Author’s response to reviews

Title: Implementing without guidelines: Learning at the coalface - A case study of health promoters in an era of community health workers in South Africa

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Author’s response to reviews:

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Rosanna Gonzalez-Mcquire
Managing Editor
BMC Health Research Policy and Systems

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Dear Rosanna,

We would like to thank you and the peer reviewers for the opportunity to have received constructive feedback and comments that have strengthened our manuscript, entitled “Implementing without guidelines: Learning at the coalface - A case study of health promoters in an era of community health workers in South Africa”. The section below describes how we made the revisions and refined our manuscript addressing the reviewers’ reports; each comment is presented point-by-point:

We look forward to hearing your response to the revised version of the manuscript.

Brief Editor’s report

We thank the Editor for her comments and re-submission guidelines. We have highlighted all changes made during the revision of our manuscript with 'tracked changes'.

Reviewer #1

General comments
1. Dear Authors, thank you for sharing this interesting manuscript on a very important topic and congratulations on conducting the research, this manuscript is based on. Your findings are very important to inform policy also in other settings, so a thick description of your methods is key, to assist readers' decisions on transferability but also to the wide dissemination of your results. I would therefore recommend a revision especially of the methods part along the lines of the COREC guidelines (Consolidated criteria for reporting of qualitative research) or the SRQR (Standards for reporting qualitative research). Both can be downloaded from the EQUATOR network webpage and are internationally agreed standards that are also required by publishers. I think this will improve your manuscript importantly. I have used the SRQR for my suggestions below.

We would like to thank the reviewer for her thoughtful and detailed comments. We have selected the COREQ for use to the report the methods section. Line 164 – 347: pages 7-15. We would also like to acknowledge inference to the SRQR guideline as well, as referred herein by the reviewer. All suggested major and minor comments have been addressed and described below. We believe that addressing them has substantially improved our manuscript, particularly the methods.

2. Since this re-vamp will need additional words, I suggest to shorten the introduction and make it more concise and fitted to your major findings. The description of the history of health promotion for example is very interesting, but clearly not so relevant for your findings.

We acknowledge the comment by the reviewer. We have deleted the paragraph about the history of HP in RSA. Background section, line 103-112, page 4.

3. I would also like to suggest to leave out the review of the two policy documents and rather put this in the introduction to construct the rationale for your study and discuss your findings later against these documents, because they clearly show the short comings of these documents. In addition, the description of data collection, processing and analysis of these documents is not well elaborated and would need much more writing to help the reader understand what the added value of this methods to your findings is.

We have moved (cut and pasted) the review of the two policy documents from the Results section, line 417-443, pages 19-20 to the Background section, line 162-188, pages 7-8 of the manuscript.

Background
4. The introduction is good, you could provide a bit more information on the study countries you are citing in 98-100.

We have added the specific names of the countries and deleted the words ‘In some places’. Background section, line 98 -100, page 4 now reads: Different countries provide numerous examples for HP delivery, for example Canada, Australia and Guatemala, health promotion practitioners (HPPs) provide HP (1, 2), in others such as Lesotho and Cambodia, CHWs are responsible (3, 4).
5. 73: I guess you mean the sustainable development goals.

Deleted the word ‘social’ on the background section, line 73 page 3 and replaced it with the word ‘sustainable’ now reads: sustainable development goals

6. 86: What is the PHC-led UHC package. This was not mentioned before.

Deleted the words ‘universal health coverage’ on background section, line 86, page 3 and replaced it with the word ‘led reforms’. Sentence reads: the new PHC-focused reforms package.

7. 87-88: I suggest " Research has a potential role in influencing PHC reform policy.....

Background section, line 87-88, page 3. Deleted the words ‘the’, ‘to play this’ and ‘by’. The new sentence reads as: Research has a potential role in influencing PHC reform policy formulation and implementation

Methods

8. Briefly describe the design you used and why. Period of data collection can go under that heading. I suggest to describe the mixed methods study in more detail, because this may have influenced your site or participant selection and the reader needs to know this.

