

Ho Chi Minh City, Vietnam: Studi Kasus Pemasaran Kesehatan Mental

Ho Chi Minh City, Vietnam: A Case Study in Mental Health Marketing

Lena Bucatariu¹ & Babu George^{2*}

¹School of Communications and Design, RMIT University, Vietnam

²College of Business and Entrepreneurship, Fort Hays State University, United States

Abstrak

Mengikuti metode studi kasus fenomenologis, artikel ini menyoroti skenario pemasaran kesehatan mental (KM) di Kota Ho Chi Minh, Vietnam. Sementara negara maju menemukan metode modern untuk berhubungan dengan dan melayani pasien KM, Vietnam dan sebagian besar negara berkembang lainnya masih berjuang untuk mengubah pandangan dari penyakit mental menjadi kesehatan mental. Meskipun demikian, khususnya di antara sekelompok kecil penyedia berpikiran maju, ada tren yang terbentuk menuju identifikasi, akuisisi, dan retensi yang lebih proaktif dan cerdas secara digital dari pasien kesehatan mental. Selain menghilangkan stigma masalah kesehatan mental, hal ini juga memiliki efek memberikan pasien akses, kepercayaan diri, dan keterlibatan yang bermakna. Orientasi pemasaran juga menghasilkan peningkatan perhatian terhadap perawatan kesehatan mental preventif.

Kata kunci: Kesehatan mental, pemasaran kesehatan mental, pilihan pasien, budaya, teknologi, studi kasus, Vietnam.

Abstract

Following the phenomenological case study method, this paper highlights the mental health marketing scenario in Ho Chi Minh City, Vietnam. While the developed world is finding modern methods to connect with and serve MH patients, Vietnam and most other developing economies are still struggling to shift views from mental illness to mental wellness. Despite this, particularly among a small group of forward-thinking providers, there is a trend taking shape towards more proactive and digitally-savvy identification, acquisition, and retention of mental health patients. In addition to de-stigmatizing mental health issues, this has the effects of providing patients access, confidence, and meaningful engagement. Marketing orientation also resulted in increased attention to preventive mental healthcare.

Keywords: Mental health, mental health marketing, patient choices, culture, technology, case study, Vietnam.

Introduction

For centuries, the Vietnamese believed that mental illness is caused by evil spirits, and thus past healers employed rather barbaric exorcist methods including “drowning the patients in water, burning their limbs, or fasting them in chamber” (Tran, 2017, p. 291). With the ambitious goal of making a change, from 2000, the Ministry of Health officially launched the National Mental Health Care Program with various diseases targeted for treatment in turn, as reflected by the latest WHO reports: schizophrenia and epilepsy account for the majority of

*Corresponding author: bpgeorge@fhsu.edu

cases (about 70%) until 2015 when the second phase focused on anxiety/depression, and autism/ADD in pediatric patients.

Despite some progress in correcting MH-related superstitions and improvements in community care, the regulators' efforts still had much ground to cover in terms of availability and accessibility of care and quality of medical service (WHO, 2014), with incidence of mental disorders estimated at 20% to 30% of the country's population (Tran, 2017). As Le (2017) pointed out, most MHC providers have very limited marketing skills and rely on ad-hoc, underfunded, and poorly designed campaigns with no formal strategy to back them up. On the demand side, prospects have limited and often incorrect understanding of MH and mental illness, and may fail to gauge the benefits of psychology, psychiatry, and counselling services to their life (Le, 2017). Marketing orientation is lacking in developing world healthcare contexts in general, observed Henthorne, Salgaonkar, and George (2009). In the context of public hospitals in India, Mekoth et al. (2012) also made a similar observation.

To illustrate, many public Vietnamese hospitals and clinics did not even specifically mention Psychology/Psychiatry services on their website although their medical body comprised specialist MH doctors who received patients from referrals by general practitioners and lower-tier hospitals (Le, 2017). Mental wellness, "the degree to which one is positive and enthusiastic about oneself and life" (Manderscheid & Freeman, 2010, para. 1) is still a distant dream. Moreover, the idea of customer relationship management too seemed to be at an underdeveloped phase in the overall health system.

