and yet poor infrastructures to tackle it (Chhea, C., Warren, N., & Manderson, L., 2010). As a matter of fact, there is no mental health hospital in the country, there are only mental health services integrated into public health system (DMHSA, 2023). There are 131 public hospitals (12 national hospitals, 25 referral hospitals and 94 district hospitals), yet only 101 of them include mental health services (2 national hospitals, 25 referral hospitals and 74 district hospitals) (DMHSA, 2023). They are organized through Minimum Package of Activities (MPA) and Complementary Package of Activities (CPA) (DMHSA, 2023). Thus, on the one hand, CPA are operating within district hospitals where diagnosis, treatment and care delivery to patients with mental health and substance abuse are performed (DMHSA, 2023). CPA also include consultation and recommendation to additional medical facilities, psychoeducation, teaming up with associates to achieve a comprehensive treatment and care (DMHSA, 2023). Then, on the other hand, MPA are taking place in health centers, but only 305 out of 1305 health centers are delivering basic mental health services, and the most recuring mental disorders are anxiety, depression, psychotic disorders (e.g.: schizophrenia), sleeping troubles, stress, trauma, substance use disorders (mainly alcohol and tobacco), developmental and behavioral conditions, self-inflicted harm, and dementia (DMHSA, 2023). Still, there is a lack of the appropriate equipment at the health centers, making it challenging to diagnose certain conditions, for instance, X-Rays, ultrasound, and pathological examination are conducted at the referral hospitals that are usually situated far from the health centers (Chhea, C., et al., 2010).

Even though, mental health is high on the agenda, the Ministry of Health has not yet allocated the proper funds for mental health services within the country (Chhim, S., 2027). Indeed, there is a significant lack of financial support considering that there is only 0,02% of the global health resource that goes to mental health expenses (McLaughlin, D., Wickeri, E., 2011). Additionally, there are also external and international financial aids, but they are unreliable to cover mental health spendings as they are often reduced or terminated (Parry, S., 2020).

As a result, Cambodians privately spend a lot of money to seek health care huge (Van de Put, W. A., et al., 2002). Their out-of- pocket money contribution amounts to 82% of total health care expenditure, or US $33.3 per capita per year, and constitutes with 13.2% of GDP far more than many households can afford (Van de Put, W. A., et al., 2002; World Bank, 1999). Indeed, one illness episode can ruin a family, especially when they desperately need treatment with immediate effect to restore the working capacity of one of the family members (Van de Put, W. A., et al., 2002). Although, the most disadvantaged do not always have a choice, most people opt to go to a pharmacy or a private clinic when illness occurs (Chhea, C., et al., 2010).

4. Barriers related to mental health services accessibility and delivery

Cambodia presents weak mental health services, especially in the post-Pol Pot regime, the country had to restore its economy and infrastructures, including setting up mental health services, the assistance of NGOs (c.f. Appendix 1) and international collaborations have greatly helped with that matter (Parry, S., 2020). As a matter of fact, NGOs play an active role in the mental health matter, for as long as they maintain political neutrality (Parry, S., 2020). Through this point, the first challenge in the development of mental health services emerges, the need to ensure collaboration (Parry, S., 2020). Indeed, the related actors and partners chose to operate independently rather than hand in hand with each other (Parry, S., 2020). According to Parry (2020), this absence of effective collaboration has to do with « the long period of civil war and a long history of trauma » experienced by Cambodians that highly affected their ability to trust. This lack of cooperation also impacts the different disciplines given that psychiatrists and psychologists work independently (Parry, S., 2020). In fact, the different actors and organizations from different backgrounds assume that they have different status and thus, different priorities while in the end, they work for the same matter (Parry, S., 2020). Therefore, a cross-sectoral cooperation between the different partners is essential to seek strategies to increase public awareness and foster their understanding of mental health, especially with regard to combat discrimination and stigma towards the mentally ill, to organize mental health promotional and prevention interventions in schools, to prepare individuals to disasters, to address mental health at the workplace, to promote parental and maternal psychological wellbeing, and to prevent suicide (DMHSA, 2023).

Additionally, no linkage service nor psychosocial rehabilitation exist for mental health care (DMHSA, 2023). Hence, there is a clear need for the development of mental health services, especially for the rural communities considering most people live in the rural areas (Maddock, A., et al., 2023 & Parry, S., 2020). To do so, task-shifted programs of mental health services can be useful to the expansion of mental health provision to community-based primary care facilities (Maddock, A., et al., 2023). Additionally, it will also help with the limited performance of mental health provision located in the rural areas (Chhea, C., et al., 2010). Yet, the mental health services based in rural regions still must meet the governmental benchmarks for healthcare provision (Chhea, C., et al., 2010).

Besides, while health centres get their monthly medicines and medical equipment supplied by the Ministry of Health (MoH), they still lack in drugs and medical tools (Chhea, C., et al., 2010). This predicament decreases the patient's presence as they usually come to health centres to seek medication instead of consultation (Chhea, C., et al., 2010).

Therefore, patients feel reluctant to seek health assistance from the public medical centers, they find government medical establishments unappealing as they are often short of staff, are time consuming, and come with unexpectedly high costs and neglect their patients (Van de Put, W. A., et al., 2002 & Chhea, C., et al., 2010). Besides, the insufficient use and the underappreciation of the mental health services has a negative effect on the mental health staff, it affects their confidence, their motivation, sense of responsibility and their satisfaction (Chhea, C., et al., 2010).

Finally, stigma is also a barrier regarding the services accessibility, especially in term of treatment as stigma undermines the patients with mental disorder to effectively get their treatment (Alfredssona, M., et al., 2017). Besides, due to stigmatization and discrimination, the likelihood of a relapse is much higher (Alfredssona, M., et al., 2017). Indeed, stigma and discrimination towards the mentally ill affect negatively the attitudes and the judgment, as even some doctors perceive them as dangerous and unpredictable (Alfredssona, M., et al., 2017). Yet, they value mental health as important as physical health (Alfredssona, M., et al., 2017).

5. Challenges faced by mental health workforce as for availability, performance and quality

Regarding mental health workforce, there is a significant lack of qualified specialists (in terms of psychiatric nurses, social workers, counselors, clinical psychologists, psychotherapists, and psychiatrists (Maddock, A., 2023; Parry, S., 2020). In fact, in 2015, there were only fifty psychiatrists with one child and adolescent psychiatrist (Alfredssona, M., et al., 2017). This limited human resource causes the existing services to overwhelm as there are too many patients in need of assistance but not enough mental health providers to treat them (Parry, S., 2020).

