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Community health workers fostering trust and engagement in a community-based intervention for depressive older adults in Peru: a qualitative study

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Abstract

Background Innovative community-driven approaches, such as task-sharing interventions with Community Health Workers (CHWs), are essential to reduce the mental health care gap. This study explored how CHWs' actions, experiences, knowledge, and resources contributed to fostering the acceptability and feasibility of a community-based mental health intervention (VIDACTIVA) for older adults.

Methods We examined the role of CHWs ($n = 16$) delivering VIDACTIVA, an evidence-based CHW-led intervention for older adults with depression. VIDACTIVA integrates Problem-solving therapy and Behavioral Activation in eight home-based sessions. Data included in-depth interviews and field notes collected across a 3-year period of piloting, adaptation, and implementation. An inductive thematic analysis identified key CHW practices that enhanced the intervention's engagement.

Results Sixteen CHWs (aged 39–72, median 60 years) participated. Three main themes emerged as central: (1) establishing trust with older adults through active listening, empathy, and addressing urgent needs; (2) adapting session settings and creatively introducing tools to sustain engagement; and (3) fostering strong peer support networks that enhanced CHWs' confidence, learning, and commitment throughout implementation.

Conclusion CHWs play a pivotal role in community-based mental health interventions by building trust with participants, leveraging their community knowledge, and working as a collective that supports learning, self-care, and teamwork, factors that humanize care and strengthen the sustainability of programs.

Trial registration The current trial registration number is NCT06065020, which was registered on September 26, 2023.

Keywords Older adults, Mental health, Community health worker, Community-based intervention, Depression, Trust

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Background

Late-life depression is one of the most common mental health conditions among older adults and represents a major public health concern worldwide. A recent systematic review and meta-analysis estimated that nearly one in three older adults experience depressive symptoms globally [1]. In Peru, the prevalence of depression among older adults is estimated between 10% and 15% according to the 2020 Demographic and Family Health Survey [2]. Marked inequities have also been documented: prevalence reaches 30% among older adults with low income compared to 15% among those with middle or higher income [3]. In urban resource-constrained settings, broader social determinants such as poverty, unsafe housing, limited health infrastructure, mental health stigma and ageism further exacerbate the risk of depression [4–6]. These challenges are worsened by the scarcity of mental health professionals and trained providers, leaving many older adults without timely or appropriate care.

To address this gap, the World Health Organization has promoted task-shifting and task-sharing interventions as strategies to integrate non-specialists into routine health care and expand access in low- and middle-income countries [7]. Community Health Workers (CHWs) have been increasingly recognized as trusted contributors to mental health interventions, with evidence supporting their roles in prevention, treatment, and ongoing support across diverse contexts [8, 9]. Trusted and embedded within communities, CHWs bridge gaps between health systems and populations, and their involvement in the design and delivery of community-based programs enhances acceptability, feasibility, sustainability, and effectiveness [10–18].

In Peru, CHWs, known locally as *agentes comunitarios de salud*, are voluntary individuals recognized by their communities and formally registered by health authorities. Traditionally, CHW extend access to healthcare services by serving as bridges between community members, formal health professionals, and institutions, contributing to areas such as infection disease prevention, and maternal and child health [19, 20]. However, it has been less common for CHWs to lead the delivery of interventions themselves, particularly in the field of mental health [14, 21].

A pilot trial of VIDACTIVA, a multi-component community-based intervention delivered by CHWs that included eight sessions of a low-intensity psychological program for older adults with depressive symptoms, has been conducted [22]. As part of its design, the program incorporated core components from the *Program to Encourage Active, Rewarding Lives* (PEARLS), an evidence-based intervention originally developed at the University of Washington. Specifically, VIDACTIVA integrated PEARLS' focus on problem-solving skills and behavioral activation, two approaches shown to be effective and feasible in home-based interventions for older adults with depression in the United States [23], and combined them with locally relevant strategies and the active role of CHWs to respond to the Peruvian context. This study examined the role and contributions of CHWs in fostering trust and engagement in the intervention. Specifically, we analyze the actions, experiences, knowledge, and resources mobilized by CHWs as strategies to strengthen their bonds with older adult participants and to facilitate the delivery of VIDACTIVA. We also reflect on the practical implications of these strategies for the design and implementation of community-based interventions in similar settings.

Methods

Study setting

This study was conducted in Villa El Salvador (VES), an urban low-income district located in the south of Lima, Peru, mostly populated by long-standing migrants from the Andean Peruvian central and south regions that arrived between 1970 and 1980 due to insecurity, poverty and seeking better socio-economic opportunities. In Peru, formal mental health services are delivered through primary healthcare centers (PHCs) and community mental health centers (CMHCs). PHCs typically manage mild cases and may or may not have a mental health professional on staff [24]. More moderate to severe cases are referred to CMHCs, which have multidisciplinary teams that include psychiatrists and other mental health specialists. In 2024, there were 3 CMHCs and 16 PHCs in VES, many of which were supported by a network of CHWs [22].

