Exploring Nonspecialist Preparedness to Deliver an Evidence-Based, Family Strengthening Intervention in Rwanda: A Qualitative Study

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Abstract

Families in low- and middle-income countries (LMICs) face significant mental health and psychosocial care gaps. In recent years, researchers and practitioners have addressed these gaps by task-sharing evidence-based mental health and psychosocial support (MHPSS) interventions to nonspecialist community providers. Supervision and training approaches are intended to prepare 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 intervention. This qualitative study uses data from a cluster-randomized trial of a family strengthening and violence prevention program in Rwanda, known as Sugira Muryango. In semi-structured interviews, the nonspecialists provided examples of using skills such as rapport-building, empathy, and active listening to deliver Sugira Muryango effectively. Because nonspecialists were serving in their own communities, they found that it was easier to earn trust with friends and neighbors, and this facilitated effective delivery of Sugira Muryango. Nonspecialists discussed how training,

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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 effectiveness. [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-effective 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 in the original protocol or as it was intended by the program developers," [21] and competence, which refers to cross-cutting skills such as active listening, managing problems, and tailoring intervention strategies to the specific context. [22–24]

In the field of global mental health, barriers to supervision and training of nonspecialist providers have included geographical and communication challenges that are common in low-resource settings. [19] Facilitators to supervision and training of nonspecialist include the availability of experts to provide mentorship and support, peer learning and group feedback sessions, role plays, and digital technology. [8,19, 25–28] In addition, recent studies have shown that training is most effective when content is included that is relevant to the broader MHPSS field beyond the specific intervention, when nonspecialist providers have previous experience delivering MHPSS interventions, feel they are compensated fairly, and are interested in the content of the intervention itself. [27–29]

However, the empirical research remains scant with much of the existing studies focusing on treatment outcomes rather than implementation outcomes. Insufficient research exists on training and supervision approaches for nonspecialist providers or on experiences that nonspecialist providers have with training and supervision. [4,28–32] Few studies have examined the relationship among supervision, training, and quality of delivery while conceptually distinguishing between fidelity and competence. In addition, few studies have discussed experiences of training and supervision from the perspectives of nonspecialist providers. Further research is needed to illuminate the relationship among supervision, training, and quality of delivery and to propose recommendations for supporting nonspecialists to deliver evidence-based interventions with fidelity and competence that are effective across contexts.

The Barriers and Facilitators in Implementation of Task-Sharing in Mental Health Interventions (BeFITS-MH) Framework suggests that macro-, meso-, and micro-level factors serve as barriers and facilitators to implementation outcomes. [33] While fidelity and competence are also not explicitly mentioned in this framework, the BeFITS-MH Framework more clearly lays out the relationship between intervention components and implementation outcomes. Micro-level barriers and facilitators include provider fit (being able to provide service and helping participants receive services), provider competence (understanding client needs, sympathizing, communicating well, and tailoring services to clients' unique needs), and provider congruence (being from the same community, demographic factors such as age, gender, social status). However, the BeFITS-MH Framework does not discuss training or supervision and their role in preparing nonspecialists. Therefore, while this study is informed by the BeFITS-MH Framework, findings from this study and others can expand upon existing implementation frameworks and further our understanding of the quality of delivery, a key component to ensuring that implementations are effective.

Study objective

This study builds upon emerging research in the field of global mental health to identify how, if at all, Community-Based Volunteers' (CBVs) supervision and training experiences equipped CBVs to deliver Sugira Muryango with quality, including both fidelity and competence. This study will use qualitative data from key informant interviews to illuminate barriers and facilitators to supervision and training and describe how such factors have impacted the overall quality of delivery. This study will also describe how, if at all, CBV preparedness to deliver Sugira Muryango is a result of training and supervision experiences during intervention delivery. Finally, this study will examine what, if any, differences across CBV gender and/or district exist regarding supervision and training experiences or CBV quality of delivery.