This shortage results from various factors. The first one is financial as their incomes are irregular and low (Van de Put, W. A., et al., 2002). For instance, following their position and competences, their net salary is between 40$ and 110$ with an average of 60 $/day which is insufficient to meet the cost of living and result in staff dissatisfaction (Chhea, C., et al., 2010). Hence, as they cannot properly meet ends, most of them has side/private jobs (Chhea, C., et al., 2010; Van de Put, W. A., et al., 2002). In fact, in rural regions, there is an increase of informal jobs in the health sector with mostly not certified and unskilled practitioners (as they mostly constitute of traditional midwives and healers) (Chhea, C., et al., 2010). Due to these circumstances, when people get sick, they rather seek health advice from these private medical providers who are community-based and more geographically and financially accessible (Chhea, C., et al., 2010). Consequently, this situation not only affects public health providers performance, but it also undermines patient's reliability to use public health services, and this contributes to poor public healthcare delivery (Chhea, C., et al., 2010).

Another factor regards staff retention and motivation, especially in rural regions (Chhea, C., et al., 2010). Indeed, there are various parameters that affect staff retention and motivation which are in a high need of improvement to ensure long-term staff retention (Chhea, C., et al., 2010). These factors concern monetary incentives, professional growth, ongoing training, safe workplace climate and terms, better guidance and leadership, more resource provision, and lastly, work gratitude and acknowledgement (Chhea, C., et al., 2010).

Besides, an uneven staff distribution can explain the workforce shortage (Chhea, C., et al., 2010). Indeed, 54% of the medical practitioners are serving in Phnom-Penh where merely 9% of the inhabitants live (Chhea, C., et al., 2010). This high staff presence in the urban areas can

be attributed to a feeling of insecurity, challenging working environment and poor administration of the governmental infrastructures in the rural locations, which makes it unappealing for the mental health staff to work (Chhea, C., et al., 2010).

Moreover, the mental health performance is also subjected to other obstacles. One of them is also linked to low government incomes while it has been proved that financial incentives contribute to good performance outcomes (Van de Put, W. A., et al., 2002). The following challenge concerns the sense of powerlessness (Chhea, C., et al., 2010). Indeed, health workers believe that public health improvement is out of their reach and that is the duty of the executive authorities to endorse it (Chhea, C., et al., 2010). This mentality prevents the workforce to take initiatives and instills the idea that they are not entitled to display leadership (Parry, S., 2020; Chhea, C., et al., 2010). This might be influenced by a Cambodian cultural aspect that places high value and respect on the authority figures, and hence makes it reluctant to people to voice their opinions (Parry, S., 2020). For this reason, they lack empowerment to embody as agents of change (Parry, S., 2020; Chhea, C., et al., 2010).

Besides, the limited availability of primary medical equipment and essential psychotropic medicines that prevent the mental health providers to deliver proper mental healthcare (Parry, S., 2020; Chhea, C., et al., 2010).

Then, another challenge is patients neglect due to poor mental health performance as mental health providers focus on other tasks (e.g.: meetings) (Chhea, C., et al., 2010). In addition to that, inadequate patients' receptions, inappropriate management, and supervision also weaken staff effectiveness (Chhea, C., et al., 2010). Additionally, the current mental health workers also lack interpersonal communication skills, therefore, they happen to use inappropriate language with their patients (Parry, S., 2020). Furthermore, the absence of intimacy makes patients uncomfortable and unsafe, hence, it is essential to guarantee private rooms for out/inpatient care (Parry, S., 2020).

Lastly, the quality of mental health care and treatment need to be regularly assessed, and to guarantee that, a standard mental health service requirement need to be set (Parry, S., 2020).

6. Mental health training

Cambodia only counts 97 psychiatrists and 33 psychiatrist nurses which show a clear need to expand mental health coverage with integrated trainings (DMHSA, 2023). According to DMHSA (2023), mental health trainings consist of two types, the first one is the « specialized » training (DMHSA, 2023). It was conducted in 2004, by the University of Health Sciences, that is the official institute for the training of psychiatrists and psychiatric nurses, and with the assistance of the University of Oslo (Chhim, S., 2017). However, since 2006, psychiatric nurses training has ceased to be (Parry, S., 2020). The second training is called the « non-specialized » training that is aimed for doctors and nurses (DMHSA, 2023).

Moreover, due to lack of psychiatric trainers within the country, there are a lot of international professors who volunteered to help with basic classroom training and clinical supervision (Chhim, S., 2017). For example,

> « a group of Singaporean psychiatrists led by Dr Angelina Chan, a consultant psychiatrist from Changi General Hospital in Singapore, came to train residents over a 2-year period from 2006-2008. There were many psychiatrists from other countries such as from Europe, America, and the Netherlands » (Chhim, S., 2017).

In addition, Ministry of Health has implemented on-the-job trainings in the interest of doctors and nurses (DMHSA, 2023). In consequence, in 2020, 296 and 627 nurses received mental health and substance abuse trainings (DMHSA, 2023). Still, in health centers, the staff needs in-service trainings to guarantee an efficient performance which is key to primary mental health care (DMHSA, 2023).

Furthermore, to strengthen mental health competences, the undergraduate medical curriculum has integrated psychiatry within it, and the Royal University of Phnom-Penh also has psychology and social work programs (Chhim, S., 2017). Yet, the academic mental health training needs to be more diverse as child and adolescent psychiatry, geriatric psychiatry, and addiction psychiatry (DMHSA, 2023).

Finally, the quality of mental health professionals is not guaranteed until a strong accreditation system is established to ensure mental health workforce (Parry, S., 2020).

7. Community health workers role, positive contribution, and constraints

In 2003, to improve the health system development, the Community Participation Policy for Health was established and thanks to it, the Community Health Workers (CHWs) has received more importance (Ozano, K., et al., 2018). In Cambodia, the community health workers are referred as the Village Health Support Groups (VHSGs) and they handle a great number of tasks (c.f. Appendix 2) (Ozano, K., et al., 2018). Indeed, they play a key role in the community, as its spokesman, they advocate for health progress for its members, enabling them to take part in health decisions (Ozano, K., et al., 2018). Besides, there are many duties when it comes to CHWs, such as analyze people with a health issues, share information to other health centers, help to increase health-seeking and advice, and do promotion on health topics within the community (Ozano, K., et al., 2018).

