Address correspondence to Laura Bond, Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA. laurabond79@gmail.com.
Laura Bond, Boston College School of Social Work, Chestnut Hill, MA, USA.
William Byansi, Boston College School of Social Work, Chestnut Hill, MA, USA.
Theresa S. Betancourt, Boston College School of Social Work, Chestnut Hill, MA, USA.
Faith Cheptoga, Centre for Mental Health, University of Rwanda, Kigali, Rwanda.
Eve Puffer, Centre for Mental Health, University of Rwanda, Kigali, Rwanda.

The Journal of Behavioral Health Services & Research, 2024. 1–16 © 2024, National Council for Mental Wellbeing.
DOI: 10.1007/s11414-024-09913-3

Family Strengthening Interventa7mf e7nonspecialist community providers. Supervision and training approaches are intend nonspecialists to deliver evidence-based interventions with quality. However, there is still little research exploring nonspecialist experiences with training and supervision and how, if at all, their training and supervision experiences result in fidelity and competence in delivering the interven-

Published online: 25 September 2024

monthly supervision, in-person monitoring visits, and the use of the manual and audio recorders equipped them to deliver Sugira Muryango with quality. Nonspecialists also provided examples of barriers to quality of delivery, including supervisor lack of availability, delayed compensation, and technology issues. Preparedness was consistent across gender; however, nonspecialists serving in a better-resourced district had previous experiences delivering evidence-based interventions and felt more prepared at the beginning of Sugira Muryango.

Introduction

The mental health and psychosocial support (MHPSS) care gap is well documented in low- and middle-income countries (LMICs). [1–6] Given a dearth of specialized providers in LMICs, nonspecialists are critical for delivering evidence-based interventions (EBIs), including caregiving and family-focused interventions that holistically support family well-being and early child development. [7,8] Evidence is growing that trained nonspecialists, such as peers, community health workers, or volunteers, can deliver evidence-based MHPSS interventions with e ectiveness. [4,9, 10] Utilizing nonspecialist providers, who are often deeply embedded into local communities, provides an opportunity for those living in LMICs to receive accessible, evidence-based interventions from members of their own community [11] and for researchers and practitioners to have a cost-e ective solution to addressing the MHPSS care gap in LMICs. [12–14]

Training and supervision are key components of ensuring that nonspecialist providers can deliver evidence-based interventions with quality. Ingredients for equipping nonspecialist providers have included training, mentorship, and supervision from intervention experts or mental health specialists. [5,15–19] Supervision often entails assessing the nonspecialist quality of delivery with a checklist during in-person monitoring or via audio or video recorders. [20] Quality of delivery is defined as both fidelity, which is “the degree to which an intervention was implemented as it was prescribed

Table 1

Sampling matrix for key informant interviews

Rubavu district		Ngoma district		Nyanza district	
16 male CBVs	12 female CBVs	8 male CBVs	13 female CBVs	8 male CBVs	12 female CBVs

Data analysis strategy

Data was analyzed using thematic content analysis [41] with a combination of both deductive

(Supervision) helped us so much because in the case of any problem, the supervisor used to help me. For instance, I had a family which had a child with a physical disability. I sought advice from my supervisor, and it ended with the support of local leaders. The child was taken to the Gahini hospital (Female CBV in Ngoma).

CBVs described in-person quality monitoring visits from supervisors as helpful:

What helped me and boosted my confidence is when my supervisor came to visit me. They followed how I led the session and at the end they gave me helpful advice. It helped me be where I am now. (Male CBV in Rubavu).

However, several CBVs in both Ngoma and Rubavu mentioned issues getting ahold of supervisors or getting the support they needed, particularly requesting more in-person supervision. Several examples from CBVs are below:

We would like to meet our supervisors more regularly. I know they have many responsibilities and many coaches in other areas to supervise, but it would be helpful if our supervisors gave us guidance or advice in-person, not doing everything on the phone. It would be great if they were available anytime we need them (Male CBV in Ngoma).

