Author's response to reviews

Title: Assessment of primary care facilities for cardiovascular disease preparedness in Madhya Pradesh, India

Authors:

Abhijit P Pakhare (abhijit.cfm@aiimsbhopal.edu.in)
Sanjeev Kumar (sanjeev.cfm@aiimsbhopal.edu.in)
Swati Goyal (swati_97in@yahoo.com)
Rajnish Joshi (rajinsh.genmed@aiimsbhopal.edu.in)

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Author's response to reviews: see over
To,  
Editor  
BMC Health Service Research  

Sub: Manuscript ID 1465898477110732 - Submission of revised manuscript with response to reviewer’s comments  

Dear Sir,  

Thank you for the peer review and suggested corrections. Manuscript has been revised and responses to comments are given in this document.  

Our responses follow reviewer comments (in red font). Corresponding changes have been made in the manuscript (referenced below and indicated in red font)  

Reviewer 1:  

Major Comments:  
1. Lack of Context: The main drawback of the paper is that it does not place the study in proper context. In the Global as well as National Monitoring Framework for NCDs in India, there is an indicator and a target for availability of essential technologies and medicines in primary health care in both public and Private health facilities and a target of 80% is set for it by 2025. There is no information on their current availability levels. If the work has to add to this critical gap, then it has to follow the definitions use by WHO and adapted by India.  

We thank the reviewer for this suggestion, and we have included the above information in the background section (Page 3, second paragraph)  

2. Lack of clarity of guidelines used: In the paper it is not clear what guidelines have they taken. What was in IPHS guidelines, did they took it as it is If so; how did the PEN guidelines contribute to it. In the end also while we come to know of individual items, we do not get a full picture. Are these defined under NPCDCS, are there national treatment guidelines which support their decisions to deviate.  

We had taken items in our questionnaire from two main sources – Indian Public Health Standards for primary and Community health centers, and PEN (Package of essential non-communicable disease interventions for primary care). While WHO-PEN provides for a list of essential technologies and drugs required in primary care, it neither details human resource requirements, nor does it discriminate between levels of Primary care. IPHS has separate standards for PHC & CHC, including human resources, infrastructure, equipment & drugs, but does not have a NCD focus. We took most items from the PEN and relevant items from IPHS standards in the current study. We have modified the text (Page 5, Procedures, first paragraph) and Table 1 of the manuscript to include this rationale the source of the included items.  

3. Tool Development: Authors need to describe the source tools in terms of applicability, completeness for this objective and its validity for setting. There is a WHO SARA (Service Availability and Readiness Assessment) Tool for such
surveys. Was that used in tool development? Describe how you went about designing your questionnaire, was any pretesting done? Was a different questionnaire used for CHC officers? If not, why not? IPHS has separate standards for CHC.

We have included the source of items in questionnaire in Table 1. We had considered WHO SARA, which is a much extensive questionnaire for facility assessment and readiness across reproductive health, neonatal and infant care, malaria, tuberculosis, HIV, emergency care and NCDs. Further this tool is meant for a in-person facility evaluation. We did not use SARA in our study as it was a questionnaire based, and we wanted to keep a NCD focus in our work. The development of this questionnaire was done in consultation with the core team of medical and public health specialists who were also involved in the designing training curriculum for the medical officers. The list of items was based on simple tools and technologies required for primary care management of key NCDs such as hypertension and diabetes and its complications. Further, items in this list that were also included in PEN and IPHS guidelines were retained. We expanded the questionnaire in later part of the study, largely to assess for availability of essential drugs and medications pertaining to NCDs. We have included the above information in the Methods section (Page 5, procedures, first paragraph)

While CHC and PHC are two distinct entities in Indian Public Health system, (with PHC being primary-care and CHC being a level above) in areas with weak public health system such as Madhya Pradesh, their functionality often overlaps. Many PHCs do-not have full time medical officers, and often one PHC medical officer rotates days across multiple facilities. Further, NCD readiness is still in its infancy both at PHC and CHC level, hence we did not use separate questionnaires for them.

4. Data Collection procedure: This is not a health facility survey in real sense and this has to be acknowledged and it does not actually measure current availability but perhaps a general sense of availability. The best method to achieve the stated objective would have been a facility survey. But medical officers’ interviews were taken as proxy for this purpose. Contrast and compare these two methods.

We agree that physical verification is more robust as compared to questionnaire-based method, something we have already acknowledged in the limitations (discussion section, Page 9, first paragraph).