Additionally, there are great benefits with CHWs work, especially when they are properly trained, supervised, and supported (Ozano, K., et al., 2018). Moreover, when their work commitment is high, it leads to more effective use of health services, improves workforce behaviors towards their patients, and optimizes health centers efficiency (Ozano, K., et al., 2018).

However, they also face several challenges (Ozano, K., et al., 2018). One of them is the volunteer status meaning they dedicate their time to community work while most of them come from disadvantaged background, which impedes them to increase their personal incomes (Ozano, K., et al., 2018). Besides, there is a lack of financial and technical assistance from the government to develop their skills, to ensure management, and to better communities' organization by connecting the health providers (meaning health staff and CHWs) with the community by providing supervision and guidance to health centers and local administrations (Ozano, K., et al., 2018). The CHWs also lack adequate monetary aids, especially to cover their transportation costs when they do home-based visits or community-based activities (Ozano, K., et al., 2018).

Then, another barrier is related to their personal commitments (e.g.: civic duties) which can prevent them to attend training (Ozano, K., et al., 2018). Another point concerning their

personal life is their limited education background that makes it difficult to grasp some health information (Ozano, K., et al., 2018).

Furthermore, an additional challenge regards their poor training as there is no refresher sessions to guarantee their skills and knowledge, and on top of that, there is no structured training program dedicated for CHWs (Ozano, K., et al., 2018). In addition to that, there is skepticism regarding their knowledge which lowers their confidence to practice (Ozano, K., et al., 2018). This might be resulting by the fact that traditional healers are known to be a great reference of health knowledge (Ozano, K., et al., 2018). Lastly, the absence of an accreditation system to legitimize their job leads to a lack of acknowledgement and respect from the community members (Ozano, K., et al., 2018).

Finally, CHWs find it difficult to support behavior change in community members through health promotion intervention sessions and group activities (Ozano, K., et al., 2018). This is due to the fact that the community members are focused on their work and household tasks, and therefore could not attend group discussions on health topics and mostly, because they struggle to grasp the relation between poor health habits and poor health conditions (Ozano, K., et al., 2018).

8. Beliefs system and traditional healings

When it comes to mental health, the socio-cultural dimension is essential, especially in Cambodia where 97% of the population are Buddhist, more precisely, they believe in the Thereveda Buddhism doctrine which mainly consists of beliefs in the spiritual/supernatural forces (Van de Put, W. A., et al., 2002; Pringent, S., 2016). This means that when it comes to people living with mental health diseases, their interpretations and their traditional ways to cope have to be highlighted given that beliefs system greatly shape Cambodian's attitudes regarding bad luck, poverty, social and emotional distress, mental health conditions (Van de Put, W. A., et al., 2002; Pringent, S., 2016). It also influences the concept of health, as it is impacted by Hinduism, Animism, Karma and Astrology concepts, (Van de Put, W. A., et al., 2002). As a result, Cambodians attribute their ordeals to supernatural forces, especially when it comes to mental issues (Chhim, S., 2017). Besides, the mentally ill are believed « to be possessed […] or cursed » and that their poor mental condition is the result of bad doings in their past life

(Chhim, S., 2017). In addition, anxiety and depression are experienced as « being caught up by the imbalance of inner wind which is called *khyal chab* » and in order to treat this overload of wind they practice cupping (Chhim, S., 2017). Thus, healthcare can be sought through traditional healers or through spiritual guides (e.g.: monks, *kru khmer*[5]) (Van de Put, W. A., et al., 2002).

In parallel, there are multiple traditional approaches to cope with illness, misfortune, stress, poverty, and conflict (Van de Put, W. A., et al., 2002). And with the aim to give support, pagodas also act as provider as for guidance, assistance, and consolation (Van de Put, W. A., et al., 2002). Hence, the traditional field is very popular in the country owing to the strong respect and value placed in the traditional healers and guides (Van de Put, W. A., et al., 2002). Besides, thanks to their geographical proximity, as they are also available in isolated places, especially in rural regions, people tend to seek their help instead of « official » support (Van de Put, W. A., et al., 2002). Indeed, with the lack of mental health services in the rural areas, the traditional sector has become a common place where Cambodians head to when they need support for their mental distress (Van de Put, W. A., et al., 2002; Chhim, S., 2017). Another factor that explains the high recognition of the traditional healers is their shared traumatic history with their visitors in need of mental health support (Van de Put, W. A., et al., 2002). Hence, their common past makes the traditional healers more understandable and compassionate (Van de Put, W. A., et al., 2002). However, this empathy may sometime impede them to help when it comes to warfare trauma, and it is also because their practices seem to be inadequate to deal with such issues (Van de Put, W. A., et al., 2002).

That said, the traditional sector is somehow reassuring as the healers help to give hope and a system of responses to assist people living with mental disorders (Van de Put, W. A., et al., 2002). Therefore, « they are essential in offering people at least a thread of continuous identity in the massive turmoil that threatened their existence and their culture » (Van de Put, W. A., et al., 2002). For this reason, traditional healers « might act as trauma therapists in many countries recovering from wars » (Van de Put, W. A., et al., 2002).

[5] The traditional Cambodian medical doctors

Conclusion

To conclude, mental health in Cambodia has been neglected, and the several past conflicts and Pol Pot regime had only made it worse as it has seriously impacted the development of mental health services and care over the past decades. Indeed, mental health development, especially in the rural areas of the country, must now face various challenges, such as limited human and national financial resources to implement the appropriate mental health services and to assist mental health programs creation, the absence of collaborative efforts, lack of adequate mental health infrastructures and equipment, non-recognition of mental health workers, the non-accreditation mental health training, and stigma and discrimination towards individuals living with mental disorders.

3) Methodology

Research question

What are the different challenges and lessons learnt from a comprehensive and community mental health approach regarding mental healthcare services in Cambodia's rural areas?

Study design

Following a thorough literature review based on academic articles and reports, and a specific case-study to limit the research on one geographical zone, a qualitative methodology with a descriptive approach is opted to conduct this thesis. This kind of methodology is useful when it comes to collect complex insights to gain a thorough understanding of a contextual situation (Coron, C., 2020). Indeed, it helps to articulate interpretations, to unveil a pattern (Paillé, P., & Mucchielli, A., 2021).

