Author's response to reviews

Title: A framework for community ownership of a text messaging programme to improve adherence to antiretroviral therapy and client-provider communication: a mixed methods study

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Version: 2
Date: 12 September 2014

Author's response to reviews: see over
Dear Editor,

Below are our responses to the reviewers comments.

Sincere regards,

Lawrence Mbuagbaw

Responses to reviewers’ comments

Reviewer 1:

Overall, my main problem with the paper is the lack of clarity about what was actually being asked and what has been found. By the end of the paper I had – to some degree – achieved an understanding that this was a consultation with people living with HIV asking them if they would participate in a text messaging programme taking on roles from fairly normal passive recipient of reminders through to people who might actually run the service. Is that right?

That is right. We were exploring the possibility of scaling up text messaging interventions by transferring ownership to the community of people living with HIV. They will be both recipients and service providers.

It perhaps needs less space on rather textbook descriptions and more on the context and the actual findings.

We followed recommended guidance on how to report mixed methods studies. This includes justifying why the research question should be addressed with a mixed methods design and why the design chosen is the most appropriate.


The Abstract and probably the title need work to make clearer from the start what was meant by community ownership. It took me a while to understand what this paper was about. It was not obvious to me from the title or the abstract what was meant by the key phrase ‘community ownership’. As I started reading the abstract I was not sure if ownership meant ‘ownership of an idea’ (as many authors use the word) or ‘real’ ownership (i.e. the legal and financial owners of a service). I was also not at all sure what community was referred to – the local community? (That would depend on whether the context was a publicly funded or privately funded health service). It was only really when I got down to page 6 line 20 that I started to understand that community meant what I would call the ‘community of service users’ and what ‘ownership’ meant. It could still do with more explanation of the range of different meanings of ownership.

The phrase “community ownership” is a commonly used public health term that refers to public participation in priority setting, decision making and management. In other words the public “owns” the problem and tries to develop solutions. This often leads to better uptake and sustainability. In this kind of research, the researchers know what they mean by ownership but have to tie that with what the participants understand by ownership. Specific definitions would not be useful in this case. We present
our definitions and participants understanding of the concepts in the manuscript. We also note in our published protocol (which may provide more clarity for readers) that the definitions of concepts may change as the research unfolds.


We have made some changes to the abstract and methods sections to clarify the concept further, given the word count limitations. See pages 2 and 3.

In the Abstract I was similarly unsure which ‘people’ were willing to pay for a text messaging service – in the context of a state run health service for example it may be that you were asking people (i.e. members of the public who contribute through taxes) about willingness to pay. In fact, as I discovered later, you are referring to the service users. I think using that term throughout would have made it clearer (at least to me!).

We have provided more clarity on the health system in Cameroon, and replaced “people” with “service users”. See page 2, line 19.

So – still seeking clarification in the Abstract – when it says “training community members in project management, securing sustainable funding, demonstrating clear benefits to users”, am I right to understand that the community members and users are both ‘service users’? Are the ‘community members’ those service users who were willing to take on the running of the service?

Yes. They are. We have modified the abstract to make it clearer. The community members may take both service user and service provider roles.

In the results in the Abstract it says “In the qualitative strand more people were willing to pay for a text messaging service, preferred participation of health personnel and...”. More than what? Preferred it to what?

We are referring to more people than in the qualitative strand compared to the quantitative strand, and that they preferred participation of health personnel as opposed to no health personnel involvement in management. We have edited this statement. See page 2, lines 17 -20.

Introduction (page 5, line 21) a sentence describing/classifying the type of health service that Cameroon has, would be helpful.

We have provided some detail on the health system in Cameroon. See page 9, line 16-18.

Page 8 line 1, Theoretical background. Some reference to the work of Mair, May et al, Greenhalgh et al, is probably appropriate here.