Study design

This qualitative study employed a thematic inductive approach, drawing on multiple data sources, including in-depth interviews and field notes to analyze CHWs' experiences and perspectives over a three-year period of piloting, adaptation, and implementation of the VIDACTIVA intervention.

The VIDACTIVA intervention

In summary, VIDACTIVA consists of eight in-person sessions delivered by pairs of CHWs over a 14-week period (reference anonymized). The sessions are semi-structured and conducted either in the participant's home or in a convenient community location, such as a relative's home or a public park (Fig. 1). In addition, weekly supervision meetings were held with the group of CHWs, facilitated by a clinical psychologist and a general practitioner. During these meetings, CHWs shared their experiences with participants, discussed challenges,

VIDACTIVA SESSION GUIDE	
1st	Greet and establish RAPPORT in the preferred location for the participant
2nd	Administer the PHQ-9 to the participant
3rd	Ask about CURRENT PROBLEMS or difficulties regarding their affective and mental state
4th	Invite the participant to choose A PROBLEM THEY WANT TO FOCUS ON IN THIS SESSION
5th	Complete the 4 steps of the VIDACTIVA WORKSHEET in constructive dialogue with the participant: 1) Define the problem together and a corresponding goal for it 2) Look for possible solutions and analyze each for advantages and disadvantages 3) Let the participant choose a solution and define together steps for its implementation 4) Ask the participant to rate their level of confidence for the solution
6th	Plan PHYSICAL, SOCIAL AND PLEASURABLE ACTIVITIES for the week
7th	If necessary, provide PSYCHOEDUCATION FOR THE PARTICIPANT AND FAMILY MEMBERS
8th	Set an appointment for the next session and warmly say goodbye

Fig. 1 English version for the VIDACTIVA session guide used by CHWs on field

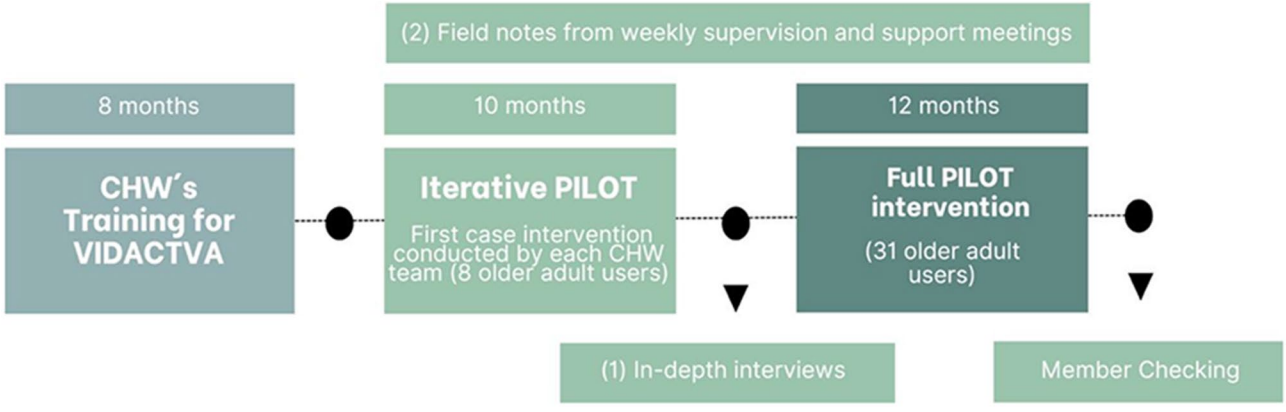

Fig. 2 Program implementation stages and data collection timeline including final member checking procedure

uncertainties, and initiatives that emerged in relation to each VIDACTIVA session, and engaged in reflective and collaborative dialogue. These spaces allowed CHWs to explore the meaning of their work and to collectively identify lessons learned throughout the intervention.

Participants

A total of 31 CHWs were initially recruited through open calls disseminated by the local health network and community channels to participate in the adaptation and design of VIDACTIVA. All attended the first training phase (September–December 2022), which included workshops on late-life mental health, depression, anxiety, active listening and positive mental health. In January 2023, individual interviews were conducted to select 16 CHWs for the next phase: the iterative pilot. Selection was based on active engagement and lessons from training, prior experience with older adult care, empathy, interpersonal skills, aptitude for learning, commitment, and availability. The selected CHWs then participated in the iterative pilot and the subsequent pilot trial [22].

Data collection

We explored CHWs' experiences, actions, and perspectives using a multi-methodological approach across various time points (Fig. 2). First, 16 in-depth interviews were conducted, one for each CHW, following the completion of eight sessions with an enrolled older adult. The interview guide was developed specifically for this study (see supplementary file). Held between September and November 2023, these sessions lasted approximately 45 min and focused on the acceptability and feasibility of

the intervention, as well as feedback on program tools. Second, we analyzed 89 sets of field notes (42 from 2023; 47 from 2024) derived from weekly supervision meetings spanning the iterative pilot to the pilot trial intervention. Field notes were recorded by the supervising clinical psychologist and a designated note-taker and captured contextual observations, key discussion points, and reflections on CHWs' experiences, strategies, and challenges in the field. These notes were intended to document ongoing implementation processes rather than to provide verbatim transcripts.