In other words, qualitative analysis allows to get access on interviewee's thoughts, feelings and behaviors in order to understand their experiences and the meaning attributed to them (Sutton, J., & Austin, Z., 2015). Besides, the qualitative method is used to fathom social phenomena in their natural and everyday context through texts and interviews (Smythe, L. & Giddings, L., 2007). Hence, the qualitative approach helps to « answers the *hows* and *whys* instead of *how many* or *how much* » (Tenny, S., Branan, J.M., & Branan, G. D., 2022).

Data collection

Then, the data collection was possible through an internship within Louvain Cooperation (LC) (c.f. appendix 3), it was supervised by Dr. Thann Khem, who is also the program manager, advised by Mrs. Giuliana Zegarra, the program assistant, and also supported by Dr. Zoulikha Faraj, the Health Technical Referent at Louvain Coopération.

Moreover, for the purpose of this thesis, the semi-structured interviews with the interviewees were preferred. The semi-structured interviews were conducted through video calls with health centers' staff, NGOs, and one from the Department of Mental Health and Substance Abuse.

Besides, Khmer language was mainly employed to conduct the interviews, as it made the interviewees more confident to share their information with us, and some was conducted in English. Moreover, a standard questionnaire (appendix 4) was established to guide the interviews. Indeed, these types of interviews were preferred to enable the interviewees to act as information givers, meaning the knowledge holder on the interviewer's research topic (Pin, C., 2023).

Furthermore, the data gathering took place in Phnom-Penh, also in two main provinces: Tboung Khmum and Kampong Cham which are the targeted rural areas.

Data analysis

Once the interviews are conducted, the data collected will be organized following the highlighted challenges and lessons learnt. Then, specific categories of challenges and lessons learnt will appear. This will enable us to organize the results. In other words, a thematic analysis will be proceeded.

4) Results

In this chapter, the results provided by the interviews will be analyzed, thereby enabling us to respond to our research question: *What are the different challenges and lessons learnt from a comprehensive and community mental health approach regarding mental healthcare services in Cambodia's rural areas?* The results are organized into seven main sections, namely public awareness and knowledge on mental health, ministerial recognition and leadership, stakeholders' collaboration, community-based interventions, social work, determinants of the mental health workforce's motivation, and substance abuse.

Public awareness and knowledge on mental health

One of the main challenges regarding community mental health is the public, meaning the community members themselves. This preventing individuals with mental health issues to seek mental healthcare.

Firstly, to be able to get the community members to care, the public must understand the importance of mental health in their daily life.

> « When mental health is well, everything is going to be well. » (Hean Seyleang, doctor at Preah Teat Health Center)

> « … need to strengthen the knowledge in the community, because they do not really understand the matter, so they do not really care. » (Iyamato, CW at CCAMH)

According to one of the health centers' doctors, mental health knowledge and awareness campaigns will allow the public to grasp its importance.

> « To me, it's because they don't have the knowledge, contrary to us with the different trainings, we are able to grasp. » (Eav Then, doctor at Boskhol Health Center)

> « After a campaign is held, patients do come for mental health assistance. As they understand, they will come. » (Eav Then, doctor at Boskhol Health Center)

In addition, mental health interest should be a concern for the parents since their child's early stage of life. Early awareness will strengthen them once they grow up, and foster their self-esteem, because in Cambodia, social injustice is behind poor mental health, especially for young high schoolers, and it appears to be important to educate the young ones on self-esteem.

> « The social hierarchy has impacted children and teenagers' mental health, as the poor hang with the poor, and the rich hang with the rich. This results in low self-esteem because comparisons occur. And, there is a lot of competitions in Cambodia between poor and rich. The rich kids' future is secured while the poor kids' future is to fight for. Therefore, parents must support them, then, the children will have determination to face social inequalities. » (Hean Seyleang, doctor at Preah Teat Health Center)

Besides, what impedes the individuals to seek mental health support is the stigma and discrimination going around mental health diseases within the community.

> « They tend to make it (their mental health condition) a secret and go seek help out of their community. They are afraid that people might know. » (Lear Yem, doctor at Damrill Health Center)

> « It comes from their neighbors. They are afraid to be labelled as *chkout.* » (Iyamato, CW at CCAMH)

> « It mainly comes from their family, they are more discriminating and more sever about it. For example, if a child is feeling less confident, they will blame the child. » (Hean Seyleang, doctor at Preah Teat Health Center)

This stigma and discrimination prevent individuals with mental health disorders to come to health centers to seek assistance, which also affects the mental health staff status.

> «… they were afraid to come (to seek mental health service) as they are called *chkout* (crazy). And some, even tell me *why do you work with crazy people? aren't you afraid to become crazy too?* » (Heng Kanha, CW at «TPO)

> « We (mental health providers) were called *pet chkout* (doctors for the crazy ones). » (Sry Sreysross, doctor at Speu Health Center)

> « There are some who are afraid to come seek assistance at health centers […] there are some who will ask their relatives to go for them (to pick up their medicines). » (Eav Then, doctor at Boskhol Health Center)

Then, regarding the lessons learnt from that level, when the individuals get to know about mental health topics, they are more willing to understand about their own mental health and are not afraid anymore to use mental health services.

> « They (health center's staff) are able to identify their patients' suffering and thanks to the knowledge, we are able to treat them through the symptoms we have learned. » (Eav Then, doctor at Boskhol Health Center)

> « Patients now know when their mental health is affected. When they overthink, have sleeping issues, are angry, they are not anymore afraid, ashamed to seek mental health services. Especially, when I do community-based intervention and say that mental health issues can be treated, people stop to discriminate. People now, know a lot. » (Sry Sreysros, doctor at Speu Health Center)

> « … but now, they are more opened, they don't hide. » (Dearozet, psychologist at CCAMH)

This lesson also applied to mental health providers :

> « I didn't work in this area (mental health services), I didn't know anything. I was always hearing that patients couldn't sleep, but now through knowledge, I am able to understand and to identify symptoms related to poor mental health. […] Thanks to training, I am able to use the correct terms. » (Sry Sreysross, doctor at Speu Health Center)

Therefore, the rise in public knowledge and awareness on mental health will make the public care for mental health development, and it will also help to limit stigma and discrimination.