5. Two phases in the study: It is not clear why the authors expanded from 15 items in first phase to 36 items in the second phase. Could they not have asked the first phase participants to answer the other questions say on Phone or email as these are doctors with much better connectivity? This difference in two phases has resulted in serious difficulties in interpretation. What was the need for using two versions?

As explained earlier (Question number 3), we expanded the questionnaire in
later part of the study, largely to assess for availability of essential drugs and medications pertaining to NCDs. Except for drugs and medications, all other items were answered by all respondents. While we considered getting responses on these additional items from earlier respondents, but concerns about reporting bias due to different methods of data collection, and loss of confidentiality prevented us from doing the same.

It is not clear why comparisons are warranted between CHCs and PHCs as the guidelines are different for them. It might be much better to compare the facilities in districts where NPCDCS has been launched (both CHCs and PHCs) with other districts to get a sense whether the program has made an impact in this regard.

We agree with the reviewer. A previous previewer raised the same issue, hence we have revised table 2, and removed such comparison. We have also removed from the text any direct comparisons between these two types of facilities. (Abstract, Results, and Discussion sections) Comparison of NPCDCS districts has been done and mentioned in results section. Availability of various facilities amongst CHCs of NCD districts (n=14) and Non-NCD districts (n=25) was similar.

Are nutritionists and physiotherapists expected to be present in PHCs or CHCs as a part of any national guidelines. Perhaps not, so why are they there in the checklist?

IPHS standards desire dietician (nutritionist) to be available at CHC level. Similarly there is a provision for a multipurpose community rehabilitation worker at CHC level. IPHS standards also enlist physiotherapy equipment at CHC level, supposedly to be used by a physiotherapist or equivalent personnel. We have indicated these nomenclatures in Table 2. Expectedly availability of these personnel is scarce at CHC level. None-the-less these personnel or their skills will be important to implement various objectives as underlined in WHO-PEN guidelines.

Both the sample size and sampling is convenient and the discussion has to address the implication.

We have addressed this in the discussion section.

Minor Comments:
Figure 3 can be deleted altogether or at best presented for HT and DM separately only.

We have deleted figure 3

The term ‘facilities’ is used to refer to PHCs and CHCs throughout the script, but it is also used to refer to items present in these facilities. Adopt a standard terminology.

We have revised the manuscript and now we use the term ‘facilities’ for PHCs and CHCs only.
Give an indication of the total number of PHCs and CHCs in the state and what proportion does your sample cover.

There are total of 1157 PHCs and 334 CHCs in MP state. Our sample covered 1.72% of PHCs in total and 11.67% of CHCs. Among nominated districts there were 640 PHCs and 169 CHCs and our sample covers 7.5% PHCs and 23% PHCs. We have included this information in the methods section. (Page 4, methods section, first paragraph)

Were doctors from the same facility also present? And where both response included?

No, because doctors from same facility were not nominated by DHS.

Whether any distinction was made for consumable and non-consumable items? For eg., drugs may be available at present but are they present most of the time? And a BP apparatus once available is taken to be present at all times,

Current availability was assessed. For assessment of functionality in real sense visit would have required. This issue of non-assessment of functionality has been addressed in limitations under discussion section.

Why not p value < 0.05?

We have deleted any comparison and p-values.

Reviewer 2:

No additional comments. Seems good to be published.

We thank reviewers for their encouraging comments.

Reviewer 3:

I am fine with authors’ stated responses in cover letter (and corresponding changes made in manuscripts) to the comments/concerns I had on the first version of the manuscript submitted to the journal. I was able to see the comments made by other two reviewers but I do not see, in cover letter, authors’ responses to comments made by third reviewer. I found some of those comments useful in improving the manuscript. May be Editor shall look into this aspect.

We thank reviewer for pointing out issue about comments of third reviewer. We have addressed the comments in current revision.
Editorial requests:

Please include the details (name) of the ethics board that approved this study in the manuscript.

It is Institutional Human Ethics Committee of AIIMS Bhopal. We have included this information in methods section.

Please rename Introduction to Background

Introduction has been renamed to Background.

Please include an Abbreviations section

We have included abbreviations section at the end of manuscript.

We thank the editorial team and reviewers as their suggestions have significantly improved this revised version of the manuscript.

Thanking you,

Rajnish Joshi
Assistant Professor
Department of General Medicine
All India Institute of Medical Sciences Bhopal
Email: rajnish.genmed@aiimsbhopal.edu.in
Phone: 91-9425303401