Data analysis

We analyzed data using a reflective thematic analysis approach as outlined by Braun & Clarke [25]. An initial codebook was developed inductively by experienced research staff based on the first transcripts, which were transcribed verbatim in Spanish. Codes were then grouped into broader categories and refined into final themes through an iterative process of team discussion and review. Field notes from supervision sessions were reviewed alongside interview transcripts and used as a complementary data source to support triangulation, provide contextual depth, and clarify the interpretation of emerging themes. In particular, field notes informed understanding of group dynamics, supervision processes, peer support, and adaptation strategies that were not always explicitly articulated in individual interviews.

In a subsequent step, we examined how the emerging themes related to acceptability, the extent to which a practice, program, or treatment is perceived as agreeable or satisfactory by stakeholders, and feasibility, the extent to which it can be successfully applied within a given context [26, 27]. To enhance the trustworthiness and credibility of our findings, we conducted a member-checking procedure with participants to discuss preliminary themes and interpretations [28]. Participants were presented with the thematic structure, key quotations, and preliminary analysis. Their feedback was positive, confirming the proposed themes. Additionally, they emphasized the importance of two main aspects of the findings: the importance of building trustful relationships with participants and the mutual support CHWs provided to one another during the intervention. Data were managed and organized using MAXQDA software (VERBI GmbH, Berlin, Germany, Version 18.2).

Ethics

This study received ethical approval from the Institutional Review Boards of *Asociación Benéfica PRISMA* and *Universidad de San Martín de Porres*, both in Lima, Peru. Participants provided written informed consent, granting permission to use interview quotes in academic publications. To ensure confidentiality, all data were de-identified during analysis, with personal identifiers replaced by codes and securely stored in a password-protected, locked online folder. In this manuscript, we use pseudonyms when referring to study participants.

Results

Sample characteristics

The study participants consisted of 16 CHWs, ranging in age from 39 to 72 years (Median = 60; SD = 10.4). All participants were female except for one (CHW 7). They all have lived in VES for over 15 years (Median = 42; SD = 12.6). Most participants had significant years of experience in community leadership (Median = 12.5; SD = 11.9), collaborating with local public health services and other community-based interventions or programs. Initially, five more experienced CHWs were recruited for the VIDACTIVA intervention. Additionally, in coordination with local Community Mental Health Centers (CMHCs), 11 participants initiated the formalization procedure for their Ministry of Health CHW registration concurrently with the VIDACTIVA training program (Fig. 2). This official recognition was granted in time for the Iterative Pilot. For more detailed information about the participants see Table 1.

Main themes

We identified three key aspects in the process of piloting and adapting VIDACTIVA that CHWs considered important for strengthening bonds with participants and facilitating engagement and delivery of the program: (1) *establishing trusting relationships* (2), *adapting session settings and adding tools, and* (3) *supporting one another throughout the intervention.*

Establish trusting relationships

Active listening and building trustworthy interpersonal connections were essential components of the intervention, especially when working with older adults. CHWs observed that many older adults were hesitant to trust, even with community members like themselves, particularly in neighborhoods affected by crime and violence. They also noted that limited literacy and, at times, deceit by close relatives made older adults vulnerable to scams. One CHW recounted the case of a participant who lost legal ownership of his home after unknowingly signing fraudulent documents.

CHWs collectively recognized that widespread mistrust created significant challenges for implementing VIDACTIVA. They emphasized that earning participants' trust required sustained effort, sensitivity, and a consistent presence in communities where confidence in both people and institutions had long been undermined. The CHWs described several strategies they used to generate trust with older adults:

Table 1 CHW´s sociodemographic, education and community service information

	Age in years	Born in Lima (Yes/No)	Marital status	Living with whom	Years living in Villa el Salvador	Level of Education	Experience as community leader in years
CHW 1	66	No	Married	Husband	25	Technical qualification	25
CHW 2	38	Yes	Single	Children	20	Technical qualification	30
CHW 3	59	Yes	Married	Husband and children	52	Completed High School	7
CHW 4	42	Yes	Single	Mother and children	37	Technical qualification	7
CHW 5	65	No	Married	Husband, children and son in law	51	Completed High School	40
CHW 6	63	Yes	Divorced	Children and grandchildren	36	Technical qualification	10
CHW 7	74	No	NA	Partner and niece	50	Completed High School	20
CHW 8	52	No	Life Partner	Partner, children and grandchildren	30	Completed High School	10
CHW 9	50	No	Married	Husband and children	22	Completed High School	8
CHW 10	75	Yes	Widow	Children, sons and daughters in law and grandchildren	46	Bachelor's degree	20
CHW 11	67	Yes	Widow	Children and godson	49	Bachelor's degree	24
CHW 12	63	Yes	Single	Sister, children and grandchildren	50	Technical qualification	40
CHW 13	61	No	Married	Husband, children and grandchildren	38	Completed High School	7
CHW 14	57	Yes	Divorced	Parents	49	Technical qualification	15
CHW 15	49	Yes	Married	Husband and children	16	Bachelor's degree	3
CHW 16	56	Yes	Divorced	Children	50	Completed High School	8