Ministerial recognition and leadership

The Ministry of Health presents itself as a barrier, given that mental health is not acknowledged by them as official affairs. Their recognition is needed, it will empower the mental health staff to provide efficient performance. It will enable them to focus and integrate mental health services into their work duties, and not put mental health work aside. Basically, to consider it as important as the physical health.

> « The first difficulty I identified is that I want mental health to be considered as an official affair by the Ministry of Health, to be acknowledged all over the country. Because, if the Ministry recognizes it, I will be very happy! […] And as (Dearozet, psychologist at CCAMH) does not acknowledge mental health, it makes it difficult for me, because if I am needed another service that has ministerial recognition, I will have to go there, therefore it can weaken the mental health services. » (Hean Seyleang, doctor at Preah Teat Health Center)

Therefore, for the mental health services to sustain and to underline the importance of mental health matters, the official acknowledgement is highly required. Besides, the acknowledgment will help to budget the appropriate staff.

> « MoH don't employ psychiatrist or psychologists at health centers 'cause not enough budget to pay their salaries. » (Dr. Thann Khem, Project Manager at LC)

In addition, the ministry's leadership is weak, and it impacts negatively on mental health work and development.

> « … lack of monitoring support and visits from DMHSA, in order to follow up the work done, but mainly to give appreciation and support. » (Dr. Thann Khem, Project Manager at LC)

Moreover, the Ministry's priorities do not align with the reality, as they prefer to increase the quantity of services rather than strengthening their performance and quality.

> « DMHSA is only focused on increasing mental health services in all Referral Hospitals and Health Centers all over Cambodia. But their quality is still poor. It needs more time and support. » (Dr. Thann Khem, Project Manager at LC)

Additionally, the lack of guidelines coming from MoH is impacted the mental health development, as they are only concerned about planning, not executing.

> « MoH only plan, no actions taken. We need more guidelines and leadership. » (Leap, psychologist at TPO)

> « They (MoH) are willing to have mental health services but present no clear policies. » (Heng Kanha, CW at TPO)

Besides, as there is no collaboration between DMHSA and the NGOs, the latter cannot be updated about ministerial policies concerning mental health and cannot participate in elaborating them.

> « We don't work closely with DMSA, so, we are not clear about what are the strategies and governmental policies to support and develop mental health and child mental health. […] I don't know much about what DMHSA has developed. » (Dearozet, psychologist at CCAMH)

The absence of collaboration between NGOs and MoH/DMHSA is weakening the mental health development.

> « NGOs and DMHSA should have regular meetings to discuss about the challenges and the lessons learnt: no regular meetings, only invited to specific meetings and to present projects. It needs better collab and communication among NGOs and DMHSA. In 2016, DMHSA organized sub technical working groups with NGOs, DMHSA, it was only few meetings but it has stopped with no reason given by DMHSA. It is important to work together, to build relationship and to understand each other well. » (Dr. Thann Khem, Project Manager at LC)

Furthermore, the DMHSA's implication is also required regarding the training. The mental health staff needs an official training package. Therefore, it will ensure them regular sessions that will help to guarantee and to increase their knowledge and to enhance their skills.

> « It has to be governmental training, the government should provide the training, because it is mainly conducted by NGOs. » (Sry Sreysross, doctor at Speu Health Center)

Yet, according to Dr. Sin Leap the Head of DMHSA, NGOs work regarding mental health needs to be based on the government guidelines.

> « [They] need to follow the government guideline in order to integrate the health system. » (Sin Eap, Head of DMHSA)

There are no actual lessons learnt from this level, but rather a recommendation was given by Iyamato, a community worker at CCAMH, to help the Ministry to be informed and to guide them regarding mental health policies.

> « NGOs could help to hold mental health topics discussion to Ministry's members, so, they can get the importance of mental health. » (Iyamato, CW at CCAMH)

Stakeholders' collaborations

Indeed, the case-study showed that a multisectoral collaboration is highly needed, to work hand in hand in order to implement good quality mental health services.

However, according to the DMHSA, there is no efficient collaboration.

> « They (the collaborations) are not harmonious: it is like an orchestra who sound bad, all playing out of tune. » (Sin Eap, Head of DMHSA)

Moreover, for the collaborations to be effective and to cover every angle of the mental health matter, it needs all levels participation.

« I recommend that NGOs need to collaborate with the community's head, it will be better. » (Iyamato, CW at CCAMH)

« … Those people have to come together and collaborate. We need more participation and involvement from the different levels to better referrals to different agencies." » (Dearozet, psychologist at CCAMH)

Then, the lessons learnt from this section is that a multisectoral collaboration helps to provide a comprehensive assistance in terms of mental health services and knowledge.

« I learnt about technical knowledge on mental health through workshops conducted by partners. » (Dr. Thann Khem, project manager at LC)

« CCAMH, we work with child mental health, TPO with adult's mental health. We co-work for ages groups. So, if the parents also have mental health problems, we can refer them to TPO, and if they identify children with mental health problems, they can refer them to us. » (Dearozet, psychologist at CCAMH)

« The health centers' staff can also learn from both. They can learn on child mental health and know how to work with adults' mental health like they know how to do the diagnosis, identify adults' mental health problems, and also provide counselling. » (Dearozet, psychologist at CCAMH)

The multisectoral collaboration also helps with training, as it allows different technical skills sharing following different public targets.

« Partnership with NGOs is important as it helps with the competences. » (Hean Seyleang, doctor at Preah Teat Health Center)

« They (TPO) train on counselling. » (Lear Yem, doctor at Damrill Health Center)

« SSC provides us training on how to handle child abuse, on social work, and we (CCAMH) train them on basic listening skills, they learn to be attentive to patients

worries, concerns and their needs, and with specific cases, to refer to us. » (Dearozet, psychologist at CCAMH)

Besides, a good entente between NGOs and the health center's staff also benefits the patients, as when health center's staff have difficulties with some cases, they can delegate and refer to the competent NGO to enable the patients to get the appropriate help.

« We have a good relationship, when there are challenging cases, they are present to help. » (Eav Then, doctor at Boskhol Health Center)

« They give good training, we can process well. » (Chhiv Limseng, doctor at Health Center)

Community-based interventions

There are some challenges regarding community-based interventions, especially when it comes to female community workers, as they are afraid for their safety.

« I'm afraid to go for security matter, the destination sometimes not clear. » (Heng Kanha, CW at TPO)

« … especially for women, scare to travel to the village on motorbike alone. Some villages are far, they are scared about their security. » (Dearozet, psychologist at CCAMH)

Another challenge is related to financial incentives, as when the mental health staff do not perceived incentives, they are not willing to do home-visits.