Study context: Sugira Muryango cluster-randomized trial

Sugira Muryango is an evidence-based early childhood development and family-strengthening intervention with mental health outcomes. Although the government of Rwanda has invested heavily in rehabilitating a post-genocide society, many families still face mental health challenges and cannot access specialized care. [34,35] Sugira Muryango was first implemented as a four-arm, cluster randomized controlled trial (CRT) that tested the intervention on Ubedehe 1 families in Rwanda (the Rwandan government's highest poverty categorization). The purpose of the CRT was to assess the effectiveness of Sugira Muryango in promoting responsive caregiving, reducing violence and harsh punishment, and promoting early child development in families living in poverty. Compared to the control group, caregivers receiving the Sugira Muryango intervention have had greater decreases in depression and anxiety and improvements in emotion regulation. [36,37] More details of the design of Sugira Muryango are reported elsewhere. [36–38]

Community-Based Volunteers (CBVs) delivering Sugira Muryango were selected for the purpose of the study using the following eligibility criteria: (1) Rwandan nationals, (2) over 18 years of age, (3) sufficient time to deliver Sugira Muryango, and (4) recommendation from a local authority such as a village chief. A total of 118 CBVs participated in intervention delivery. Prior to intervention delivery, CBVs attended a 3-week training on Sugira Muryango. CBVs were responsible for facilitating the Sugira Muryango intervention to families in their local district, which entailed 12 90-min sessions. During intervention delivery, CBVs were assigned a designated supervisor with a bachelor's degree in clinical psychology or social work. Most supervisors were affiliates of the local implementing partner, FXB Rwanda, and had helped develop training and monitoring tools. In addition, many supervisors had previous intervention experience delivering Sugira Muryango in its earlier iteration as a family-strengthening intervention for HIV-affected families. [39,40] Sugira

Muryango was implemented in three districts (Ngoma, Nyanza, and Rubavu), which were selected based on existing programming areas of FXB Rwanda.

Supervision entailed two in-person monitoring sessions (ideally during the third and sixth week) and monthly group supervision sessions with all CBVs in a geographic cell whereby common implementation challenges were discussed and problem-solved. There were six total supervisors, half male and half female, with one supervisor taking on a larger workload and supervising CBVs across two districts. On average, each supervisor had 24 CBVs. CBVs received a monthly stipend to cover airtime to call supervisors, transportation to and from participant homes and supervision sessions, and compensation for 3 h of work per day. This stipend was funded by the study and intended to make implementation more feasible. [37]

Supervisors assessed CBV quality of delivery during in-person monitoring sessions, which included both competence and fidelity. In both smaller groups and individually, supervisors worked with CBVs throughout the process of implementation to improve both their adherence to the Sugira Muryango manual and problem-solving (fidelity) and their ability to relate with families through active listening, showing empathy, and clear communication (competence).

Methods

Data collection and sampling

In 2019, the study team conducted 69 qualitative key informant interviews to identify core competencies of CBVs, effective training and supervision strategies, and mentorship that enables CBVs to function optimally within health, education, and other delivery systems. The study team used a semi-structured interview guide, which included questions such as *tell me about your experience with Sugira Muryango training/supervision*; *in what ways, if at all, did you feel prepared when you began?* and *what could we do to improve training/supervision?* The intention was to collect data from CBVs that could answer several implementation-related research questions.

CBVs were selected for key informant interviews using a sampling matrix to ensure representation across three districts of implementation, to ensure variability in data, and to capture the experiences of both male and female CBVs. Table 1 portrays the matrix based on gender and district. While the study team originally aimed for at least 10 CBVs of each gender per district (60 total), budget and time allowed for several back-up candidates to be interviewed as well, which resulted in a total of 69 interviews. The study team aimed for at least ten male CBVs and ten female CBVs to be interviewed in each district, but not all male CBVs could be recontacted in Ngoma and Nyanza, and therefore, female CBVs were selected as back-ups. Thus, more male CBVs were interviewed in the Rubavu district while more female CBVs were interviewed in the Ngoma and Nyanza districts due to CBV availability and schedule. However, the sampling matrix still allowed for variation and representation across both gender and district strata. CBVs within each stratum of the sampling matrix were randomly selected by study ID number and contacted for recruitment into the study.

