Author’s response to reviews

Title: Peer-to-Peer Support Model to Improve Quality of Life Among Highly Vulnerable, Low-income Older Adults in Cape Town, South Africa

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Author’s response to reviews:

REVIEWER 1:

1. Please revise the abstract:

Background - please delete the repeated sentences ("In other contexts, the use of…").

* Thanks for picking this up. We have made this edit.

Methods: please describe the intervention in more detail and the outcomes of interest.

* We have described the purpose of the AgeWell visits and the outcomes of interest in more detail as requested.

Results: the results are described a little bit too superficial. Please add some more detail.

* We have provided numerical results on the outcomes reported. We have also added some additional results on wellbeing and social support to the main results section, also reported here.

Discussion: please take the limitations of the study into account (see my last comment)
* We have highlighted the main shortcoming of the study (that there was no control group, but because of space constraints in the abstract your other comments are addressed in more detail in the main discussion section).

Background Line 131: Please add some more information about the link between the Mothers2Mothers program for HIV positive mothers and your study. Did you recruit only aged people from this program?

* We have included more detail on this programme. M2M empowers and employs HIV-positive Mother Mentors to work in local communities to ensure that women and their families get the health and support they need. This model was adapted for older people in the AgeWell study, using older volunteers to support other older people. M2M provided programmatic support, but neither volunteers nor study participants were recruited from the M2M programme for the AgeWell programme.

Please move the description of the intervention to the method section and merge the information described (general information in the background section and information about recruitment and training).

* We have done this as per your suggestion.

Please describe the content of the intervention in more detail.

* We have now added more detail on the intervention in the text.

Methods:

1. Please add some information about the rational for the sample size. What was the primary outcome for this study?

   * We have added that the sample was based on the number who could be recruited from the area who met the selection criteria. As already noted in the paper it is was a convenience sample and we weren’t trying to achieve a representative sample.

2. Please add some more information about the assessment instruments (e.g. validity, information about the quality of the results assessed by the trained raters).
* We have included some more information about the assessment instrument (interRAI CheckUp) and its validity. We have also now reported on findings from two other instruments used – MOS-SS 8 and WHO-5 Wellbeing Index and also commented on their validity etc.

3. The study was conducted in 2014 and the results might be of limited interest.

* Although the study was conducted some time ago, no work has been done in this area in developing countries since then and we feel that this information is still important to publish. The geriatric issues addressed by the intervention are NOT time sensitive and therefore, remains relevant to this day.

Results Please revise the results section according to the reporting guideline mentioned above.

* We have done this to the best of our ability given available data and the structure of other sections of the paper.

Discussion

* Please consider the study limitations, e.g. uncontrolled study, lack of blinding, subjective outcomes and the risk of Influence of socially desirable responding, multiple testing in the discussion, conclusion and implications.

We have responded to the comments on it being an uncontrolled study and the subjectivity of responses (in that it is a self-report instrument which may introduce particular biases or issues around recall etc). However, the assessment does not require any competence on the part of older persons and therefore the risks of multiple testing in terms of a learnt response does not really apply.

REVIEWER 2:

1) It should be acknowledged that the sample of older participants in the study may not be entirely representative of the target population. For one, the participants had phones, whereas others in the target area (Khayelitsha) have 'no piped water, no flush toilets, or electricity'. Also, very few of the participants lived alone (7%), and over one third were primary caregivers. It is possible that a more vulnerable, lower-income population would have responded differently, and this should be clearly recognized by the authors.

* Thanks for your comment. However, we must respectfully disagree here. We believe that our sample is a good representation of the older population in Khayelitsha. Having a cellphone
should not be associated with greater wealth in an area like Khayelitsha. Cellphone penetration is very high in South Africa (approximately 9/10 people own a cell phone) and the rest of Sub-Saharan Africa, including among the very poor who don’t have access to other basic services, including electricity (people charge their phones in innovative ways). While AgeWells had access to smartphones, most older people have cheap, basic phones on a pay-as-you go basis and use low-cost services such as Whatsapp to communicate and would be able to receive calls from AgeWell visitors.

Furthermore, living alone is very uncommon among the African population and the group selected for the study are hardly unique in this regard. Most older persons live in multi-generational or skip-generational families, with older persons’ pensions often supporting the entire family (South Africa provides non-contributory old age pensions to all over 60s meeting the means test) and often take care of grandchildren.

2) The paper purportedly reports on selected longitudinal outcomes. It seems that health outcomes did not show any improvements whereas quality of life outcomes did. This finding in itself is important: either the authors have reported the health outcomes elsewhere and refer the reader to that work, or they ought to report the null findings in the current paper. The null findings do not detract from the psychosocial improvements the authors report.

* The main focus of the study was on improving wellbeing rather than health outcomes, which are unlikely to change in just 5 months. We initially focused exclusively on data from the interRAI instrument, which also collects a lot of data on health and function, but realise now that this made our results seem spotty and have also included data collected using the WHO-5 Wellbeing index MOS-SS 8 (social support) instrument in the hope that this will strengthen our findings on psychosocial outcomes. We have not published results on health outcomes elsewhere and do not wish to distract from the main focus of the paper by discussing these findings – we have mentioned that we had no findings in this regard in the discussion. A longer-term, control trial would hopefully show improvements in health outcomes.

3) The authors devote little attention to the AgeWell visitors. What were their characteristics, how were they identified? They are referred to as volunteers but appear to receive a small stipend. What skills, if any, were they required to have beyond 'being active'?

* We have included some more information on the recruitment of AgeWell visitors. Stipend-paid volunteering is common in South Africa given high rates of poverty – in South Africa the AgeWells will still be considered volunteers and an explanatory footnote has been added.
What were the criteria used in the process of selecting these volunteers? Did the AgeWell volunteers report any improvements due to their activities in the program? If this was not assessed, the authors should at least mention such a possibility.

* The criteria of selection are discussed on lines 243 to 253. As part of M&E activities, a group AgeWells were engaged in focus group discussions. They reported numerous positive changes. We have now added a sub-section entitled ‘Programme effects on AgeWell visitors’ to the results section.

4) It would be helpful to have a table summarizing the demographic and health data on the participants. The reader is given very little information. It appears that participants had access to healthcare, and a primary care provider. How typical is that of the population targeted by the study?

* Thanks, we have now added this table. Primary healthcare and medication at community clinics is free in South Africa. Older people with chronic conditions are usually part of chronic clubs where they receive regular follow-ups and their medication. However, quality of care for older people is often poor. We have added a note on this.

5) The description of outcome measures is confusing.

* We have provided more clarity in the section on outcome measures and added more detail to Table 2.

6) The intervention was provided for 5 months but there is not much information around the feasibility of the intervention and its acceptance. What problems if any were encountered? Did some participants refuse some of the visits? Were there mismatches between participants and AgeWell visitors? How was the intervention received by participants?

* We have added some additional information on the rollout of the programme in the discussion section. Overall, there was very high acceptance of the programme within the community (although refusal rates were not tracked) and attrition rates were low (10%). Problems encountered were of an operational nature and this is now discussed briefly in the paper.
7) Since there was no control intervention, it is not possible to know whether it was the peer-to-peer support that produced the improvements in psychosocial outcome measures. This is a possibility that should be explored further in more rigorous trials.

* Suggestions about where this research should go next would be helpful in that regard.

We agree that there are limitations in attributing outcomes to the peer-to-peer programme given the study design and have now mentioned this in a sub-section in the discussion on study limitations and have made suggestions regarding further study.