We agree that the normalization process theory developed by May and Mair may be relevant to some aspects of this research, but it will be most useful when we actually start implementing the programme. Some readings from Greenhalgh were used, though not cited in the development of this project. We are of the opinion that the theory of diffusion of innovation is the most appropriate for this piece of research.
Personally I don’t think the (rather textbook style) section on ‘why mixed methods’ is needed. The space could be better used to clarify ‘ownership’ and the context. I also thought that the research questions section could be shortened. Using mixed methods is fairly standard and does not need much justification or explanation, whereas the context and overall aims are novel and require more explanation.

This section is relevant to the manuscript for readers unfamiliar with mixed methods and is based on recommendations for writing mixed methods papers.


Further clarifications of our aims and context have been provided throughout the manuscript.

Page 9, line 21. I don’t understand why you say the exploratory... rather than an exploratory...?

We say “the” exploratory because it is a specific mixed methods design. It is the only exploratory sequential design (qualitative followed by a quantitative strand).

Page 11, top. I don’t understand “Participants with significantly different characteristics were interviewed separately to create homogenous groups. Focus groups of 6 to10 participants were constituted until saturation of ideas.” So what is the process of recruitment and allocation to focus groups? Was the ‘interviewed separately’ a pre-focus group interview to help in the allocation to focus group, were some people interviewed in groups?..... I don’t understand this section. Please clarify. (It did not become any clearer when I got to Results on page 15).

Some of the participants were leaders of community associations. We put them in one group. Page 14, lines 5-7 describes this.

Page 11, I don’t understand the sample size paragraph. I know that further down you say that you carried out a regression to look at the impact of demographic variables on involvement in community groups. So is this sample size calculation based on the estimated smallest group within that regression analysis? (I think a statistician should review that).

The sample size formula we used is referenced. It gives an estimate of the number of people who should be included in a survey based on the total population under study. It was not estimated based on the regression analysis, but is largely sufficient for regression analyses.

Page 12, line 4 Focus Group Discussion abbreviation not previously introduced.

The abbreviation for focus group discussions has been introduced at first use at first use. See page 10, line 20.

Page 15 – so returning to my confusion about the term ‘community activity’ when it says ‘Participation in community activities. Almost three-quarters of the participants did not participate in any community activities...’ we are talking about the ‘community of service users (i.e. people with HIV). We are not talking about ‘general’ community activities such as church membership, or other things that might go on the (general) community? Do you see the reason for my confusion? Did you give some examples to your interviewees of these community groups? Can you give some examples for the reader please?
The word community here as defined in the introduction refers to the community of people living with HIV at the Yaoundé Central Hospital. They may have community activities, such as support groups, pill buddy groups, associations for lobbying, associations for home-based care and other forms of social networks among themselves. We have provided more details. See page 14, line 15-16.

10. Page 20, line 14 and Page 21 line 3. Does a non-significant chi-squared mean that the Hosmer and Lemeshow goodness-of-fit shows that it is NOT a very good fit? (I am not familiar with Homser/Lemeshow without looking this up, needs statistical review).


There are numerous typographical errors. I have not listed them as I assume they would be picked up at copy edit stage.

We have revised the entire manuscript for errors.

Page 23 (discussion). The paper itself does not describe or differentiate well the difference between (a) being a participant in a text reminder system run by ‘someone else’ whether that someone else is ‘other service users’ or some regional or national health service, and (b) being the service user who with others runs such a service.

We are working with the same target population. They are all living with HIV so they are all potential recipients of text messages (service user) and managers (service providers). Previous research, cited in the background section show that people living with HIV are willing to receive text messages. The questions here is whether they are willing and ready to run the text messaging programme themselves. The distinction above doesn’t come into play if we follow our definition of community ownership. Partnership with other institutions and potential funders is not excluded.

It looks as if that confusion was also present in the focus group discussions “In our protocol we sought to investigate acceptability and readiness, however, in the course of our research the questions changed somewhat. Acceptability was better conceptualised as willingness to participate. Also, in our discussions about “readiness”, participants perceived readiness not only as having the skills and resources to manage a programme, but rather expressed positive or negative feelings with respect to community management”.

What the reviewer refers to as confusion is a process of refining and defining the research question with the participants. This does not represent confusion, but rather consensus between the researchers and the participants. It is an integral part of research on complex issues and serves as a measure of internal validity.