We have added a new sub-section ‘Study design’, Methods section, line 202, page 9. Under this sub-section the following changes have been done:

o Line 203, we deleted the word ‘approach’ in the introductory sentence, and replaced it with the word ‘research design’. The sentence now reads: We used a qualitative case study research design in two provinces in South Africa.

o Line 204-205, we added the words ‘was selected because it...’ and ‘...particularly in the context of PHC revitalization’. The new sentence reads: This design was selected because it enabled an in-depth understanding of the roles of health promoters at PHC level, particularly in the context of PHC revitalization.

o Line 208-211, we deleted the words ‘to describe the “what” and the “how”, including impact of the rPHC WBOT strategy implementation on HP at district level’. We then added the words ‘the impact of the rPHC WBOT strategy implementation...’ The restructured sentence now reads: In this study the case of interest was the impact of the rPHC WBOT strategy implementation on health promoters; we describe their roles and activities (the “what”) and “how” they are working with CHWs.

o Line 215-218, deleted the words ‘policy, structure and practice’ and ‘different levels of’. Restructured sentence reads: Data for this paper were collected as part of a mixed-methods research aimed at answering the research question ‘how is HP institutionalized within the South African health system?’
9. Both COREQ and SRQR suggest to add information on the researcher characteristics and how they relate to the context, i.e., the participants. This is because the researcher is also the research instrument and his/her approach to data analysis may be also influenced by this relationship. E.g., it is a difference if the researcher who collected the data comes from within or from outside the setting, whether these data were collected for a master thesis or not. It is also important to know the background of the researchers. Are they medical personnel or have a background in health promotion etc. This section doesn't need to be long, but it helps to understand what you made out of the data you collected and to understand possible bias.

We would like to thank the reviewer for this comment. We added a new sub-section named ‘Researcher characteristics and reflexivity’. Methods section, line 220 – 2230, pages 10. The sub-section is described as follows:

**Researcher characteristics and reflexivity**

At the time of the study, the first author (TR) and principal investigator was a doctoral research fellow. TR conducted all the interviews and initial document reviews. Study participants did not know TR, prior to conducting this research. TR has a HP qualification and previous experience in HP. Although her professional training and experiences were mainly from another country, enabling her to assume the role of an outsider. Her education in HP made her more openly received, particularly by HPP participants. However, she found that some of the HP challenges highlighted by participants during the research resonated with her own experiences. In this regard, she consciously found herself making efforts to assume her role as the researcher vs. being the practitioner and trying to keep an objective mind throughout the research process.

**Study sites**

10. I suggest you add more information on the context of your study provinces and also the sites and why you chose these and not others. Probably this is linked to the mixed methods study, this study was nested in.

We agree and have added new information stated below: Methods section, line 238–245, page 10-11.

Selection of the two provinces was based on the availability of DoH health promoters practising at local PHC levels; not all provinces have designated HPPs at lower levels (district to clinics). Of the two provinces, Province A represented a mainly rural context, while Province B represented a largely urban setting. The two districts included, were selected based on having the highest number of HPPs, compared to other districts in each respective province. In the same regard, sub-districts and clinics were selected depending on the availability of a HPP during data collection.
You should elaborate more on the sample and the recruitment strategy. Who recruited the participants and how. Here you should also add the rationale why you did not include CHW and WBOT leads. You do not need to defend this, just explain why. I suggest you also add the reason why you did the group interviews. The number of participants was too small to call this a focus group discussion, but surely you had a reason to interview people together. Adding focus group discussions might have been a good idea, since this method could have revealed norms and how different HPPs have assigned meaning to their work. It would have also been a more effective way to get information. I suggest you explain why you opted for in-depth interviews.

We have added more detail to the sample sub-section, Methods section, line 247-266, pages 11 as follows:

- Line 247, we renamed the sub-section title from just ‘Sample’ to “Sample, sampling and sample size’
- Line 248, we added a new sub-sub-section entitled ‘Description of participants’
- Line 251-256, we added more detail to how sampling was carried out:

  Multi-stage purposive sampling was used to recruit the participants into the study. This was done to represent all levels of the health system for maximum variability. At each level, the HPP participant identified would assist in identifying and recruiting other participants from the next level (district, sub-district and PHC clinics respectively). The principal investigator (TR) used direct face-to-face invitations to recruit participants.

