Author's response to reviews

Title: Lessons learned from stakeholders in a facilitation intervention targeting neonatal health in Quang Ninh province, Vietnam

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Author's response to reviews: see over
Dear Ms Janelyn Ann Cruz

Thank you for the careful work on our paper. We are pleased to have the opportunity to resubmit a revised version of our manuscript. The comments from both reviewers have been most helpful and we believe the manuscript has improved substantially after revision. Below you find the reviewers’ comments followed by our responses. All authors have reviewed and approved the new version of the manuscript.

Sincerely
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Comments to remarks from reviewers

Reviewer 1: Lisa Howard-Grabman

In your article, you have done a very good job of describing the roles of facilitator and group members and the dynamics around participation and facilitation of the group, but you don't provide much information on the actual processes and content of the meetings and how group members moved from knowledge to promoting and fostering action, which is one of the main challenges around which the article is framed. It may help readers to have a better understanding of what may have led to the changes in mortality to provide some more examples of what the group did that produced the positive results, beyond spreading messages. Did they develop plans? Did they act in some way to strengthen service providers' skills/quality of care? Did they help communes address social, economic, geographic barriers to accessing care, and if so, how? To what extent did the groups monitor their progress during their meetings?

Thank you for your positive feedback. As suggested, we have added more information regarding identified problems and action taken in the MNHGs in the Background section. We suggest this information, in combination with an extended description of the intervention in the Method's section, provides a more complete picture of the process. However, with a complex intervention and an extensive intervention process, including all details is difficult. Rather, we have written two papers on the intervention process of the NeoKIP intervention; the current qualitative paper and an additional, quantitative paper reporting in detail on the recruitment procedures of facilitators and MNHGs, attendance, number of meetings performed, in-between meeting activities, problems and actions taken, etc (Eriksson et al, manuscript in progress). In a paper by Persson et al. in PLOS Med (2013) we report on the main outcome of the NeoKIP trial (see reference 20 in the current manuscript). In the Persson et al paper there is more details regarding the activities in the groups, suggesting that we may not need to repeat them in the current paper.

To monitor the activities, the groups and the facilitators continually completed a structured diary constructed by us in the NeoKIP research team. The diary template was developed over the intervention process by the facilitators and their supervisors. In the diary, each facilitator could summarise the meeting in her own words and in a structured sections enter data on meeting time, attendance, what problems and actions the MNHGs identified and prioritised, etc. This was shared with the research team, and included in the paper described above (Eriksson et al, manuscript in progress). In the current paper a description regarding the diary has now been added in the Method's section (page 7).

One of the most frequent criticisms I have seen of the trials that have used participatory approaches that are more qualitatively presented, particularly from those who come from a biomedical model perspective, is that it isn't clear enough how these processes can lead to changes in mortality. Appreciating that space is limited and that it is helpful to stay as focused as possible, I think that it would strengthen the article if there is a little bit more discussion to help the reader understand the possible
causal links between this intervention and the outcome, recognizing that they may not always be linear nor direct.

We appreciate the opportunity to strengthen the link between the intervention and the outcomes. We have now added more information regarding the main results of the NeoKIP study and on the two year latent period before we could identify any differences in neonatal mortality (Background section, page 5). By doing so, we propose that this type of intervention has a non-linear function. This also provides additional justification to the aim of the paper. We believe that the three findings we chose to discuss in this paper (i.e., money, the facilitator role, and viewing the MNHG as a coalition) are important areas contributing to explain the complexity of the intervention process, relating to both the NeoKIP project and other similar projects. We suggest the understanding of why there was a latent period of two years before the intervention impacted on neonatal mortality is crucial to this paper and the understanding of health care improvement projects in general. By this revision, we had the opportunity to be more explicit about this finding also in the Conclusion section.
Reviewer 2: Cindy Liu

The aim of this study was to describe mechanisms of the intervention based on experiences of facilitators and intervention group members through NeoKIP, a project focusing on facilitation towards translating knowledge on neonatal survival. The efforts of NeoKIP to identify ways to decrease neonatal mortality in Vietnam should be applauded. The strength of the study was the qualitative method, a useful approach in providing detailed descriptions regarding the role of contributors across organizational sites. It is clear that the manuscript has the intention to critically evaluate the mechanisms of the intervention, and to determine the suitability of the NeoKIP model.