We did not get enough supervision, apart from the phone calls. For example, a supervisor visited me once, and the other families were asking why the supervisor did not show up for their families. They were promised to be visited at some point. I asked the supervisor about it, and I was told that there were other people that were going to visit them, apart from her. So, supervision did not go well (Female CBV in Ngoma).

In all three months I spent working with families, (name of supervisor) visited me only once. After a month and a half, the families were asking 'why don't those other people visit us?' Therefore, I think the supervisors should visit the families at least once a month. For supervision to go well, we should increase how often you accompany the coach to visit families (Female CBV in Rubavu).

Weekly group sessions also allowed CBVs to build relationships with peers who were CBVs as well. These relationships also served as an additional source of support for several CBVs. One CBV described how he would receive advice from a fellow CBV:

When going through the sessions I was about to give, sometimes I could see that there was something I was not understanding. There were times that I would call the supervisor and find that they were busy, so then I called a fellow facilitator, who advised me how to go about it (Male CBV in Ngoma).

Fidelity and competence

Fewer CBVs in Nyanza mentioned fidelity than competence. In general, fewer comments were about preparedness in terms of fidelity compared to competence. Several CBVs referenced their ability to deliver Sugira Muryango with fidelity because of the support they received through training. For example:

have spent a lot of time working on it, no one catches them. The goats no longer sleep in their house. If a child gets sick, they know to see a doctor. Because we humbled ourselves, we can discuss (these topics) with us (Male CBV in Ngoma).

This CBV later added "If someone asks me a question about…how a child is educated, how to have hygiene, how someone can be confident and develop, I can explain it. Before, I didn't know anything about it. I know it because I was trained on it."

Other CBVs mentioned their ability to deliver the intervention with fidelity but did not directly tie these skills to the training or supervision received during Sugira Muryango. For example, one CBV discussed the changes they saw in a family that they were working with and stated that they witnessed these changes "because I explained to them that a balanced diet does not require you to be rich and showed them that we can eat a balanced diet from the vegetables we cultivate here" (Male CBV in Nyanza). Another CBV of a di erent gender and district referenced the manual and how it helped with fidelity, stating that "I felt confident when I was coaching the families. when I would forget something, the book would help remind me" (Female CBV in Ngoma).

Across all three districts, CBVs discussed how being a member of the same community as the Sugira Muryango families made it easier to build rapport and gain trust when delivering Sugira Muryango, which are two key components of competence. In addition, many CBVs felt that their position as Sugira Muryango facilitators helped them become recognized as leaders in the community. Both male and female CBVs in each district provided illustrative examples of their relationship with their communities. Several examples are below:

I used to ask myself 'These families are my neighbors, how are they going to like the fact that I am the coach? Were they going to be neutral, or will they bring in feelings because they know me already?' But it didn't happen that way. They were happy about me being their coach (Female CBV in Nyanza).

The good thing is that the families and parents that I have worked with have made me their friend. They were familiar to me, therefore whoever had a problem could come to me and tell me whatever the problem was and ask me for advice. It is good when you talk with people who love you. I got the knowledge to help them (Male CBV in Rubavu).

Before I became coach in this program, (the Sugira Muryango families) and I lived well together. We were familiar, we had no problems, and when they saw that I was their coach, they trusted me (Male CBV in Rubavu).

Being a coach helped me to be known in the community at the village level and cell level. Because of what I have been teaching in this program, I am now considered someone who is an expert in this domain. Therefore, local leaders have asked me to sensitize about this subject and build awareness in the community (Male CBV in Ngoma).

Many CBVs referenced setting an example and how it was important to embody the skills that they were teaching to the families. For example, a female CBV in Nyanza mentioned that "To build rapport with families, first of all, you have to be a trustworthy person and an honest person. It is all about a good reputation. They had trust in me."

The majority of CBVs discussed how the training provided them with skills in competence, often referring to staying humble and calm, using communication techniques such as active listening, and showing empathy to the families with whom they were working. One CBV stated that:

What was helpful to me during the trainings is listening. That way of alternating in the conversation/discussion and relating yourself to whom you are having a conversation with. (Female CBV in Rubavu).