The study team conducting the interviews consisted of a research scientist, with mixed methods training in child neurodevelopment and employed through Boston College, and five staff members of a partner agency, FXB Rwanda. These included two males and three females. One FXB staff member was a temporary hire, and the rest were longer-term staff members in programmatic or research positions, such as Program Coordinator. Staff members had been trained on best practices for data collection during the pilot phase of Sugira Muryango. Interviews took place in a location selected by the participant, typically in or around their home, and lasted around 30 min. All interviews were recorded and transcribed from Kinyarwanda into English by bilingual members of the study team prior to analysis. All data collection procedures were approved by the Boston College Institutional Review Board and the Rwanda National Ethics Committee.

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 and inductive approaches. Codebook development was guided by the Boyatzis approach, which includes a three-level codebook with code definitions, inclusion and exclusion criteria, and examples of the code being used in the data. [42] Examples of deductively generated codes include implementation outcomes, such as fidelity and competence. [21–24] Specifically, components of fidelity and competence that were operationalized by the study team, according to the quality of delivery checklist, were included as sub-codes. Additional codes, including tools, resources, and CBV pre-existing relationship with the community, were generated inductively via an in vivo coding process during transcript review. These codes capture themes of other factors influencing CBV preparedness and influencing the relationship between training and supervision and fidelity and competence.

Interviews were transcribed and translated by local research assistants in Rwanda and transferred to the research team at Boston College via a secure platform. To begin thematic content analysis, two coders used MAXQDA software for in vivo coding, in which coders took notes on emerging themes, patterns, and questions that they had based on data from the transcripts to eventually inform a draft codebook. The two coders included a doctoral candidate at Boston College with experience working on the research team implementing Sugira Muryango and a staff member of the University of Rwanda research team, an implementation partner, based in Kigali, Rwanda. An iterative process was then used to develop an initial codebook that captures themes emerging in the transcripts from in vivo coding. Aligned with the Boyatzis approach, the codebook included three levels of codes: a definition for each code and inclusion and exclusion criteria for each code using examples from the data. [42] The codebook was tested and re-tested on subsets of transcripts, and edits were made until both coders found that the codebook was accurately capturing all themes emerging in the data relevant to the research question. The codebook was referred to throughout the coding process to ensure that both coders applied codes correctly. While the bilingual study team ensured that colloquial terms and meanings in Kinyarwanda were as accurately represented in the English translation as possible, both coders followed up with a bilingual study team member in cases of any confusion regarding data translation.

After the codebook was developed and finalized by both coders, an inter-coder agreement analysis was run using MAXQDA software. Coders achieved 80% agreement at a threshold of 20% minimum overlapping and 69% agreement at a threshold of 60% overlapping. After establishing an inter-coder agreement, both coders divided the remaining transcripts and coded them according to the codebook developed. The coders met weekly to discuss emerging themes, reflect on the data, and troubleshoot any confusing sections of the transcripts in order to maintain inter-coder agreement. After transcript coding was completed, themes and relationships among themes were identified through an axial coding process. The axial coding process included efforts to identify differences in thematic patterns across gender and district groups.

Results

CBVs participating in the study described how training and supervision experiences helped them feel prepared to deliver Sugira Muryango and provided examples of how competence enabled them to deliver Sugira Muryango effectively. In addition, CBVs described tools and resources that supported their ability to deliver Sugira Muryango, and how their personal experiences with the intervention content and relationship with their communities resulted in preparedness.

Training and supervision experiences

Almost all male and female CBVs across the three districts stated that training and supervision helped them feel prepared to deliver Sugira Muryango. CBVs who did not feel prepared after the training often mentioned feeling nervous at first, but, after delivering their first session or feeling support from their supervisor, they felt more confident. One CBV described their experience during the initial Sugira Muryango training: "I was trained enough…before, I was shy, but now I am no longer shy and I can facilitate a discussion, even in public" (Female CBV in Nyanza).

CBVs recalled the general content of the training well. Most provided generic responses and remembered that it was about child development or how families should relate to each other. However, others described what they learned in more detail: "In the trainings, we developed our knowledge and ability. We learned the advantages of early stimulation, and we learned how to handle different issues without causing any trouble. The trainings were absolutely helpful" (Male CBV in Rubavu).