Despite these strengths, the manuscript has limitations that dampen enthusiasm for the study. I believe that these limitations can be overcome with major revisions that provide greater description of the NeoKIP model in the introduction and methods and greater rigor in identifying the mechanisms that link the role of the facilitator to decreased neonatal mortality.

MINOR
(1) It appears that the quotation in the background is missing a crucial word/phrase, is the word knowledge not spelled out here? What is the important challenge for public health?

We suggest the term “know-do gap” is commonly used in research on health care improvement and evidence based practice. For example, the World Health Organization commonly uses this term when talking about the importance of knowledge translation, and when describing the existing problem with a gap between existing knowledge (know) and the lack of using that knowledge in practice (do). Thus, we prefer to keep the quote with the surrounding text explaining the quote, believing this is acceptable given the above explanation.

One of the most important challenges in public health is to translate knowledge that we know is proven and relevant (evidence-based knowledge) into practice. Within newborn care, there are several interventions known to be effective. For example, exclusive breastfeeding in the first 6 month of the newborn’s life is very important for increasing survival. Despite very established evidence on this, in many places around the world exclusive breastfeeding for this period of life is not happening, nor is it encouraged to the extent it should be. Just to bridge this particular gap would save many lives globally, and a better understanding of what support bridging the know-do gap in general is much needed (See Reference 7: Grol R, Grimshaw J, Lancet, 2003)

(2) Communes should also be defined. Is this a group of people? A site? (page 4)

A definition of a Vietnamese commune is added (page 6, Method’s section).

(3) Multi-stakeholder could be anyone in the community. Please specify exactly the stakeholders here in this study. (page 4)
Details on the stakeholders are added (page 5, Background section). A more detailed description of the people in the MNHGs is also available (page 6, Method’s section).

(4) What is a population motivator? (page 5)

We have added information outlining what a population motivator does (page 6, Method’s section).

(5) The first sentence in the design section is a bit run on. (page 6)

We have revised and shortened this sentence (page 7).

(6) I believe the role of the chair was first mentioned in the results section. This should be articulated in the description of the organization.

Thank you for pointing this out. We have now added a sentence describing the role of the chair in the Method’s section (page 6).

MAJOR

(7) Greater specificity is required in the background regarding all constructs and terminology. For instance, what is knowledge translation exactly? Who is being targeted in terms of knowledge acquisition? Is it between providers and patients? Is it with facilitators and providers? I did not quite understand who and what was being translated until later in the manuscript. This needs to be upfront.

We have added a definition of knowledge translation on the top of page 4. Moreover, to further clarify we have expanded the description of the intervention, both in the Background section (page 5) and in the Method’s section (page 6 and 7).

The type of intervention that we performed implied that in each commune, a facilitator was supporting a group of stakeholders involved with newborn health to find and target the local problems. Once the local problems were identified by the MNHGs, it was the responsibility of the group members to take action. For example, if a group identified a need to increase attendance at antenatal care among pregnant women, the groups also identified an action such as the need to interact with the women in the commune in some way. But, if a group chose to increase number of post natal home visits it was more suggested a matter of interacting with the health care providers. Thus, the problems and/or actions could have different targets. The intention of the intervention is described in more detail in the study protocol (Wallin et al BMC Health Service Research (2011), which we also refer to on page 5.

(8) What is facilitation? This should be defined and more specific examples (e.g. actual cases/programs where it has been used well) should be provided.

On page 4 in the Background, we have now added more information about facilitation as a method, and expanded on an example where it has been used and found to serve well.
The actual role of the facilitator should also be described clearly in the introduction. At times it sounded like they were a liaison to the community. I did not understand the role of the facilitator until later in the manuscript.

We have added some information about the role of the facilitator in the Background (page 5) and expanded the description of the facilitator role in the Method’s section (page 6 and 7).

Overall, the background should contain more information about the development of NeoKIP. Is the NeoKIP model focused solely on the role of facilitation or does it contain other features to help with knowledge translation? How did the facilitator role come about in the development of this intervention.

We appreciate your interest for the NeoKIP project. However, with the space limitation in one paper it is difficult to include all this information. Rather, we have tried to balance the revision necessary by adding more information about facilitation as a promising method in the Background, and by expanding on the description of the intervention (Background section page 5 and Method’s section page 6 and 7). We are also referring to the study protocol (Wallin et al 2011) and the report of the main outcome of the trial (Persson et al 2013). In addition to the current paper, we are planning a separate paper reporting on the details of the intervention process (Eriksson et al, manuscript in progress). The additional paper will contain detailed information about recruitment procedures of facilitators and MNHGs, attendance, number of meetings performed, in-between meeting activities, problems and actions taken, etc. With the extensive data from process and outcomes, it is not feasible to fit all the details in one paper.