Another described how they would use calm responses when delivering Sugira Muryango:

supervision helpful included opportunities for peer learning, regular meetings with supervisors (preferably in-person), and correction in private. When asked about their preparedness, more CBVs described their skills in competence rather than in fidelity, particularly in Nyanza, which could be a result of what stood out to CBVs personally, or it could indicate that CBVs had greater skills in competence than fidelity. If so, this could be a result of the training and supervision content received, or this could be due to interviewing techniques providing incomplete data. While CBVs often provided examples of families improving in child development, nutrition, and hygiene and decreasing family violence, the interviewers did not probe to ask if this was a result of their fidelity to the manual. Future research should use mixed methods to compare quantitative fidelity and competence scores with detailed qualitative descriptions of CBV performance in both fidelity and competence.

This study also explored what, if any, di erences across CBV gender and/or district existed regarding supervision and training experiences or CBV quality of delivery. Data did not reveal any significant gender di erences between supervision or training experiences nor their ability to deliver Sugira Muryango with quality. This finding is consistent with what is seen quantitatively in a study using data from a later iteration of Sugira Muryango, also delivered by male and female nonspecialists. [43] Some di erences in themes existed across districts, namely, CBVs in Nyanza provided examples of other trainings they had received. These trainings were about HIV prevention and reconciliation after the genocide.

In the future, it may be helpful for research teams to seek out information regarding previous training received during an initial landscape analysis or baseline data collection or through networking with other agencies working in communities. This could help clarify in training how this information builds upon or complements what nonspecialists have learned before. In the case of Sugira Muryango, CBVs felt that the Sugira Muryango training complemented what they had previously learned in other psychosocial programs. The training went deeper into skills they already had and provided new skills without negating what they had learned previously. Ideally, all training that nonspecialists receive is complementary; however, it is possible that in the future, this may not be the case, and it may be necessary to rectify any information learned previously that is not evidence-based or consistent with the latest evidence.

In addition, CBVs in Ngoma and Rubavu districts mentioned challenges getting ahold of their supervisors on the phone or in person. In Rwanda, Ngoma is more remote and more di cult to traverse; however, some of these issues may be due to the supervisors themselves and their work-

However, greater technology support may be needed regarding the integration of tablets, which were used by CBVs to record data about the families.

Nonspecialists may be likely to perform better when they believe in the content of the intervention itself and its goals. Almost all CBVs delivering Sugira Muryango mentioned seeing personal

Conclusion

This study demonstrates that supervision and training enable nonspecialist providers, CBVs, to deliver an evidence-based intervention in Rwanda, Sugira Muryango, with both competence and fidelity. Improvements to training and supervision, including more in-person monitoring, greater and more timely compensation, and technological support may help nonspecialist providers feel more equipped when delivering evidence-based interventions.

Data Availability Data for this study is available upon request.

Declaration

Conflict of Interest The authors declare no competing interests.

References

1. Jack HE, Myers B, Regenauer KS, et al. Mutual capacity building to reduce the behavioral health treatment gap globally. *Administration and Policy in Mental Health and Mental Health Services Research*. 2020;47(4):497–500. Available at https://doi.org/10.1007/s10488-019-00999-y. Accessed 3 September, 2024.
2. World Health Organization, President's Emergency Plan for AIDS Relief, United Nations AIDS. *Task shifting: rational redistribu-*

14.