Sharing personal stories and practice "good listening"

CHWs tried to establish trust in different ways. Drawing on their shared experience as long-standing migrants in the area, they often disclosed aspects of their own background and personal history to establish a common ground. They engaged participants in informal conversations about familiar topics such as food and traditions from "*their land*" to create a sense of connection. These exchanges helped participants to open up about their own personal problems and life challenges, which is seen as an essential step in the VIDACTIVA sessions:

> *I told her about my town, and she tells me how was hers… (…) I always begin telling my story to engage the person. Then I say "and what has happened to you Mamita?" (…) In that way we were able to know more about the participant, about her problems at home. (CHW 7)*
> *Well, the bond with her developed thanks to the trust she put on us. From the beginning we listened actively to her story, giving her advice and guidance. That helped a lot in her exploration about personal problems (CHW 15)*

Actively listening played a critical role in bonding and in further exploration of participants personal problems. "*Build trust. Show them that we are listening and that they can have confidence in us for next time.*" CHWs focused on listening to the participant explaining that "*they [older adults] want to be heard*". For CHWs, listening was key for establishing trust and rapport with the participants so they could build a solid commitment for the duration of the intervention. They referred that by listening, a participant could change from being avoidant with them to become eager for their scheduled visit:

> *Listening to him was the way. He had a need for being heard. For example, the first times we knock on his door, he was watching us from the window and not opening, but the last times, he was waiting outside eager to welcome us. (CHW 8)*

Nurturing a family-like approach and friendship

CHWs described showing care and genuine affection by taking a real interest in each person: "*With every user, a hug, a smile, putting interest in the person, their health, what they did last week for example*" (CHW 7). CHWs emphasized that offering love and maintaining regular visits with a reliable presence helped participants to feel valued and supported, much like the care one would expect from a close family member:

> *We hug her, give her affection, ´you are so pretty, look how much you have accomplished, is so good´. We arrived there as family (…) these persons are in need of affection, when you give it them, they feel valued, they feel good, they feel like they matter." (CHW 5)*

CHWs also described using an informal form of "laugh therapy" at the beginning of sessions, before discussing more difficult topics. By creating a joyful and trusting environment, they encouraged participants' self-exploration. CHWs noted that this approach helped participants engage more effectively in the problem-solving exercise:

> *First, we applied "laugh therapy". We laughed a lot and then she talked about a traumatic experience from her childhood and right after that she started to think better about pros and cons in the problem-solving exercise (CHW 14)*

Among other resources used by CHWs, they mentioned that to develop trust, they presented themselves as friends and not as health workers: *"A friendship. She sends us messages checking in [by phone], sharing something. We respond in a similar way, sharing good desires"* (CHW 12).

Addressing urgent needs

In their way to develop trust and establish bonds during the intervention, CHWs took concrete actions to meet some urgent needs presented by older adults and considered this to be key for VIDACTIVA intervention: "*Everything is about trust (...) we have to show them that they matter to us*" (CHW 12). They arranged medical appointments, gave orientation about social services, took blood pressure measures, instructed about procedures for bedsores homecare, and implemented local relaxation techniques. Although VIDACTIVA did not include direct assistance in its design, sometimes CHWs chose to provide this support on their own initiative, seeing it as essential to building trust and working effectively with some participants.

During a supervision meeting, CHWs 7 and 12 reported that one participant, who had shown little engagement with VIDACTIVA, was close to dropping out. In response, they decided to address a concrete need the participant had repeatedly voiced: securing a medical appointment at the local health center. The CHWs recalled her frustration, quoting her: *"You don't give any solution to my problems. My son tells me, 'Why are they visiting you and asking so many questions? Tell them to help you. What are they giving you?'"* To respond to this concern, CHWs used their knowledge of the health system and personal connections to obtain the needed medical appointment. CHWs believed that this gesture helped restore the participant's trust in both them and the intervention, ultimately preventing her withdrawal from the program. Other CHWs present at the supervision meeting acknowledged the impact of this out-of-script action, remarking *"They saved the case"* in recognition of the supportive relationship that CHWs 7 and 12 had built through their empathetic and pragmatic response.

In similar circumstances CHWs talked about how they deliver orientation to participants about different topics, such as local and national social services and programs. CHWs refer to this direct assistance orientation as something essential to their community field work: "*If we don't say anything or orient in any way, how can they trust us? I mean, we always must be focused on serving the community*" (CHW 5). Similarly, a case when the CHWs helped to arrange a medical appointment:

> *On the first visit we were rejected, but in the second he talked about a needed medication that wasn't getting from the health center, and we arranged to go there, look for a doctor and bring him the medication so that he can have confidence. So, I think that generating trust in the user is very important. What we do towards the community is generate trust with someone we want to continue to have their friendship or, as in this case to the user, continue the programmed visits (CHW 12).*

Adjust the sessions setting and add tools

Adjusting the VIDACTIVA session's setting was recognized by CHWs as an important asset to acceptability and feasibility for the program. The CHWs in charge of delivering the intervention freely adapted the basic conditions of the sessions according to the context.