A case in point is the Ho Chi Minh City Mental Health Hospital; despite being the city's major public supplier, at the time of this report the institution had a limited digital marketing presence comprised of an informational website listing main specialties, key doctors, and several stock photos and content on common symptoms of migraine, Alzheimer, bipolar disorder, anxiety, and epilepsy (Tin Tổng Hợp, 2018). There was also an unofficial Facebook page as patients frequently checked in and wrote reviews about their service experience, but the hospital did not appear to be involved in the administration of the page (Bệnh Viện Tâm Thần Tp.Hcm, 2018).

One step ahead, private HC facilities accounted for most patient visits (OP) and a high proportion of medical out-of-pocket spending; as the World Bank noted, in Vietnam the private HC sector was 'not only the point of access for medicines, but (...) the major player in supply chain management, logistics, and distribution' (Sterlin, 2016).

Main HCMC-based providers are a total of about 30 clinics, including Sunny Care Center for Effective Work and Study, Linh Tam Psychological Counseling Center of Emotional Psychology, Better Living Life Coaching, Tanh Dat Counseling on Love & Marriage, Sexual Health, and Parenting, Nhip Cau Hanh Phuc Center for Love, Marriage, and Family Happiness, Nam An Counseling for Modern Life, Duong Gia Legal Advisory and Family Counseling, Phuc Ngan Center for Stress Counseling (treats both direct-to-consumer and B2B through employers), and Thanh Tam center for Psychology of Education (Top Nine Counseling Services in HCMC, 2017).

While all centers had a Facebook presence and some did forum seeding, the more established clinics such as Sunny Care and Better Living invested in a website and made use of a variety of online communication tools, including: listing their practice on health search portals such as tamsu.vn, vicare.vn, timviechanh.vn, or alobacsi.vn (VietnamCare, 2018), seeding on general interest forums such as psy.vn and webtretho.vn (TalkVietnam, 2018), being featured on paid listings at comparison sites like toplist.vn or placing paid editorial content and PR articles on women's sites such as phunu.8.vn and sotaychame.com (VietnamWoman, 2018).

Although private clinics appeared to afford more substantial digital budgets with doctor's videos and proprietary content updates, individual practitioners such as psychology

teachers and psychiatric doctors were more likely to be affiliated to a university or research institute and built their personal page or got involved in moderating Facebook groups/informal online communities such as Psychology Forum, Psychology of Love, Applied Community Psychology, Psychology Club, or more niche areas such as Criminal Psychology and Psychiatry Association (Tam Ly Facebook Group, 2018). Still, most doctors and counselors relied on offline affiliations to attract traffic e.g. by migrating some of their regular patients from the doctor's state hospital (employer) to their personal home clinic, by gaining new clients through word-of-mouth recommendations from family and from among the professors' medical students (Le, 2017).

As seen, marketing tools and initiatives used by MH practitioners in the public sector appear to have limited variety and effectiveness, which leads to low awareness, limited knowledge and sub-par usage of MH services, although there is growing evidence that MHC is greatly needed to improve the emotional and mental state of many HCMC residents.

Method

This case study is a subset of a larger project that investigated various dimensions of mental health services in Vietnam (Bucatariu & George, 2017). During the literature review that led to this study, the authors found that customer relationship management left a huge vacuum when it came to mental health services in Vietnam and several other similarly placed countries (Bucatariu & George, 2020). The phenomenological qualitative case study method was found most suitable to identify and describe mental health marketing practices, without losing contextual nuances and without adulterating the lived realities of practitioners in the mental health marketing profession. The authors envisaged a two-stage design in which the findings of the case studies would become statistically testable hypotheses in the second stage.

Eight face-to-face, qualitative, in-depth, interviews were conducted with a snowballing yet purpose driven sample of practitioners at public and private mental health institutions. A pre-screening questionnaire was administered to ensure that the participants met our criteria that they should be significant voices in the mental health marketing profession in Vietnam. Stakeholder diversity was also a factor in the final choice of the respondents. To increase variety and depth of the providers represented, the services of a local recruitment firm were used, who provided respondent contact information particularly for niche targets. Each participant was promised anonymity and was provided an informed consent form to sign.