« To do outreach activities in the community like home-visits to provide counselling, psychoeducation, people don't want to go, they expect incentives. » (Dr. Thann Khem, Project Manager at LC)

Therefore, a budget should be set for home-visits.

« The government should allocate a budget for this purpose. » (Dr. Thann Khem, Project Manager at LC)

In addition, to enable community social workers to handle properly their work, they need a comprehensive support.

« I recommend to support CSW (Community Social Worker) development through training, and to guide them, give them feedbacks, ensure refresher sessions. » (Heng Bong Srey, social worker SSC)

Besides, there are various lessons learnt from the community-based interventions, especially regarding home-visits. They appear to be very beneficial and essential for the community.

« I do home visits, people with mental health problems say that just by seeing the doctor at their home it makes them feel better. » (Hean Seyleang, doctor at Preah Theat Health Center)

In fact, home-visits make a big difference as behavioral change can be observed.

« As they (some patients who live far away) are not able to come here (at the health center), we have this option to visit them at their home. I observe that they are happy as we come to check on them, explain them their issues, and when we come by, we can see a behavior change. They feel like there is more care coming from the medical institute. » (Eav Then, doctor at Boskhol Health Center)

« I recommend maintaining home-visits as it helps with behavior change. » (Leap, psychologist at TPO)

However, there is no actual tool to assess that behavior change.

« But how to measure this change? It is difficult to know the outcome. It needs ≠ steps, a long process with clear objectives w/ the other partners too. The issue is to access how

> many people changed behavior, what are their preferences, if they could access this without any restraints. » (Dr. Thann Khem, Project Manager at LC)

Social work

As the nature of these services are community-reach, it appears that social work is also an essential dimension for community mental health which presents as one of the lessons learnt. This dimension is possible through the collaboration with SSC.

> « Because we work in the community, we have Volunteers for Child Development (VCD) […], in some village, VCDs are parent with a child with disabilities. » (Dearozet, psychologist at CCAMH)

Indeed, social work enables to provide a community-based support, by providing direct knowledge.

> « Social work helps to reach family within the community, we help them to communicate about their mental state. We give counselling, help them to identify their issues. » (Heng Bong Srey, social worker at SSC)

Therefore, to strengthen its importance, an academic certificate was introduced at the Department of Social Work at the Royal University of Phnom Penh.

> « At RUPP in the Department of Social Work on interpersonal skills. Many about social work like communication with the patients. It takes once a week during a year to complete to have the certificate. It teaches about trust building with patients, how to help patients to support themselves, to identify their own problems and to solve them by themselves, to develop empathy. They are important skills. » (Dr. Thann Khem, Project Manager at LC)

Determinants of the mental health workforce's motivation

The case-study taught us that in Cambodia, the mental workforce faces many challenges resulting in a human resource shortage and poor staff performance. The quality of training, the lack of recognition, inadequate incomes, and limited medical equipment were highlighted as factors jeopardizing staff retain. However, motivational elements were not explored regarding community mental health.

Indeed, to maintain the human resources sustainability in the mental health area, there must be some incentives and personal drives to work in the community as mental health caregiver.

> « … economic incentives help to motivate. » (Eav Then, doctor at Boskhol Health Center)

Moreover, personal determinants are required to engage in the mental health field within the community.

> « … determination, confidence and strength of mind are need to work in the mental health areas. » (Hean Seyleang, doctor at Preah Teat Health Center)

> « Their personality is prone to help people. » (Heng Bong Srey, social worker SSC)

> « I am able to help, and I am happy to do it. » (Iyamato, CW at CCAMH)

Besides, a great sense of responsibility was highly noted as a motivational factor to maintain their participation in mental health work.

> « I was assigned here (mental health services), so, it's my role, my function, so, I have to accomplish my job. Do as much as I can. […] I just have to take the responsibility. » (Sry Sreysross, doctor at Speu Health Center)

> «… but, if there is none (financial incentives), we must keep on working. » (Eav Then, doctor at Boskhol Health Center)

Another element that fosters the staff motivation is the power of training as it enhances their knowledge and skills, and empowers them as mental health providers.

> « Thanks to TPOs trainings, they gain knowledge and know how to treat. They do a great work of what they learnt, and they feel like they have achieved something. » (Chhiv Limseng, doctor at the Health Center)

Then, guidance and support also appear as beneficial to keep the mental health staff motivated.

> «… with TPO help, it motivates us to do the work. The support really motivates, and they (mental health staff at the health center) are not afraid to do, they gain confidence. » (Chhiv Limseng, doctor at the Health Center)

Furthermore, the other's work can motivate them to join, and inspire them.

> « I'm willing to help children with disabilities and mental health disorders 'cause my big sister help people like them. » (Iyamato, CW at CCAMH)

Therefore, a lesson learnt here, is that working in mental health can benefit the people who wants to help as it enables them to actually assist their own community and being valued for their work which strengthens their role within the community.

However, there is still lot of staff resigning as most of the time the new staff come and are trained but then, they leave for other opportunities.

> « We train them but then they will leave for another service, there is no sustainability regarding staff. Or sometimes, we recruit, but they don't do the job. » (Sry Sreysroos, doctor at Speu Health Center)

> « Some just stopped, a lot of turnovers, a lot moved to the province because there is a hospital there. Therefore, there are always newcomers staff. » (Lear Yem, doctor at Damrill Health Center)

> « They will resign because better salaries are offered elsewhere. The new job doesn't include safety concerns and is not difficult work. » (Iyamato, CW at CCAMH)

Substance abuse

Lastly, regarding substance abuse, there is one main challenge. Indeed, as substance abuse is related to drugs use, which is illegal, it becomes a police affair.

> « Before, there were more patients with substance abuse problems who come seek assistance here (at the health center), but when the police know, they will just come to arrest them. » (Eav Then, doctor at Boskhol Health Center)

Hence, they are prevented from getting a proper mental health assistance.