Session's location

Although VIDACTIVA was originally designed as a home-based program, CHWs occasionally shifted sessions from the older adult's home to nearby public spaces (e.g., a local park) according to participants' preferences and needs. These adjustments were often motivated by concerns about comfort, privacy, or household conditions such as the presence of family members, the closeness of rooms, or the lack of proper doors, that limited participants' ability to speak freely and confidentially. By adapting in this way, CHWs followed a participant-centered approach aimed at making sessions more accessible and meaningful:

> *We told her, ´Miss, should we do the sessions at home? ´ And she replied ´No, because of my family, my sons are there, I don't want to interrupt. My feelings are for outside. What if we go to the park? ´. ´Which Park? ´ we replied… So, we did the third session in the park, and then all the rest of them. We said to her, ´the program does not tell us to go out from your home, but it is fine, we will go anyway´. She was so delighted. Till now we write to each other. (CHW 7)*

New tools for the session

CHWs resourcefully introduced tools beyond the basic program structure to address challenges that arose during sessions. For instance, CHW 6 informed in supervision meeting that she proposed a knitting lesson for a reluctant participant with whom conversation was

stalling. During supervision, the CHW explained that as they learned a specific stitch together, the dialogue began to flow more naturally, which in turn facilitated the exploration of problems needed to achieve the session's objectives. In this way, the added activity functioned as a tool to stimulate conversation and led to a favorable outcome. Another tool also informed in supervision meeting by CHW 3 was a handmade reminder created by them for a participant who would frequently forget about the scheduled program sessions. Recognizing that the continuity of the intervention was at risk, CHW 3 tore a piece of paper from their field notebook and wrote, in large letters, the day and time of the next home visit. The participant was encouraged to place the reminder in a visible location within their home to avoid missing future sessions. During a supervision meeting, CHW 3 later reported that this simple strategy was effective in supporting the participant's engagement and helped sustain the continuity of care throughout the intervention (field notes from supervision meeting).

Support each other throughout the intervention – the supervision "space"

Focusing on CHWs' dynamics, we found that the development of a supportive peer group was a key factor contributing to the intervention's acceptability. What began as weekly supervision meetings with a clinical and community psychologist and a general practitioner gradually evolved into much more than a technical space. Over nearly two years (2022–2024), the 16 CHWs shared their field experiences, reflected on challenges, and supported one another. Through this process, they forged a strong sense of team, recognizing the supervision space as not only a forum for professional guidance but also a form of self-care that fostered solidarity, mutual support, and trust among them.

CHWs often found themselves needing information, advice, or other inputs to better support their participants. In this context, CHW 6 highlighted the value of peer support and the collective approach fostered by the intervention, recognizing it as an important part of her training and overall experience:

> *First, they (research team) met us, they explained the program to us, they trained us, (…) then they organized us in couples and then we came and held our meetings explaining, telling how it had gone, our experiences, and that enriched our learning a lot (CHW 6)*

CHWs highlighted that belonging to the group was especially helpful, as peer inputs during supervision played a crucial role in building their confidence and skills. While guidance from the research team was valuable, the support and shared knowledge among peers often proved even more important for their ongoing learning and implementation:

> *At the beginning, you know that we have not done things right. But along the way, with the contribution of our colleagues and of you really, one has begun to improve, to get on the right track. Also, since we have had several users, we already have a little more experience, more confidence. We have built that with the user as well as we have gained it for ourselves, and we already feel safer. (…) That is why the supervision sessions that we have every Thursday are very valuable, very important, for our learning. (CHW 10)*

We found that hearing about colleagues' experiences and challenges strengthened CHWs for their fieldwork. The confidence gained from these weekly meetings contributed to recognizing themselves as a learning group, consolidating their sense of unity and collective support:

> *Of course, the fact that after sharing here, listening to the other colleagues going through the same thing, (…) the fact of sharing here helps one a lot, doesn't it? (…) listening to others also strengthens us, it continues to strengthen us, and when we start with the new user, we are now calmer, more convinced. (CHW 11)*

> *This is sharing. Since we have started, after each session we get together and each one of us can share their experience. (…) So, we feel together, united and sharing in every meeting, gaining a lesson and leaving a lesson. (CHW 12)*

Discussion

Our study describes the actions, experiences, insights, and resources mobilized by CHWs during the intervention, contributing to the strengthening of bonds with older adults. First, CHWs emphasized the importance of establishing trusting relationships, which they nurtured through active listening, sharing personal stories, showing affection, and, at times, addressing urgent needs. Second, they adapted the program by adjusting session settings and incorporating creative activities to overcome barriers to engagement and sustain participation. Finally, weekly supervision sessions evolved into spaces of peer learning, solidarity, and self-care that strengthened CHWs' confidence and sense of teamwork.