Creswell (2007) recommended sample sizes of 3 to 10 subjects for similarly placed studies. The researchers were willing to revisit the sample size question; however, as expected, theoretical saturation was evident after interviewing the 6th respondent. Given differences in salient meanings and cultural realities, bi-lingual local research assistants were employed to provide the subjects additional explanations. Fieldwork was conducted during April - June 2018, for a duration of about 30-80 minutes/interview, and took place at the respondent's workplace to further ensure that interviewees indeed held the positions they claimed. A trial interview was also conducted 4 weeks before the official data collection period to further refine questions and smoothen the Vietnamese translation, but answers were excluded from the final sample not to affect dependability. This trial interview helped the researchers refine the initial set of semi-structured questions that were identified from the literature, based on the larger purpose of this study.

Results

Loss of Insights in Patients

Need is unrecognized or misunderstood, which refers to the patient's inability to recognize need or to incorrectly label the need, as the patient does not have sufficient understanding of what mental illness and mental wellness mean, how they manifest themselves

and how they affect one's ability to function cognitively and emotionally. Several factors related to this emerged during our interviews.

Loss of insight due to illness means that the patient is unable to identify the issues and unable to self-diagnose as the very nature of a mental disorder means that a healthy brain can assess that everything is in order, but an ill brain loses the ability to recognize that it is ill. Supporting arguments with evidence from respondents are provided below:

Unable to 'see' the problem as a result of loss of insight

SP1 "A disorder like psychosis triggers loss of insight, that means they don't know they're ill, they don't have self-awareness. In a case like depression, it's slow developing, so it's hard for the patient to see the threshold after which they must seek medical help."

Lack of awareness that a "solution" exists

P1 "Even when you know you have a problem, you don't know what to do about it. When you have a headache, you go to the doctor, you get medicine. You know what you need. But what to do when you are sad? Is that for a doctor to treat?"

Challenges in matching content with the target

I1 "No matter what your product is, people might see the benefits of it but they might not understand the methods used to bring that benefit."

P1 "There is a big problem with the current advertising, creating content that sparks interest and still catches the eye of the target audience. If the message isn't clear the audience brought in will be messy and they won't accept this way of treatment as a solution."

The exception are more affluent and educated targets who have some self-awareness and are easier to trigger through communications:

P1 "Only about 10% of patients fully understand the need and benefit of MH – they tend to be more educated, higher income – but they are in the minority and they almost always choose very expensive international hospitals because they can afford it."

To overcome the challenge of loss of insight, some premium MH providers have implemented "tangibilizing" methods as a solution:

- Use of videos/online demo sessions to illustrate the service

P1 "We have online sessions for couples' therapy. We do these to help people understand, to make them experience the service."

Cultural Barriers

Cultural barriers refers to cultural dimensions, norms, beliefs, and practices that are unique or pervasive in the Vietnamese society and result in delay of or incorrect self-diagnosis of mental illness. Supporting examples of cultural barriers with evidence from respondents are provided below:

- Superstitions and pseudo-science that attributes mental illness to non-medical factors:

I2 "In Vietnam, older people in low income families still think that mental illness is a curse, karma for the mistakes of the parents. Among the younger generation, some believe that

autism for example is the result of bad parenting while in fact it's all science – linked to infectious diseases and genetics.”

- Stigma of mental illness among peers and resistance to acknowledging its existence:

SP 2 “In Vietnam, mental illness is taboo. Nobody in their family has it. Mental illness doesn't exist.”

SP 2 “Some clients don't add me on Facebook because they don't want others to suspect they use my services. If I meet a client accidentally outside my office, like in a restaurant, I always pretend I don't know them. Some of my regular clients don't even tell their spouses about me.”

P2 “If the patient is in school or an employee in a local company, doctors have to be very careful about discussing cases. Universities and HR don't know much about MH. The patient might get bullied or get fired.”

- Gender roles dictate what is acceptable and unacceptable behavior for male and female adults in the Vietnamese society:

SP1 “In the Vietnamese society, men play an important role, so they must appear strong. They don't want to admit that they have a problem. They see the doctor only if there are clear physical symptoms.”

SP2 “If they don't feel comfortable in their mind, Vietnamese men will go drinking. This is the <<manly>> thing to do. Or they may chat with friends, get the human connection. Or they try exercising at the gym. If all three fail, then they come to me.”

- Treatment is culture-bound and a nation's societal norms affect the treatment methods and success factors in treating MH

SP2 “The MH treatment approach in the UK for example is suitable for the Western Cultures, where people have more awareness, take more responsibility for themselves. If you don't understand the Vietnamese culture you cannot do good therapy.”