When I look at Table 2, the only question that seems to have any relevance to (a) is “What kind of community organisation is best suited to run a text messaging programme”. All the other questions are about receiving text messages. This increases my confusion about what this paper is about.

Table 2: practical functioning of a text messaging programme, covers other issues that may help in setting up the programme. It contains supplementary information collected in the quantitative surveys that helped in the development of the framework.
My confusion continues, Table 3 has statements

- Believes community can run programme in a sustainable way
- Currently participates in a community support initiative
- Prefers participation of health personnel
- Prefers project be based in hospital

Which DO seem to relate to (a).

So I am left not being sure how much your participants were aware of these different levels of participation. Can we see the focus group headings and questions asked in the survey? More clarification is needed of what your participants were asked and about the changes you made as you moved from qualitative to quantitative stages.

The focus group discussion guide is shown in our published protocol. Table three shows the themes addressed and how these themes were converted into variables for the quantitative strand. For example, the theme “acceptability” was operationalised as the variable “Would adhere to an SMS support initiative”. The main objectives of the study are addressed in table 3. Table 2 serves to add some context to the research and support the development of a framework.

**Reviewer 2:**

Major Compulsory Revisions

Given the prior research mentioned under "Influence of context and researchers", it would be helpful to note the proportion of participants in this study that also participated in the prior research, if known.

The prior research was conducted 3 years before this one. If any of the participants participated in both studies, they would be few.

In addition, it would be helpful to know the temporal order and whether these studies were related. For example, was this current study conducted prior to the other studies mentioned and just not published yet or did implementation of this study actually follow those other studies. It seems as thought this study would be a precursor to outcomes research and RCTs that were reported in the other publications.

This study follows all the previous cited research. It serves to investigate a strategy for implementation after the RCT and other studies which established efficacy, health worker and client support.

It would be helpful to understand how the characteristics of the study's participants (Table 1) compare with the larger population of PLWH in Cameroon.

Unfortunately we do not have a breakdown of the characteristics of people living with HIV in Cameroon. Our findings are relevant to the community of clients in the Yaoundé Central Hospital who were the subject of this research.
Table 2 reports that risk of disclosure of status was cited as a reason why participants would not participate in a text messaging program by 46.7% of participants. This is very important and I do not think the authors addressed this finding in the narrative results. I would like to see this included in the narrative.

How would the authors suggest addressing this important barrier to participation?

The risk of disclosure of status is an important one that remains a major concern for all text messaging interventions. This is particularly true in settings were stigma and discrimination are high. The framework we propose identifies confidentiality as an important part of implementation. This can be done in the following ways: using encrypted messages, using message content that doesn’t mention the patient’s condition or the kind of medication to be taken. However, the strategies we will use to ensure confidentiality are beyond the scope of this paper. The message here is that it is an issue which must be addressed in order to ensure adherence to a text messaging programme.

Minor Essential Revisions

There are several places where there are typos or misuse of words. I will try to point them out below, but I also encourage the authors to give the paper a close read for needed editorial changes.

- Theoretical framework, page 7, line 19, change "will" to "with"
- Theoretical framework, page 8, line 3, missing word "programme" after "messaging"
- Quantitative research questions, page 9, line 6, missing "?"
- Design and rationale for design; page 10, line 5, should say "where there" not "where the"
- Setting, page 10, line 13, should say "to" not "for"
- Sampling, page 11, line 7, should say "conducted" not "constituted"
- Community Readiness, page 18, line 7, should say "a" not "as"
- Quantitative results, page 19, line 18, should say "responded" not "respond"
- Factors associated with positive feelings..., page 21, line 6, should say "thought" not "though"
- Challenges to programme, page 21, line 21, should say "from" not "form"
- Explaining the lack of convergence, page 26, line 21, should say "There" not "They"
- Figure 2, Monitor, should say "feedback" not "feeback"

We thank the reviewers for identifying these errors. They have all been corrected. We have read through the manuscript in detail to identify any other errors.