Building trusting relationships emerged as a central element of CHWs' work and was critical for making sessions feasible, accepted, and meaningful for older adult participants. While prior studies [29, 30] have

consistently identified trust as fundamental for effective CHW engagement and for the implementation of community-based interventions, particularly in violence-affected settings [15, 31, 32], our findings provide concrete insight into how trust is actively built in practice. CHWs described using affection, personal disclosure, active listening, and responsiveness to immediate needs as deliberate strategies to establish and sustain these relationships. In addition, the supportive relationships among CHWs themselves, fostered through supervision and peer interaction, appeared to strengthen their emotional well-being and self-efficacy, reinforcing their capacity to engage effectively with participants. Together, these findings extend existing literature by showing how interpersonal trust operates simultaneously at the CHW–participant and CHW–peer levels within a community-based mental health intervention.

Our findings suggest that, within VIDACTIVA, peer self-disclosure emerged as a meaningful and contextually appropriate strategy when implemented under supervision. CHWs described using selective self-disclosure to foster rapport, empathy, and mutual understanding with older adults, particularly when discussing depressive symptoms and personal challenges. While previous studies [33, 34] have reported similar benefits of peer self-disclosure in depression care, our study adds clarity by highlighting the conditions under which this practice was perceived as appropriate and beneficial, namely ongoing supervision and collective reflection. Although this manuscript does not include older adults' perspectives, evidence from other settings [35] supports the value participants place on CHWs' peer self-disclosure, cultural closeness, and practical support. Together, these findings underscore how relational practices commonly avoided in formal clinical encounters may play a constructive role in community-based mental health care when adequately supported.

Additionally, this study contributes to the literature on CHW-led interventions by illustrating how non-professional providers operating in non-clinical settings can engage in mental health care within community-based programs. In many low- and middle-income countries, including Peru, CHWs are often positioned primarily as community leaders supporting health programs through logistical, data collection, and informational roles [19, 20]. Findings from VIDACTIVA indicate that, when adequately trained and supervised, non-professional CHWs can also participate in structured, guided approaches to depression care. Rather than suggesting a novel model of task-shifting [14, 21, 36], these results add context-specific evidence on how existing CHW roles may be expanded within community mental health initiatives, particularly in settings with limited availability of specialized mental health professionals.

Regarding implications for practice, findings from VIDACTIVA suggest that trust-building skills may be a relevant component of training for community-based mental health programs as shown in a similar study regarding the effective functioning of public health systems [37]. Across the study, CHWs emphasized relational practices as central to engaging older adults and sustaining participation, consistent with Grant et al. findings [35], indicating that, regardless of professional background, program deliverers may benefit from training that supports the development of trustful and meaningful relationships, particularly in community mental health contexts. Participants also highlighted the value of training approaches that emphasize active and compassionate listening, supported through simulations, case-based discussion, peer learning, and supervised practice as pointed out in previews insights on CHWs' training [38]. In addition, flexibility for local adaptation emerged as an important practical consideration when working with CHWs [36], facilitating adjustments to the intervention while preserving its core components.

We consider the close and sustained relationship built with the CHW team during weekly meetings over three years to be a major strength of this study. These ongoing interactions not only generated strong bonds between CHWs and supervisors but also provided a unique opportunity to observe the team's dynamics over time. This long-term immersion, centered on the adaptation and implementation of VIDACTIVA, enabled an in-depth understanding of CHWs' knowledge, resources, and limitations, an approach that reflects the value of prolonged engagement in qualitative research for capturing the complexity of a phenomenon [39]. As with any study, there are limitations to consider. In-depth interviews may have been perceived by CHWs as a form of evaluation following the development phase of VIDACTIVA, which could have influenced their responses through social desirability bias. Similarly, during supervision sessions, social desirability may have shaped how CHWs described their interactions with participants and with one another. Member-checking also carried a potential risk, as CHWs may have been reluctant to contradict the researcher leading the project. Nevertheless, the openness with which CHWs shared difficult or negative situations with older adults suggests that the impact of these biases was likely limited.

Conclusions

After examining CHWs' actions, experiences, knowledge, and resources, this study emphasizes the central role of trust-building in community-based interventions and research. In VIDACTIVA, CHWs consistently demonstrated that establishing and sustaining trusting relationships supported participant engagement and

facilitated intervention delivery. These findings suggest that attention to trust may be an important consideration in the design and implementation of community-based programs.

The study also highlights the value of recognizing and leveraging CHWs' experiential knowledge when conducting community-based interventions. In this context, drawing on CHWs' familiarity with community dynamics and lived realities contributed to intervention delivery that participants experienced as more relational and responsive, while making use of personal and social resources already present within the community.

Finally, our findings point to the importance of considering CHWs not only as individual deliverers or supervised pairs, but also as a collective. Opportunities for CHWs to share experiences, provide mutual support, and engage in self-care appeared to strengthen their confidence and sense of teamwork. This collective dimension may play a role in supporting learning processes and could contribute to the longer-term sustainability of community-based intervention.

Abbreviations

CHW	Community Health Worker
PEARLS	Program to Encourage Active, Rewarding Lives
VES	Villa El Salvador
PHC	Primary Healthcare Center
CMHC	Community mental health centers

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-026-14130-z.