- Some MH doctors abide by culturally-acceptable norms of saving face or not displeasing the patient rather than treating the root cause:

SP2 “Many times, doctors here treat the symptoms and not the root cause because they don't want to upset the patient. A couple brought their very distressed son and I realized that the child is being affected by the parents' fights. Following the Vietnamese culture, I should agree with them and calm the child. But I confronted them directly and suggested couple's therapy or even divorce. Most Vietnamese doctors would have taken the easy way.”

Mis-aligned or negative experience refers to incorrect expectations that patients have regarding MH treatment, due to only partial understanding of causes of mental illness, lack of understanding of suitable treatment methods for MH, comparison with non-MH related treatment (e.g. heavily reliant on medication), or past experiences with MH treatment that was incorrect, ill-intentioned or ineffective:

- Patients expect immediate results – a bias that stems from exposure to non-MH medical practices:

SP1 “Many Vietnamese patients do not understand that a mental illness is a slow process that starts with changing oneself. They

- wait 1 or 2 weeks, if symptoms don't improve, they stop taking the medicine and want to change doctors; they blame the doctor because they don't want to take responsibility for their own life.”
- Affluent patients are quite demanding and/or prefer international providers
I2 “Sometimes children of rich families have issues like they're very spoiled, and the parents put them into normal schools, and that makes things worse. Then the parents panic and they call me on my personal number late in the evening, and ask to meet me at my home.”
 - Mass patients do not value “talk time” unless the doctor prescribes medicine, again a bias resulting from typical exposure to non-MH practices:
SP2 “Vietnamese patients don't pay for chatting. They think that a good doctor must give medicine, and a better doctor will give better medicine.”
 - Mistrust from past negative experiences, for example when over-medicating or prolonged treatment plan were used as a way to increase the overall spend:
SP1 “This country is full of over-medicating, not only mental health but everything else.”
SP2 “Many counsellors have this <<retention>> strategy – they find weak-willed people and lure the patient back again and again. This ends when the patient runs out of money.”

Current market solution to reduce negativity has been implemented by a minority of MH providers, mainly in the private sector and centered on putting the client's benefit above all else:

- Transparency to cement client trust
P2 “I want to make everything clear from the beginning, show that I am honest with them. I clarify the diagnostic, treatment options, price, duration, any complications that may arise. This way the patient will not misunderstand and will trust me enough to return.”

CRM Activities: Public versus Private Providers

Low to medium income patients depend on a monopolistic state system that heavily subsidizes treatment at government providers without ensuring high quality standards of care. Further evidence from respondents is provided below:

Specialist national MH centers benefit from instant brand recognition and a near monopoly on severe cases, which results in limited marketing repertoire for public hospitals:

- SP1 “I don't need to look for business, business comes to me. They come from everywhere: from Ho Chi Minh City, from the provinces, from the Mekong Delta – we're never short of patients.”
- SP2 “Big hospitals like this one don't care about losing patients because the [brand] name always attracts new ones.”
- Public institutions tend to have a rather transactional view of the relationship with their patients:
S1 “We receive the patient from the local police, we find the problem, we treat the problem and that is all. We don't manage them. It is not our job to check on them after months or to see how they're doing.”

- Retention is not an issue due to affordability which limits the bargaining power of buyers:

SP1 “I feel sorry for some [patients] – they live as far as half a day away, they take a 4AM bus from another province to come see me because only this hospital offers SHI [social health insurance] reimbursement for their illness.”

Customer-centric, especially premium establishments refers to the focus on customer experience, satisfaction, and long-term loyalty that premier clinics employ to increase customer lifetime value and generate multiple income streams from their growing customer base. Further evidence is provided below:

Client experience and retention are paramount at more upscale clinics:

- Matching the channel with the right segment or readiness stage
 - P1 “The website is only effective with certain types of people because it is a more direct tool; it works well for people who are not shy to use the service.”
 - P1 “The YouTube videos work well for people who are aware of their problem already and are looking for a clinic.”
 - P1 “Every channel focuses on a specific niche, FB is more for young people that want to try, usually aren’t serious about the service. YouTube is more focused on people who are actually willing to pay for it.”
- Sophisticated niche approach to capture special targets
 - P1 “Take workshops and seminars for example. This is for a special group of people, it’s for those who believe in science, who are persuaded by scientific evidence. Not many people are like this in Vietnam.”
- Rooted in commercial marketing, respect for the customer comes first
 - P1 “First of all, we don’t call them patients. We refer to them as ‘clients’ and treat them as professionals. Our client is our partner and he or she plays a major role in self-awareness and self-healing together with the right doctor. The client chooses the provider and can decide to change one or two doctors until they find someone that fits their requirement. The doctor is long-term oriented, treats the patient in a polite and helpful manner, and respects the client’s rhythm – everything goes at the client’s pace.”
- Care is taken to protect the user’s privacy
 - P1 “From the very first step, everything is kept private. If you see our place from outside, you don’t know it is a clinic: there is no sign, no business, just a premium-looking villa in a good neighborhood. The client rings the doorbell and is invited in, like a guest in a rich man’s home.”
 - P3 “We have two Facebook communities – both private, closed membership because MH is a sensitive topic. One Group is for individual clients, the other is for my corporate patients.”
- Focus on understanding the need and scheduled follow-ups
 - P2 “I arrange 2-3 sessions to fully assess the case, then schedule intensive treatment (2-3 sessions/week for several months), then there is a monthly follow-up.”
- Flexibility in satisfying the need, even if it incurs some loss of revenue

P2 “If someone asks for something that none of us [team of doctors] have done before, or something we don’t have expertise in, we will always try our best to deliver – even if we have to bring in a lecturer from the Faculty of Psychology or outsource to a competitor.”

- Prioritizing the client’s best interest

P2 “Sometimes, when people come to us, they are not ready [for treatment]. We don’t want to waste their money, so we transfer the patient to another specialist or hospital outside our network to stabilize the patient, then transfer the person back when the patient is at the right stage in awareness and ready for development.”

- Follow-up to manage premium patients

P1 “We always keep track of our clients’ progress. We call about offers and email our newsletter at appropriate times, we send reminders via SMS to confirm a scheduled appointment. A free follow-up session is organized with the same doctor about 3 to 6 months after the treatment.”

P1 “We see this as a long-term, continuous improvement curve. After the clinical issues were treated and the patient is doing well, the doctor explores self-development opportunities.”

Discussion

Revisiting Schiffman & Kanuk’s Consumer Decision-Making (2010), findings tend to match the evidence from literature especially in the areas of internal and external factors that influence MH patients in Vietnam. In detail, Vietnamese potential users of MH services were greatly influenced by the Socio-cultural environment, especially by stigma, superstitions, and collectivistic norms (Hofstede, 2018), which posed a major barrier to further Information search into services available. Among prospects who did exhibit some self-awareness of need, a combination of non-commercial and informal sources such as peers, neighbors, colleagues, online forums, and social media groups helped to validate the choice of the best commercial offering. In terms of the firm’s marketing efforts, the product itself was not a major draw, since many prospects failed to fully understand the mode of action and tangible benefits of MH care. Promotional activities had various degrees of usage and effectiveness, greatly dependent on whether the MH provider was public or private and more or less sophisticated in its approach.

Pricing was found to play a role, albeit a negative one, as a deterrent from usage for mid- to low-income consumers, and was less consequential in the case of more affluent users. Place appeared to pose challenges mainly to users who had to travel from suburban areas and nearby provinces, but being bound by SHI coverage was found to enhanced the prospect’s willingness to overcome Channel barriers.

A number of prospects were quite skeptical, perceiving MH services to be a ‘scam’ especially talk-therapy, some even denying that mental illness existed, much less that they knew anyone suffering from it or that they themselves were afflicted. In alignment with literature (McCay et al., 2017) Vietnamese doctors pointed out that Need Recognition was a very difficult step in MH due to the nature of the illness itself (Theme 1a) – one consequence of mental disorder being that it affected the patient’s self-insight and thus resulted in lack of self-awareness of being ill. Unlike literature (Carr, 2009) from developed economies where self-help is important and families tend to take matters seriously, many parents of children with mild disorders had a rather indifferent attitude to mental illness, and perceived it to be minor in comparison to more traumatic life-and-death diseases such as cancer, high blood pressure,

or HIV. Among prospects who accepted MH treatment, attitudes were most favorable towards international MH service providers and doctors with overseas training, a finding which echoes literature (Tengilimoglu & Yesiltas, 2007) for private providers, as these were perceived to offer better quality care with more modern techniques. An important persuasive factor was the use of pharmaceutical adjuvants – most patients expected to be prescribed medicine as a ‘real doctor’ would do, and some even judged the quality of the psychiatrist based on the number of medicines prescribed and their country of origin, which was not reflected in the literature, possible due to the lack of direct-to-consumer advertising in Vietnam (Donohue, 2004; Reeves, 1998).