CBVs frequently mentioned refresher training, stating that these were helpful for reinforcing knowledge as they delivered Sugira Muryango over the course of several months. When asked what could be done to improve training, most feedback included continuing the refresher training or adding more. One CBV in Rubavu mentioned how the Sugira Muryango training built on her previous experience: "I already had an experience in working with children with HIV and working as a volunteer, so Sugira Muryango trainings I received helped me become more knowledgeable and confident" (Female CBV in Rubavu). Many CBVs in Nyanza referenced past training about HIV or community reconciliation that they received, describing how Sugira Muryango was more relevant to them: "With Sugira Muryango, the training was much more deep. I never knew how to take care of our children before, but I learned that, and it added on to what I already knew" (Male CBV in Nyanza).

Outside of training, regular supervision was intended to support CBVs on a weekly basis and help them adhere to the skills that were taught during training. Several CBVs described they were nervous to begin conducting sessions at first, but supervision reassured them. Most CBVs felt supported by their supervisors and described how supervision helped them feel more prepared throughout intervention delivery, which resulted in greater quality of delivery. One CBV described how she appreciated the way the supervisor corrected her and provided advice:

> My supervisor used to support me wherever needed. When I asked him to come to the field for visiting the families, he always did. Another thing that I appreciate from him was that if something was wrong with my work, he never corrected me in front of the family, he did it privately. This was really good, because families could lose trust in me if it was done publicly. My supervisor even called me to remind me of our appointments with the families, even when he couldn't come. When our stipends were delayed, he told us to be patient. He was always there for us (Female CBV in Nyanza).

Other CBVs described how the supervisor provided helpful explanations on elements of the Sugira Muryango intervention, which would result in greater fidelity. For example:

> During the intervention, the supervisor took me to each of the families to introduce me to them. He followed up on our activities and he had a fixed time to give me a call. Whenever I had a challenge, he advised me. He took enough time and explained the aspects of nutrition, well-being, health insurance, and children's immunizations. In any case of confusion, he always directed me (Female CBV in Rubavu).

Another CBV echoed these sentiments and described how the supervisor helped her conduct a referral:

> (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:

> They trained us to humble yourself when you are sitting in (the families') homes…I first went and discussed with them slowly and humbly, and I showed them that I have nothing, and they started to see me as one among them. They started to converse with me, and they feel free with me. I didn't have to tell them (the Sugira Muryango content) by force, but with discussions…the community leaders used to catch them with not enough hygiene, but because we

> 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 different 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:

> I have learned to talk with people in a calm way, no matter the situation. You may go visit the family and once you are there you see that the person that you had an appointment with is already drunk, or, at the end of the session you realize the family didn't understand anything from what you were coaching them. There is a phrase, 'gusubiza neza bihosha uburukari', which means a calm response reduces anger. Sugira Muryango training has provided me with some techniques like active listening, showing empathy, and putting yourself in someone else's shoes. This gives us more skills for helping others (Female CBV in Nyanza).

Tools and resources

CBVs described other tools and resources that affected their ability to deliver Sugira Muryango with quality, aside from supervision and training. Some of the tools and resources were included in training and supervision, such as the Sugira Muryango manual, while others were provided to CBVs upon hire (stipends for airtime, travel, and time spent delivering Sugira Muryango).

The majority of CBVs referenced the Sugira Muryango manual as a key resource that helped them facilitate Sugira Muryango with quality and stay true to how they were taught in training.

Nearly all CBVs requested greater compensation, specifically a travel stipend and airtime. One CBV described how a lack of airtime affected his ability to communicate with his supervisor:

> We received airtime once a month, which is not enough. We always face a challenge of airtime scarcity. Sometimes, we wouldn't have enough airtime to call our supervisors when it was urgent (Male CBV in Ngoma).

The majority of CBVs frequently complained about their stipends arriving late and described how this affected their ability to deliver Sugira Muryango. When asked for what they needed in order to feel more prepared, nearly all CBVs asked for greater compensation or more timely compensation, for example, "we needed airtime, but they didn't get it to us on time" (Male CBV in Rubavu).