5) Discussion

Firstly, the qualitative data have shed light on certain challenges and lessons learnt regarding providing mental healthcare within a comprehensive and community mental health approach. It has helped to better grasp the staff's motivations and intentions regarding working the mental health area, despite the lack of recognition and value from the government. It also allowed us to understand the importance of public awareness and knowledge on mental health topics, and the benefits of the different trainings provided to the mental health staff. Additionally, it gave us access to the DMHSA's points of view on the situation and it resulted that to them, there are rather tense collaborations, whereas the other stakeholders await them to exercise their leadership role, and thus implement clear national policies to base their work on. Moreover, these data also demonstrated the importance of delivering community-based visits, such as campaigns awareness and home-visits, which greatly foster behavior change within the community. Furthermore, it has highlighted the power of a strong and multisectoral collaboration among all levels.

In other words, the results completed the actual literature with specific and relevant insights on community mental health in Cambodia. Moreover, these results can help to orientate future strategies by giving priority to the identified challenges and to guide the future national policies by benefiting from the lessons learnt from this thesis. However, the barriers discussed in the case-study still need attention as they are not overcome yet.

Limitations

Then, regarding the limitations of the study, we did not cover the patient's insights, hence, have no access on the mental health services benefactors. However, this can be explained by their reluctance to share with a non-professional and their wish to keep their experiences private as they did not present any interest in being interviewed for this study. Even though, the patients were not interviewed, we were able to collect some insights by the mental health staff who are in direct contact with them, as they provide them care, treatment and counselling. Another limitation is the language barrier, as there are materials on the subject written in Khmer, and as I can only interact in Khmer and due to the lack of Khmer to French/or English translators/translating tools, the information was not treated. Finally, the government inaction

makes it difficult to further efficient strategies, as the main needs (financial, acknowledgement, leadership) can only be resolved by their efforts.

Strengths

Furthermore, one of the strengths of this work lays in its data collection as it was conducted in Khmer, it gave access to direct insights on the subject matter. It allowed the interviewee to freely discuss about their experiences toward community mental health, they have provided valuable data. Additionally, the data collection was done with a variety of different actors from diverse fields: NGOs, Health Centers' doctors, community and social workers, and ministerial. Therefore, the relevance of the data collection and their providers has generated significant findings in terms of care providers involvement which is essential as they are the frontline actors in mental health development. They are the ones making a difference by sharing their knowledge to community inhabitants and to other mental health staff, and by providing assistance, care, counselling, treatment and referral to individuals living with mental health conditions. At last, on last strength within this study regards the literature in which a variety of authors was involved, they all complement each other, there were no great divergences of perspectives, but more complementary perspectives on the subject matter. This enables to have a comprehensive literature review.

Recommendations

Finally, in order to deepen the subject, further studies could consider children with disabilities, as the literature review taught us the existence of a high comorbidity between living with disabilities and poor mental health, especially children. It will be beneficial to have a thorough research on the matter. Another study could be conducted in the urban areas of the country, to see how mental health is considered and what approach is used to tackle the related challenges. Moreover, the substance abuse situation could also be an interesting topic to explore. Ultimately, a comparative study can be interesting as it can allow experience sharing on community mental health approach.

Conclusion

In conclusion, this thesis has explored the determinants behind the mental health neglect in LMICs, and the community mental health approach. These two dimensions have enabled an in-depth analysis of the thesis' topic. Besides, they can be articulated together to have a better understanding on how mental healthcare works in LMICs, especially within the case-study on Cambodia. This way, the findings and results helped to address the following research question: *What are the different challenges and lessons learnt from a comprehensive and community mental health approach regarding mental healthcare services in Cambodia's rural areas?*

Indeed, the literature review gave us relevant information on mental health neglect in the LMICs, and the reasons causing it. Then, the literature also explored the several factors behind the high occurrence of mental health disorders in the LMICs. They are related to the environment — geographical and social—, economy, demography, and culture. These two main points, mental health neglect and the high occurrence of mental health disorders, enabled to understand how community mental health fits in to allow individuals with mental disorders to be treated in such context. Hence, community mental health approach appears to be a way of response regarding mental health neglect, especially in the implementation of accessible, affordable, effective, and sustainable mental health services to provide adequate care to people with mental issues. Furthermore, as a result, a case-study on a specific LMICs appeared to be relevant to better grasp the determinants of such approach.

Then, the results retrieved from the qualitative data collection have provided new insights on the study's topic, as it gave meaningful elements of response regarding the different challenges and the lessons learnt. This latter point happens to be very beneficial as it provided valuable and optimistic perspectives while the current context is challenging. In fact, the results have demonstrated that despite the lack of leadership coming from above (i.e. MoH and DMHSA), the mental health staff, especially, the Health Centers' doctors and Community Workers, are very involved in their role, they are fulfilling their responsibilities and assist their patients as much as possible, and this in spite of the limited resources they have. Moreover, it appears that community-based interventions not only benefit the individuals with mental health disorders, but it also gave the mental health caregivers valuable recognition from the community population they visit. Furthermore, despite the absence of acknowledgment from above, they

persist in their work and are willing to improve it, to make mental health development possible. Actually, all the involvement around mental health and the resilience regardless the challenges show why mental health does matter.

Last but not least, the thesis and its participants have demonstrated the importance of investigating on the determinants that will guide a national survey on mental health, but also key elements to develop clear mental health policies with an all-levels participation and guidance in the policies-making process.

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Appendixes

Appendix 1: Table of NGOs

NGO	Description	Reference
TPO, The Transcultural Psychosocial Organization	" TPO is Cambodia's leading NGO in the field of mental health care and psychosocial support. Along with providing quality mental health care to Cambodians via a range of grass-roots projects throughout the country and our Treatment Center in Phnom Penh, we are also a training center in the field of mental health care and psychosocial support. We also conduct research and provide consultancy, often in collaboration with partner organizations and research institutes. We also aim to raise awareness across Cambodia about mental health,	https://tpocambodia.org/tpo-about/.