The ideas of the NeoKIP project were influenced by earlier studies made in South Asia, for example the Nepal study now mentioned in the Background section (page 4). However, rather than targeting women we tried out an intervention targeting people working with newborn health, expecting a more sustainable intervention with the possibility to be scaled up. To decide who were to be facilitators and how to recruit these people was a delicate decision, requiring time and consideration (e.g., feasibility, costs, possibility to scale-up the intervention if successful, etc). Also, before we decided on recruiting facilitators from the Women’s Union, we conducted a pilot where we trained two representatives from the Women’s Union who interacted with MNHGs. The results from the pilot study demonstrated that it was possible to implement the NeoKIP trial. These kinds of process details will be reported in the other process paper mentioned (Eriksson et al, manuscript in progress).

More information on neonatal mortality in Vietnam would be valuable especially since this is the outcome for the evaluation.

We have added a paragraph about neonatal mortality in Vietnam and in particular the situation in Quang Ninh province (page 8, Method’s section).
(12) I’m curious as to why an emergent design was used? Had there been previous studies conducted that lead you to using an emergent design? (I see that there was an Implementation Science paper from 2011). As well, given the previous qualitative data on NeoKIP and neonatal mortality (Acta Paediatrica, 2012), I wonder why an explanatory design was not used instead to understand how exactly facilitation would decrease neonatal mortality.

As far as we understand, the purpose of an explanatory design is to use qualitative methods to explain quantitative results. It could be a relevant term for this study. However, based on Creswell & Plano Clark (2011) we suggest it would be more accurate to use the term ‘emergent design’ as our quantitative and qualitative data collection was parallel. Moreover, not all the data collection was fixed beforehand in the NeoKIP project, we have gradually found additional needs to better understand the process and the emerging outcomes. For example, as we realised that repeated follow ups with MNHGs and the facilitators would help us get a better picture of the intervention process, we added more focus groups to the data collection. In the first paragraph (Design and study setting section, page 7) we have added the reference Creswell & Plano Clark (2011) and removed Polit, Beck (2004).

(12) I was also confused about the extent to the features of NeoKIP, either the facilitators or the MNHG were hypothesized as mechanisms leading to the translation of knowledge. The paper focuses on the perceptions of facilitators either from themselves or from the MNHG. Yet, the proposed aim was to evaluate their role in decrease mortality. Is facilitation, the coordination of MNHG members, whether fostering better relationships and greater organization, supposed to contribute to this decrease? The rationale for facilitation on infant outcomes then should be prominently described in the introduction.

The aim of the study was to describe mechanisms of facilitation based on experiences of the facilitators and intervention group members. This was planned to be done regardless of the findings concerning mortality, i.e. reduction or not). The NeoKIP intervention is the combined work of facilitators and MNHGs, which we think is now clearly described in the manuscript.

In order to better clarify the aim, we have added a definition of the concept of facilitation on page 4 (Facilitation has been described as a technique where one person (the facilitator) targets individuals or groups to make things easier by helping them to change their attitudes, habits, skills and ways of working). Facilitation implies that a facilitator and a group of people (the MNHGs in the case of the NeoKIP-project) collaborate to achieve improvements. Therefore, to understand how this collaboration between a group and a facilitator functions, we chose to conduct group discussions with MNHGs and facilitators separately, exploring the mechanisms of facilitation.

Facilitation is not a method that solely focuses on infant outcomes; it is a knowledge translation approach that could be used to influence any kind of care process and outcomes. In the NeoKIP project, we applied facilitation as an intervention as it has been described as a promising method to bridge the know-do gap and not previously used in a Vietnamese context. Within newborn
care there is already good evidence regarding what needs to be done to lower mortality. Therefore, the problem is rather to know how to implement the evidence based interventions in an effective way. To better clarify, we have added a description of a successful project in Nepal using facilitation as a method to improve neonatal health and survival (Background, page 4).

(13) Related, actual outcomes – rates of neonatal mortality and related measures should be described. How is it that facilitation is linked to these rates?