Two CBVs stated that a bicycle would be helpful for traveling between family homes. For example, one CBV mentioned that "There was a program called (name of program), and their volunteers had bicycles that they were given. It could be good if we were also provided bicycles for transport. There are places that are hard to reach" (Male CBV in Nyanza). Another described how far distances required him to use a motorbike, but this strained him financially: "One family is located 6 km from here…this was hard for me because I had to take a bike…I had to pay 2000 RWF round trip, and my salary would not cover that" (Male CBV in Ngoma).

The audio recorders used for recording each of the Sugira Muryango sessions at home were mentioned as both facilitators of quality of delivery by nearly half of the CBVs. CBVs discussed the benefits of describing how they "used recorders in order for the supervisors to hear how we provided the sessions, and in case of any mistakes, they corrected us" (Female CBV in Ngoma), and for self-correction because "you could see where you were not good, and you could correct yourself" (Male CBV in Rubavu). However, some CBVs requested more support and training for the integration of the tablets, which were used to collect participant data in the homes. For example:

> We left the training without being familiar with the tablets. It was difficult for us to synchronize data. The supervisor used to come late, and we didn't have enough time to do proper follow up…we continued conducting the sessions with tablet difficulties. We realized we needed like two days of training to get familiar with the use of the tablets (Female CBV in Nyanza).

Spillover and interpersonal effects

Without being prompted, nearly two-thirds of interviewed CBVs provided examples of how Sugira Muryango changed their personal lives and helped them relate better in their own households. The personal benefits of the Sugira Muryango content created greater buy-in to the merit of the intervention, which helped CBVs feel more enthusiastic about delivering it well and gave them confidence that they were setting a good example to the families they worked with. One CBV described this in his own life:

> There are things that I realized I had to apply in my own household. We taught them, but we taught ourselves as well… you cannot quarrel with your wife at home and then go in another household and teach them about good relationships. They could know about it. (Being a coach) required us to be blameless in our village (Male CBV in Ngoma).

Two CBVs mentioned how participating in Sugira Muryango helped them heal from the genocide and build back relationships with neighbors. One remarked:

> I was punishing children with anger. I have learned how to be humble, leaving behind the genocide ideology. Among the families I was in charge of, some participated in the killing of my family members during the 1994 genocide. Their wives took away everything from our house as well. With Sugira Muryango, I tried to relate to them in order to coach them. Everyone who was seeing me heading to their households noticed a change within myself. I learned a lot from Sugira Muryango (Female CBV in Ngoma).

Gender and district differences

There were no differences noted in the way that male and female CBVs described supervision and training experiences, fidelity and competence, tools and resources, or spillover and interpersonal effects. We noted the same themes arising within each of those topics across both male and female CBVs. In general, CBVs across the three implementation districts also discussed themes and experiences similarly. There were two noted differences in themes across the district: (1) CBVs in both Ngoma and Rubavu mentioned issues getting ahold of supervisors and this is not a theme that arose in Nyana, and (2) a majority of CBVs in Nyanza referenced past training in other social interventions, such as reconciliation or HIV-related interventions, and described how these experiences enabled them to be more prepared while delivering Sugira Muryango. This theme did not arise in data coming from other districts.

Implications for behavioral health

These findings provide important implications for moving towards developing a best practice for training and supervising nonspecialists to deliver evidence-based MHPSS and family-strengthening interventions with quality. The purpose of this study was to examine how, if at all, CBV preparedness to deliver Sugira Muryango was a result of training and supervision experiences. This study's unique contribution is that it is from the perspective of CBVs and defines preparedness as both fidelity and competence.