In terms of personality, findings aligned with literature as thinkers with introspective tendencies (US Framework and VALS™ Types, 2015), especially female (Hammer & Vogel, 2009), were most likely to self-initiate seeking the help of a MH professional. Such users tended to come from a more affluent background, often highly educated and with overseas exposure, and articulated their need as ‘something feels emotionally wrong’. Their preferred learning style about services available was based on scientific evidence of mechanism and vicarious learning (Schiffman & Kanuk, 2010) from positive word of mouth about successful outcomes. In contrast, more doer-type of personalities (US Framework and VALS™ Types, 2015), especially males, resorted to denial e.g. exercising at the gym for mood uplifting and unhealthy coping mechanisms such as heavy drinking, found in literature regarding gender but not to the detailed level of coping mechanisms (Hammer & Vogel, 2009). A number of perceived risks (Schiffman & Kanuk, 2010) also deterred users from advancing to later steps in the decision-making, namely social risk (Corrigan, 2004) that peers would perceive them as abnormal and marginalize them, Maslow’s safety needs that employers would terminate their contracts (Lester, Hvezda, Sullivan, & Plourde, 1983), financial risk that the investment would be too great, and functional risk that the service would not deliver the expected results – exacerbated by the long-term nature of most mental illness treatments.

In contrast with literature (Carr, 2009), motivation was low and did not impact behavior until the later stages of illness when physical symptoms became too strong (insomnia, headache, blackouts), in which case the patient sought GP help. Thus, the majority of MH patients arrived passively via direct referrals or transfer from non-MH specialty, judicial institutions and lower-tier clinics. By comparison with evidence from the literature (Carr, 2009), the Vietnamese MH market appears marked by lack of need awareness, subservient to traditional GP care in the public health system and much less patient-driven than in more developed markets such as the US, Australia, or Europe (Depp et al., 2010; Lamberts, 2016).

Conclusion

In the earlier periods of developing public health, marketing remained to be a detestable idea. There was something about healthcare that made it sacrosanct, which would be polluted by marketing (George & Henthorne, 2009). However, from the very marketing field, public health campaigns borrowed the concept of exchange, and started emphasizing the benefits that consumers can expect in return for the ‘cost’ to their health and well-being. With the boom of medical tourism, marketing became an inalienable companion to healthcare (George & Nedelea, 2009; George, Henthorne, & Williams, 2010). Early programs for health marketing were pioneered by international NGOs on the field in the developing world and targeted basic needs such as nutrition and family planning, and used traditional media such as radio, TV, the printed press, and mass advertising. Further developments such as social communication expanded HC messages into new channels such as personal selling, publicity, and promotional events, with some agencies even using incentives to encourage voluntary exchange (Fox & Kotler, 1980).

While recognizing that there is a problem for daily necessities such as biological needs for food, shelter, or thirst are often basic, marketers of MH must pay more attention to “the way a consumer perceives a problem and becomes motivated to solve it” (Belch & Belch, 2012, p. 116). In each situation, the marketer’s challenge is to understand the background of the potential patient so as to better tailor the communication tone, message, and appeal as well as the delivery source. In the case of misconceptions or deeply rooted mistrust, the MHC marketer may benefit more from two-way marketing media such as internet forums and highly persuasive community-oriented events (e.g. sharing and workshop sessions) as such media can foster an interactive environment where potential patients can identify with the experiences of others and receive proper guidance (Le, 2017).

In this regard, based on our case study, a summary mapping of external and internal factors influencing Vietnamese mental health consumers in Ho Chi Minh City, Vietnam (illustrated by the authors) is presented below in Figure 1.