As previously described, facilitation is a knowledge translation method that we have implemented in order to primarily evaluate its effect on neonatal mortality. In the article by Persson et al in PLOS Medicine (2013) we report on the main outcome of the intervention. In the current paper we are reporting on the process of the facilitation intervention, through the experiences of the stakeholders (facilitators and MNHG members) involved in the intervention. This is a vital part of the process evaluation performed in the project, which will contribute to the understanding of what aspects and processes that impact this kind of social intervention. Thus, the current study contributes to the understanding of the complexity of the intervention, in particular providing plausible explanations as to why there was a latent period before the effect appeared in the intervention communes. In order to clarify this earlier in the paper, we have added some text to the Background section (page 5). In addition, in the Conclusion, we have revised the text in order to better clarify that the three areas we focus in the Discussion section (i.e., money, the facilitator role, and viewing the MNHG as a coalition) are considered important in explaining the complexity and the effect latency which can occur in knowledge translation projects like the NeoKIP.

(14) There was only one quote mentioned (page 14) that focused on outcome: “With the help of the NeoKIP project, I have changed my way of communicating...now, when I communicate I focus on changing them and making them hear me.” This quote was from a MNHG member but they did not attribute this communication skill to facilitation. If so, then this would have been a convincing result that addresses the aim of this study. Similarly, the summary: “FGD participants had observed a reduction of home deliveries...the MNHG members perceived these changes as signs of an increased awareness of the public.” (page 17). If facilitation had a role in increased awareness, then this too would have addressed the aim of the study. The results in general seemed to focus on MNHG perceptions of knowledge transfer but not necessary on the facilitators role in this. As such, the results as written seem to deviate from the aim of the study. This focus seemed to spill into the discussion with new information on the lack of financial support.

In the NeoKIP project, the facilitation technique applied was that one person (the facilitator) targeted groups to make knowledge translation easier by supporting them in changing their attitudes, behaviour, skills and ways of working. The aim of the present study was to describe mechanisms of facilitation based on the experiences of the facilitators and the intervention group members. Therefore, the facilitation intervention that we have carried out underpins the findings, including the changes as represented in for instance
the two examples you highlight above; In the first quote, the person would not have improved her/his communication skills if he/she not had interacted with the other 7 MNHG members and a facilitator through monthly meetings and additional activities in-between these meetings. We suggest it is because of our intervention that this person has changed her/his way of working. Therefore, we believe the findings are congruent with what we state as the aim of the study.

The focus on lack of financial support is highly relevant to discuss as this was an area that concerned both the facilitators and MNHG members of the NeoKIP project, i.e. both parties involved in and carrying out the facilitation intervention. As the lack of financial support influenced the facilitation intervention, it contributes to the explanation of the delay of reduced neonatal mortality rate. We suggest this is important to know, in order to repeat or scale-up this study in Vietnam or elsewhere.

(15) I encourage the authors to review the conclusion in light of the above feedback. It seems to me that it is premature to conclude choice of facilitators and reimbursement of MNHG in contributing to the success of NeoKIP model, if the model itself is linked to the improvement of neonatal outcomes.

We wish to emphasize that we only presume two aspects in the conclusion; that our selection of facilitators and the fact that we did not reimburse MNHGs contribute to 1) making the intervention successful and 2) making the intervention feasible for scaling up. We would like to stay with these conclusions with some minor revisions, in particular as the findings and additional studies, as presented in the Discussion, support our assumptions. Also, when reading some of your queries (question 12 - 14) we believe that our text might have been misleading. However, we hope the revision made makes the current paper more clear while also, that our responses in this letter has better clarified the meaning of the term facilitation, as applied in numerous studies, guidelines and policy documents around the world.

In terms of your last point (i.e. ‘if the model itself is linked to the improvement of neonatal outcomes’) we do not fully follow you; We have conducted a large randomized controlled trial involving 90 communes, the only difference between the 46 control communes and the 44 intervention communes is that each intervention commune had a MNHG working supported by a facilitator. The MNHG-members and a facilitator in each commune have jointly identified problems and implemented actions targeting these problems. As there was no other intervention going on in the intervention or control communes, we suggest it is the NeoKIP intervention that contributed to the improved neonatal outcomes in the 44 intervention communes. We have clarified that it is the NeoKIP intervention that we assume appropriate for supporting similar intentions in similar settings and/or for scaling up. If we have misunderstood the point made, we would appreciate if you would kindly elaborate on how you interpreted this.