Supplementary Material 1

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Author contributions

J.P., S.P., L.S., J.G. and O.F. conceived the protocol. D.O., V.P., I.C., T.C., R.V., N.C. and O.F. conducted the study trial. O.F. secured the study funding. D.O. and O.F. wrote the manuscript. All the authors contributed to the critical review of the manuscript. All the authors approved the final version of the manuscript.

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Data availability

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethical approval

The following protocol study has been approved by Universidad de San Martin de Porres (USMP) Institutional Ethical Review Board (FWA 00015320, reference #948–2023) and Asociacion Benéfica PRISMA Ethical Committee (FWA00001219, reference #CE0453.23). Written informed consent was obtained from all participants before enrollment into the study. Our study adhered to the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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References

1. Zenebe Y, Akele B, W/Selassie M, Necho M. Prevalence and determinants of depression among old age: a systematic review and meta-analysis. Ann Gen Psychiatry. 2021;20(1):55.
2. Instituto Nacional de Estadística e Informática (INEI). Perú: Encuesta Demográfica y de Salud Familiar - ENDES 2020 [Internet]. 2021 [cited 2025 Aug 31]. Available from: https://www.gob.pe/institucion/inei/informes-publicaciones/3294010-peru-encuestademografica-y-de-salud-familiar-endes-2020.
3. Martina Chávez M, Amemiya Hoshi I, Suguimoto Watanabe SP, Arroyo Aguilar RS, Zeladita-Huaman JA, Castillo Parra H. Depresión En Adultos mayores En El Perú: distribución geoespacial y factores asociados según ENDES 2018–2020. Anales De La Facultad De Med. 2022;83(3):180–7.
4. Alon N, Macrynikola N, Jester DJ, Keshavan M, Reynolds CF, Saxena S, et al. Social determinants of mental health in major depressive disorder: umbrella review of 26 meta-analyses and systematic reviews. Psychiatry Res. 2024;335:115854.
5. Liang Jhong, Liu M, Iing, Pu Y qi, Huang S, Jiang N, Bao W, Wen, et al. Cumulative inequality in social determinants of health in relation to depression symptom: an analysis of nationwide cross-sectional data from U.S. NHANES 2005–2018. Psychiatry Res. 2024;336:115894.
6. Flores-Flores O, Carrión IV, Rey L, Otero-Oyague D, Zevallos-Morales A, Parodi J, et al. FC12: ageism and mental health stigma: key barriers to accessing