	promote mental health care and psychosocial well-being, and advocate for mental health services in Cambodia. In doing so, we aim to influence and bring about positive health policy change. Finally, some of our work is linked to – and contributes to – conflict resolution, peace building and social justice. Our mission 'to improve the well-being of Cambodian people with psychosocial and mental health problems, thereby increasing their ability to function effectively within their work, family and communities' underpins everything we do. TPO has more than 50 staff members – all experienced mental	

	health professionals as well as some management and support staff. All staff are Cambodian. We have offices in Phnom Penh (HQ, Treatment Center and Training Center), Battambang, Siem Reap, Chi Kraeng, Kampong Thom, Kampong Cham and Tboung Khmum. Our work has been made possible largely thanks to the support of our international donors. We also generate part of our income through our Training Center and Treatment Center. We are a registered not-for-profit and have been certified by the Cooperation Committee of Cambodia (CCC) since 2010 acknowledging TPO's ongoing commitment	

	to the Code of Ethical Principles and the minimum standards for NGOs. Certification is awarded to NGOs that consistently demonstrate accountability and good governance. For more info, check the CCC's website here."	
CCAMH, Centre for Child and Adolescent Mental Health	We are the first of our kind in Cambodia and are a unit of Caritas Cambodia. CCAMH was established on 17th January 1995 and was formerly inaugurated by His Majesty, King Preahbat Norodomsi Hanouk and we take in patients from ages 0-18 years old. CCAMH is a collaborative project with the Ministry of Health and Caritas Cambodia to raise the awareness of mental	https://ccamh.caritascambodia.org/index.php/who-we-are. https://ccamh.caritascambodia.org/index.php/vision-and-mission.

	health and its importance. We are solely funded by public contributions and mainly offer out-patients services. Currently there are 20 staffs and 3 departments; we closely work with patients who have psychological problem, neurological problem and intellectual disability. Our team of staff is trained to work with children of all backgrounds and their families. Our Vision: To enlighten an empathetic society in which children with disabilities have equal rights and opportunities and live with dignity.	

	Our Mission: To work with children and families to address the cause and effect of disabilities, particularly neuro-psychiatric and development disabilities at family, community and national level.	
SSC, Social Services of Cambodia	SSC is a local NGO focused on empowering community based social workers through training, coaching and mentoring. Location: Kampong Thom	https://bettercarenetwork.org/about-bcn/what-we-do/organizations-working-on-childrens-care/social-services-of-cambodia. https://www.ccc-cambodia.org/en/ngodb/ngo-information/505.

Appendix 2: Community Health Workers tasks

Table 1 Potential scope of work for CHWs adapted from the Community Participation Policy for Health

Health information systems:
- Disease surveillance/monitoring and case reporting to the health centre
- Keep a register of all children below 5 years of age in the village
- Assist the health centre in collecting registration statistics including notification of pregnancies, births and deaths
- Conduct verbal autopsies for deaths that occur in the village
- Collect information on health and health-related problems in the community, inform and report to the health centre

Provision and follow up of information and essential services:
- Facilitate the identification of the poor for fee exemption
- Provide health education, promote improved health practices and distribute health IEC materials including family planning, antenatal care, clean delivery, post-natal care, breastfeeding, complementary feeding, safe water, hygiene and sanitation, malaria and dengue control, HIV/AIDS/STIs, tuberculosis, immunizations, non-communicable and chronic diseases, mental health, tobacco and alcohol and gender-based and family violence
- Mobilise families and assist health centre staff during outreach activities and health campaigns
- Assist in the mobilisation of resources for sustainability of health centres
- Assist families with early identification of the danger signs for severe/ serious illnesses
- Promote and strengthen the health centre referral system and assist in logistics such as transportation

Provision and follow-up of essential diagnosis and treatment services:
- Promote correct home care for illnesses
- Provide community-based first aid and rehabilitation
- Identify, refer and follow up children with acute malnutrition
- Provide home-based care

In remote and difficult to access communities:
- Provide early diagnosis and treatment for malaria
- Diagnosis and treat acute respiratory infections with antibiotics in children

Provision of essential commodities:
- Distribute micronutrient and food supplementation
- Distribute mebendazol and oral re-hydration treatment with zinc
- Distribute condoms and family planning supplies
- Distribute long-lasting insecticide-treated mosquito bed nets and hammock nets

Reference: Ozano, K., Simkhada, P., Thann, K., Khatri, R. (2018).

Appendix 3: Louvain Coopération (LC) presentation

Louvain Coopération is a Belgian NGO which was formerly known as Louvain Développement (Loucain Coopération, s.d.). The NGO debuted back in 1981 within the Faculty of Agronomy of the Catholic University of Louvain, which became "ADRAI", Association for Development, through Research and Integrated Action (Louvain Coopération, s.d.) The main goal of the NGO is to fight against hunger, disease and poverty that affect the most disadvantaged populations. As the NGO was founded within the Catholic University of Louvain, they always work with the commitment to mobilize and operationalize academic skills to address development challenges and to support their projects around the globe (Louvain Coopération, s.d.). Moreover, the University and the NGO regularly work side by side to carry out various projects in common.

Plus, Louvain Coopération is operating in 9 countries (Belgium, Benin, Togo, Bolivia, Cambodia, Burundi, RD Congo, Madagascar, and Peru) with 23 different projects and works along with 140 partners (Khem, 2022). In order to set up their programs, they give support to about hundreds of local partners by providing trainings to them with the objective to strengthen local capacities and the sustainability of the projects. They are also committed to adopt a long-term view by developing long-term actions which guarantees the quality and the ownership by the local partners and populations. Besides, they also tend to share their expertise and experiences, as they have complementary expertise in health care and healthcare accessibility, food and economic security, but also in education for global citizenship and solidarity (Louvain Coopération, s.d.).

Reference: Louvain Coopération. (s.d.). Capitalisation. En ligne https://www.louvaincooperation.org/fr/capitalisation

Appendix 4: Standard questionnaire used to conduct the interviews

1. What is like to work in mental health services in Cambodia?
2. Can you identify any shortage?
3. Do people are scared or ashamed to come seek assistance at the mental health services available at the health center?
4. What are the staff motivations? What motivates you?
5. What are the reasons behind staff resigning?
6. What are your thoughts on the actual collaborations?
7. What can you say about the government motivation?
8. Following your personal experience in community mental health, what are the related challenges?
9. And what about the lessons learnt?
10. Do you have any recommendations on improving the mental health services within the community?

Abstract:

In Low-and-Middle Countries (LMICs), mental health has long been neglected. There are specific reasons behind this and various insights on the matter. All of them highlighting the alarming call for the governments to put it on their top-priorities to set up appropriate and effective policies regarding mental health. Thus, securing the mental health staff work and status, and ensuring adequate and affordable care and treatment for the individuals with mental disorders, and finally, gives mental health the recognition it so urgently needs.

To do so, the Community Mental Health approach appears to be an effective way to address the challenging situation within the LMICs and to guide the implementation of mental health services and training.

Keywords: Mental health neglect, treatment gap, mental health gap, community mental health, community health services and workers.

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