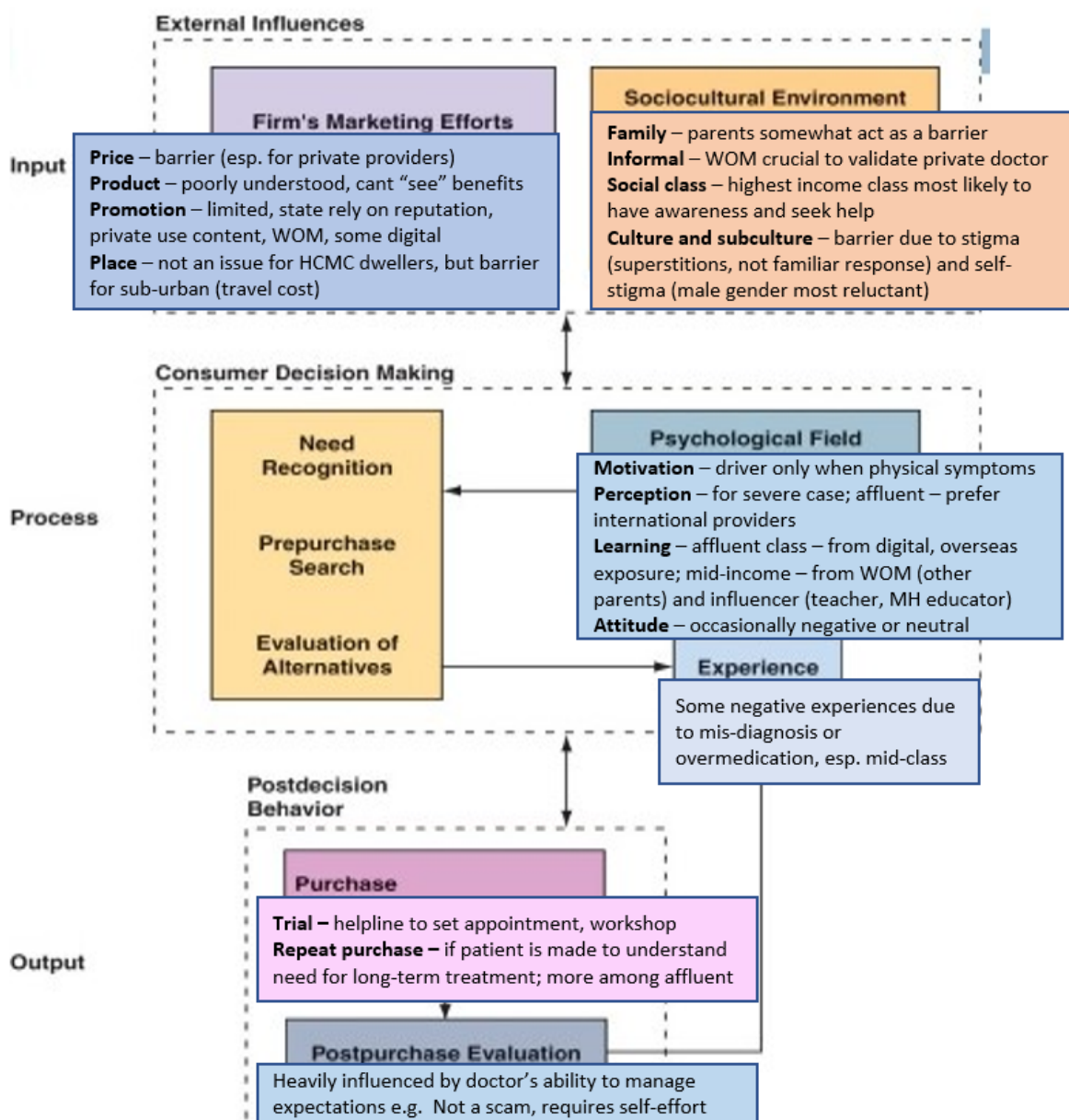


Figure 1. Mental health choices and factors affecting them

While this summary diagram unearths a lot of nuances, there are gaps in the study. Also, the study throws open numerous new research avenues. We recommend that future research on the topic include mainly users of mental health services or at least a survey on the general public's opinion. Also include insight from policy makers e.g. Ministry of Health on anti-stigma campaigns and HR recruiters to better gauge the impact of stigma in staff hiring and retention; and, extend the geographic area to include other regions and more rural respondents. To take the investigation one step further, future studies could include discourse analysis in the form of detailed investigation of themes in the execution of marketing communications for MH e.g. a comparison between PPC ads, Facebook posts, and YouTube.com videos from various providers; or perform testing and experiments to gauge the effectiveness of alternative marketing materials for MH awareness and prevention.

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