In the current study, qualitative interviews were conducted with perspectives in LMICs. There is a need for qualitative research to explore lay perspectives from other LMICs are needed; limited to western Kenya, other EBTs; had a small sample size, larger sample of lay counselors are needed. There is a lack of evidence-based treatment (EBT) for mental health in LMICs due in part to lack of trained mental health professionals. EBTs can be effectively delivered using a method of task sharing, an approach where non-specialist workers are trained to provide care under the supervision of a specialist. There is a need for qualitative research to explore lay-counselor perspectives in LMICs. In the current study, qualitative interviews were conducted with the lay-counselors to determine facilitators and barriers to the implementation of Trauma-focused Cognitive Behavioral Therapy (TF-CBT) in Kenya. The codebook was created iteratively by a coding team consisting of one PI and qualitative meta-synthesis. There are several challenges to the implementation of CBT in LMICs that can be addressed by task sharing.

Methods

- Group-based (TF-CBT) was implemented in 10 schools and 10 communities in Kenya.
- Existing staff in each sector (teachers and community health volunteers [CHVs]) served as lay-counselors to deliver TF-CBT.
- Primary supervision was provided by a local team of TF-CBT experts promoted from the counselor role after years of experience.
- Secondary supervision was provided weekly by a PI who is a certified TF-CBT expert.
- After delivery of treatment, qualitative interviews were conducted with the lay-counselors from 6 of 10 sites to identify effective IPPs, such as those within resource provision.
- Interviews (N = 32) were conducted in both English and Swahili and were audio recorded.
- Notes were taken and reconciled with the audiotape in a method similar to RA (rapid analysis).
- The codebook was created iteratively by a coding team consisting of one PI.
- The codebook was thematic and was designed to capture IPPs.
- Interviews were double-coded and reconciled when discrepant.
- Interviews conducted in Swahili were coded by a member of the coding team fluent in both languages, then verbally translated and reconciled with a PI.

Results

- **Resource Provision: Barrier**
  - CHVs reported that using their own money for TF-CBT was more of a barrier compared to teachers (Figure 1).
  - Teachers reported that materials provided was more of a facilitator compared to CHVs (Figure 2).

- **Resource Provision: Facilitator**
  - Teachers reported that airtime provided was more of a facilitator compared to CHVs (Figure 3).

Discussion

- CHV’s report of using their own money for TF-CBT may be due to their greater integration into the community.
- Delivering TF-CBT is their primary focus; teachers have other responsibilities outside delivery of TF-CBT.
- Teacher’s report of airtime and materials provided may be due to a greater appreciation of provided materials, given that the teachers have classrooms of their own.
- These findings suggest that IPPs for the implementation of TF-CBT differ in resource allocation based on which sector is delivering the EBT.
- This has implications for future tailored implementation support for those sectors and settings for certain IPPs, including resource provision.
- By pinpointing which IPPs are critical for the implementation of TF-CBT, this can allow for a better understanding of task-sharing interventions for scale-up in LMICs.
- Task-sharing in mental health care can help to bridge the mental health gap in these LMICs.
- **Limitations**: Limited to exploring TF-CBT and did not consider other EBTs; had a small sample size, larger sample of lay-counselor perspectives are needed; limited to western Kenya, perspectives from other LMICs are needed.
- **Future directions**: Utilize said implementation strategies to establish sustainable methods to bridge the mental health treatment gap in LMICs.

References