36. Betancourt TS, Jensen SKG, Barnhart DA, et al. Promoting parent-child relationships and preventing violence via home-visiting: a pre-post cluster-randomised trial among Rwandan families linked to social protection programmes. *BMC Public Health*. 2020;20(1):621. Available at https://doi.org/10.1186/s12889-020-08693-7. Accessed 3 September 2024.
37. Barnhart DA, Farrar J, Murray SM, et al. Lay-worker delivered home visiting promotes early childhood development and reduces violence in Rwanda: a randomized pilot. *Journal of Child and Family Studies*. 2020;29:1804–17. Available at https://doi.org/10.1136/bmjgh-2020-003508. Accessed 3 September 2024.
38. Jensen SK, Placencio-Castro M, Murray SM, et al. E ect of a home-visiting parenting program to promote early childhood development and prevent violence: a cluster-randomized trial in Rwanda. *BMJ Global Health*. 2021;6(1):e003508. Available at https://doi.org/10.1136/bmjgh-2020-003508. Accessed 3 September 2024.
39. Betancourt TS, Ng LC, Kirk CM, et al. Family-based promotion of mental health in children a ected by HIV: a pilot randomized controlled trial. *Journal of Child Psychology and Psychiatry*. 2017;58(8):922–930. Available at https://doi.org/10.1111/jcpp.12729. Accessed 3 September 2024.
40. Chaudhury S, Brown FL, Kirk CM, et al. Exploring the potential of a family-based prevention intervention to reduce alcohol use and violence within HIV-a ected families in Rwanda. *AIDS Care*. 2016;28 Suppl 2(sup2):118–129. Available at https://doi.org/10.1080/09540121.2016.1176686. Accessed 3 September 2024.
41. Anderson R. Thematic content analysis (TCA). Descriptive presentation of qualitative data. 2007;3:1–4. Available at http://rosemarieanderson.com/wp-content/uploads/2014/08/ThematicContentAnalysis.pdf. Accessed 3 September 2024.
42. Boyatzis RE. *Transforming qualitative information: Thematic analysis and code development.* Sage; 1998 Apr 16.
43. Bond L, Placencio-Castro M, Byansi W et al. Factors Associated with Nonspecialist Quality of Delivery within a Family Strengthening Intervention in Rwanda: A Parallel Latent Growth Model. *Manuscript under review.*
44. Atif N, Bibi A, Nisar A, et al. Delivering maternal mental health through peer volunteers: a 5-year report. *International Journal of Mental Health Systems*. 2019;13:62. Published 2019 Sep 17. Available at https://doi.org/10.1186/s13033-019-0318-3. Accessed 3 September 2024.
45. Pu er ES, Friis-Healy EA, Giusto A, et al. Development and implementation of a family therapy intervention in Kenya: A community-embedded lay provider model. *Global Social Welfare*. 2021;8:11–28. Available at https://doi.org/10.1007/s40609-019-00151-6. Accessed 3 September 2024.
46. Rahman A, Akhtar P, Hamdani SU, et al. Using technology to scale-up training and supervision of community health workers in the psychosocial management of perinatal depression: a non-inferiority, randomized controlled trial. *Global Mental Health (Cambridge)*. 2019;6:e8. Available at https://doi.org/10.1017/gmh.2019.7. Accessed 3 September 2024.
47. Freeman JA, Farrar JC, Placencio-Castro M, et al. Integrating the Youth Readiness Intervention and entrepreneurship in Sierra Leone: A hybrid type II cluster randomized trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2024;63(7):708–719. Available at https://doi.org/10.1016/j.jaac.2023.09.552. Accessed 3 September 2024.
48. Dorsey S, Pullmann MD, Kerns SEU, et al. The juggling act of supervision in community mental health: Implications for supporting evidence-based treatment. *Administration and Policy in Mental Health and Mental Health Services Research*. 2017;44(6):838–852. Available at https://doi.org/10.1007/s10488-017-0796-z. Accessed 3 September 2024.
49. Bond L, Simmons E, Sabbath EL. Measurement and assessment of fidelity and competence in nonspecialist-delivered, evidence-based behavioral and mental health interventions: A systematic review. *Social Science and Medicine- Population Health*. 2022;19:101249. Available at https://doi.org/10.1016/j.ssmph.2022.101249. Accessed 3 September 2024.
50. Desrosiers A, Freeman J, Mitra R, et al. Alternative delivery platforms for expanding evidence-based mental health interventions for yon in ci4Ss in nonsps(Sep)Tw/Span<ualText(b)3BDC( )TjEMC[sdy)713.9( )]TJ.005 Tc.. A32 inte[beha)32(vior)2.1(al and ment)-10(al healt)-v t al. Integra