mental health services among Peruvian older adults. Int Psychogeriatr. 2023;35:75.
7. World Health Organization. World health statistics 2008 [Internet]. 2008 [cited 2025 Aug 31]. Available from: https://iris.who.int/handle/10665/43890.
8. Miranda JJ, Diez-Canseco F, Araya R, Cutipe Y, Castillo H, Herrera V, et al. Transitioning mental health into primary care. Lancet Psychiatry [Internet]. 2017;4(2):90–2. Available from: https://doi.org/10.1016/S2215-03661630350-9.
9. Lavretsky H, Pot AM. Global crisis and mental health and well-being of older adults. The American Journal of Geriatric Psychiatry [Internet]. 2024;32(4):409–11. Available from: https://doi.org/10.1016/j.jagp.2023.10.021.
10. Baynes C, Semu H, Baraka J, Mushi H, Ramsey K, Kante AM, et al. An exploration of the feasibility, acceptability, and effectiveness of professional, multitasked community health workers in Tanzania. Glob Public Health. 2017;12(8):1018–32.
11. Chang W, Oo M, Rojas A, Damian AJ. Patients' perspectives on the Feasibility, Acceptability, and impact of a community health worker program: A qualitative study. Health Equity. 2021;5(1):160–8.
12. Kwiringira A, Migisha R, Bulage L, Kwesiga B, Kadobera D, Upenytho G, et al. Group-based education and monitoring program delivered by community health workers to improve control of high blood pressure in Island districts of lake victoria, Uganda. BMC Prim Care. 2024;25(1).
13. Lehmann U, Sanders D, Policy Brief. Community health workers: what do we know about them? The state of the evidence on Programmes, Activities, costs and impact on health outcomes of using community health workers. Evidence and Information for Policy; 2007;2.
14. Ayala R, Toffoletto M. Agentes comunitarios de salud: ¿cómo articular Esta estrategia En El contexto chileno? Interface - Comunicação. Volume 28. Educação: Saúde; 2024.
15. Kennedy AC, Prock KA, Adams AE, Littwin A, Meier E, Saba J, et al. Can this provider be trusted? A review of the role of trustworthiness in the provision of Community-Based services for intimate partner violence survivors. Trauma Violence Abuse. 2024;25(2):982–99.
16. Egaña Rojas D, Vejar L, Rioseco R, Carrasco P, Galvez P. Participación social En La atención primaria En salud: tensiones y contradicciones. Aten Primaria. 2020;52.
17. Galvez CA, Neish C, Balabarca Y, Rojas L, Serrano C. Programa educacional efectivo en la formación de agentes comunitarios de salud voluntarios en Lima, Perú. Glob Health Promot [Internet]. 2010;17(2):82–91. Available from: https://doi.org/10.1177/1757975910365266.
18. Schubert J, Neves da Silva R. Los modos de trabajo de los agentes comunitarios de salud: entre el discurso institucional y el cotidiano de la vulnerabilidad. 2021.
19. Gobierno del Perú. ¿Qué es un Agente Comunitario de Salud? [Internet]. [cited 2025 Aug 24]. Available from: https://www.gob.pe/41348-que-es-un-agente-comunitario-de-salud.
20. Perú, Ley 30825, que fortalece la labor de los agentes comunitarios de salud [Internet]. Lima; Jul 20, 2018. Available from: https://cdn.www.gob.pe/uploads/document/file/1039345/30825.pdf?v=1595862387
21. Schaaf M, Warthin C, Freedman L, Topp SM. The community health worker as service extender, cultural broker and social change agent: a critical interpretive synthesis of roles, intent and accountability. BMJ Glob Health [Internet]. 2020;5(6):e002296. Available from: https://ghsite-bmj.vercel.app/content/5/6/e002296.
22. Cruz-Riquelme T, Zevallos-Morales A, Carrión I, Otero-Oyague D, Patiño V, Lastra D et al. Pilot trial protocol: community intervention to improve depressive symptoms among Peruvian older adults. Pilot Feasibility Stud [Internet]. 2024;10(1):112. Available from: https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-024-01540-1.
23. Steinman LE, Gasca A, Hoeft TJ, Raue PJ, Henderson S, Perez R, et al. We are the sun for our community: partnering with community health workers/promotores to adapt, deliver and evaluate a home-based collaborative care model to improve equity in access to quality depression care for older U.S. Latino adults who are underserved. Front Public Health. 2023;11.
24. Toyama M, Castillo H, Galea JT, Brandt LR, Mendoza M, Herrera V, et al. Peruvian mental health reform: A framework for Scaling-up mental health services. Int J Health Policy Manag. 2017;6(9):501–8.
25. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qual Res Sport Exerc Health. 2019;11(4):589–97.
26. Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, et al. Outcomes for implementation research: conceptual Distinctions, measurement Challenges, and research agenda. Adm Policy Mental Health Mental Health Serv Res. 2011;38(2):65–76.
27. Proctor EK, Bunger AC, Lengnick-Hall R, Gerke DR, Martin JK, Phillips RJ, et al. Ten years of implementation outcomes research: a scoping review. Implement Sci. 2023;18(1):31.
28. Stahl NA, King JR. Expanding approaches for research: understanding and using trustworthiness in qualitative research. J Dev Educ [Internet]. 2020;44(1):26–8. Available from: http://www.jstor.org/stable/45381095.
29. Nicolaidis C, Wahab S, Trimble J, Mejia A, Mitchell SR, Raymaker D, et al. The interconnections project: development and evaluation of a community-based depression program for African American violence survivors. J Gen Intern Med. 2013;28(4):530–8.
30. Pinto RM, da Silva SB, Soriano R. Community health workers in Brazil's unified health system: a framework of their praxis and contributions to patient health behaviors. Soc Sci Med [Internet]. 2012;74(6):940–7. Available from: https://www.sciencedirect.com/science/article/pii/S0277953612000470.
31. Takashima Y, Blaquera AP, Betriana F, Ito H, Yasuhara Y, Soriano G, et al. Psychiatric Home-Visiting nurses' views on the care information required of psychiatric hospital nurses. J Med Invest. 2024;71(12):162–8.
32. Aisenberg E, Ell K. Contextualizing community violence and its effects: an ecological model of parent-child interdependent coping. J Interpers Violence [Internet]. 2005;20(7):855–71. Available from: https://doi.org/10.1177/0886260505276833.
33. Anstey Watkins J, Griffiths F, Goudge J. Community health workers' efforts to build health system trust in marginalised communities: a qualitative study from South Africa. BMJ Open. 2021;11(5):e044065.
34. Truong C, Gallo J, Roter D, Joo J. The role of self-disclosure by peer mentors: using personal narratives in depression care. Patient Educ Couns. 2019;102(7):1273–9.
35. Grant V, Litchfield I. Acceptability of community health worker and peer supported interventions for ethnic minorities with type 2 diabetes: a qualitative systematic review. Front Clin Diabetes Healthc. 2024;5.
36. Falgas-Bague I, Ramos Z, del Cueto P, Kim E, Zhen-Duan J, Wong YJ, et al. Adaptation of an Evidence-Based intervention for disability Prevention, implemented by community health workers serving ethnic minority elders. Am J Geriatric Psychiatry. 2021;29(3):260–9.
37. Jamison AM, Brewer J, Hamlin MD, Forr A, Roberts R, Carey A, et al. The *Be REAL* framework: enhancing Relationship-Building skills for community health workers. Health Promot Pract. 2024;25(6):939–44.
38. Schleiff MJ, Aitken I, Alam MA, Damtew ZA, Perry HB. Community health workers at the dawn of a new era: 6. Recruitment, training, and continuing education. Health Res Policy Syst. 2021;19(S3):113.
39. Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. Qual Health Res. 2015;25(9):1212–22.

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