Overall, the majority of CBVs self-reported their ability to deliver Sugira Muryango with both fidelity and competence and pointed towards the supervision and training that they received as reasons for their success. Specific elements of training that were helpful were the provision of the manual and the refresher training received. Regarding supervision, factors that made

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, differences across CBV gender and/or district existed regarding supervision and training experiences or CBV quality of delivery. Data did not reveal any significant gender differences 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 differences 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 difficult to traverse; however, some of these issues may be due to the supervisors themselves and their workstyle during the interventions. Most CBVs within a district had the same supervisor. In-person training was largely considered to be preferable and tied to competence and fidelity. However, this may be difficult to achieve in low-resource settings. Though some MHPSS interventions in low-resource settings have utilized in-person supervision methods. [19,44] many opt for remote supervision or a hybrid approach. [44–47] CBVs also frequently cited a lack of airtime and delayed transport stipends as factors that influenced the quality of their work. While compensation is not directly connected to training and supervision, it may influence the effectiveness of training and supervision. [27] In situations where remote supervision is required, it may be helpful to provide these resources adequately so that calls can be made regularly to supervisors and to ensure that the ratio of supervisors to nonspecialists remains small. For example, in a later iteration of Sugira Muryango, about three nonspecialists were assigned to one supervisor. In addition, supervision was done weekly instead of monthly. One study testing supervision modalities suggests that a smaller caseload may improve supervision functionality. [48]

Many interventions delivered by nonspecialists use audio or video recorders to monitor quality. [49] In Sugira Muryango, CBVs referenced the recorders as helpful tools that allowed supervisors to self-monitor. In addition, the Sugira Muryango manual, which was discussed in-depth during the initial 2-week training, was the most useful tool for helping CBVs stay prepared.

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 benefits in their own families because of what they were learning in the manual. While this is not a topic that, to our knowledge, has been explicitly explored in literature, a recent study provides examples of nonspecialists using skills in their own lives from the intervention that they were delivering. [50] Future research can explore the connection between nonspecialists' personal satisfaction with the intervention and fidelity and competence.

A plethora of reasons exist for using nonspecialists to deliver evidence-based MHPSS interventions, including cost-effectiveness and clinical effectiveness. [4,9–14] access to communities, [11] and capacity-building and power-shifting. [251, 52] CBVs across all districts of Sugira Muryango provided examples of being seen as leaders in the community because of their position delivering the intervention. In addition, CBVs spoke to community access—suggesting that trust and rapport were easier to build when they had pre-existing relationships with their neighbors to whom they were delivering the intervention. This aligns with the BeFITS-MH Framework, [33] which suggests that provider characteristics, such as a role in the community, facilitates implementation. As the CBV stepped into a greater community leadership role while facilitating Sugira Muryango, their shared characteristics with the community allowed them to lead more effectively.

Task-sharing with nonspecialist providers can catapult CBVs into leadership positions in communities, which can result in capacity building and shifting power and knowledge to local communities. MHPSS interventions that deeply involve local leaders can be helpful in cementing the relationship between nonspecialists and leaders and providing future opportunities for nonspecialists. For example, if community leaders are also involved in or aware of the intervention, they may be more likely to provide future opportunities for nonspecialists to continue sharing the skills learned in the intervention. This could also lead to greater sustainability of evidence-based interventions. [53]

As interventions begin to scale and plan for sustainment, future studies may need to consider the amount or modality of supervision and training, and how or if this needs to be planned for or measured differently as providers gain experience or are expected to work more independently. Digital technologies such as Ensuring Quality in Psychological Support (EQUIP) [54] and EMPOWER [55] serve as leading tools enabling monitoring and ensuring quality at scale, but there is a dearth of guidance regarding supervision and training best practices during scale-up phases. Findings from this study may inform and expand frameworks such as BeFITS-MH, which currently portrays nonmodifiable micro-level factors that influence implementation, such as provider characteristics. However, findings from this study suggest that modifiable factors, such as training and supervision, play a significant role in influencing the quality of mental health implementation.

Limitations

This study has limitations. First, the key informant interview guides were designed for various purposes and intended to answer many possible research questions in 2019. While the guides do include many questions on training and supervision experiences, for this study, it would have been beneficial to have included probes explicitly about CBV preparedness with both fidelity and competence, separately. Secondly, as Rwandan culture is incredibly hierarchical, the practice of constructive feedback or sharing negative experiences with authority figures is discouraged. This may affect the reliability of the data and lead to social desirability bias, particularly when the study team conducting the interviews is associated with implementation.

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.

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