- Line 258-265, we added more detail to the description of the group interviews and the rationale for excluding CHWs and WBOT leaders:

  Group interviews were conducted when more than one potential participant was present at a site and all willing to participate in the study. We could not exclude one over the other. The first author, made the decision to interview these participants in one interview. This enriched the interviews conducted. CHWs and WBOT leaders were excluded from this study. We felt that facility managers were able to provide a non-HP perspective to the study data. Facility managers directly supervise clinic-based health promoters, with the aid of HP coordinators at sub-district level.

Line 698, Discussion section, page 33. We state that, Studies on rPHC in South Africa have mainly concentrated on CHWs and WBOTs.

- Line 268-277, pages 12. Methods section. We added a new sub-sub-section title was added ‘Units for document review’. Under this section more detail was added on how the two policy documents included in the study were selected:

  Units for document review
In addition, to the participants described earlier, two national policy documents were included in this study and specifically reviewed:

i) rPHC implementation guidelines (2012), and
ii) HP Policy and Strategy (2015-2019)

The researchers used their knowledge of the availability of these national documents and guidelines. We regarded these two main policy documents as most relevant for this study, compared to any other and purposefully selected them for inclusion in the research. The two documents are publicly available. We retrieved copies of them online, through searching for their titles via the Google web search engine and downloaded them for analysis. Links to these two rPHC and HP documents are as follows:

- rPHC implementation guidelines
  http://policyresearch.limpopo.gov.za/bitstream/handle/123456789/882/Provincial%20Guidelines%20for%20the%20implementation%20of%20the%20three%20Streams%20of%20PHC%20Re-engineering.pdf?sequence=1
- RSA HP policy

Ethical issues

12. Should be added here unless stated otherwise by the journal. I suggest you move the consent procedure here, any data security (pass-word secured computer, data transfer/sharing outside the country etc) and protection of confidentiality and privacy.

We thank the reviewer for the comment. BMC journal submission guidelines require ethical issues to be stated under the section ‘Declarations’, line 778. Page 36.

Line 783-787, we have added more detail that describe data security and confidentiality. The new sentence reads: Data were stored in principal investigator’s password protected computer, which is password protected. The study uses unique identifiers to refer to participants. In addition, names of study sites (except for the national DoH, which is the only one countrywide) have also been anonymised to protect their identity and confidentiality.

Data collection

13. I suggest you add the context, the interviews were conducted in (setting, chosen by whom, privacy) and also something on how you define saturation.

We have added more detail about the context of the data collection setting and data saturation. Methods section, line 298-336, pages 13-15. The new additional sentences read as follows:

- Line 298-308, we added: In-depth interviews were chosen to as the main method to collect data for this study, as they allow collection of comprehensive and complex data about a participants’ feelings, thoughts, perceptions and experiences (5). During the study, most interviews were conducted from the participants’ workplaces. The study participants themselves selected the space to be interviewed, which they considered private. We utilized DoH offices, for HP managers (apart from one that was done at the PI’s office, as the participant had come for another meeting in the area), and clinics staff rooms and or consultation rooms for PHC facility-
based staff (except for one which was conducted in the PI’s car due to lack of space and privacy at the clinic). Interviews were audio-recorded using both a mobile device and a recorder. Field notes were taking down by the PI during the interviews in a notebook.

Line 311-314, we added: One clinic was excluded from the study, as the health promoter was not feeling well. Although, both the health promoter and the facility manager were willing to participate in the study. Another clinic facility had to be chosen instead.

Line 317-319 we added: Data saturation was considered as data collection stopping when we considered we had the answers we expected to answer research questions, coupled with no new data expected to emerge from further collection of data (6).

14. To replicate your research in other settings it will also be important to know more about your interview guide: What are the topics you covered, what informed these topics (I would have expected the Lewin’s theory here for example, the research team's personal experiences with the guideline, or the literature). I suggest you also state if the guide was pre-tested, the language of the instrument and whether you have made changes after pre-testing.

We added a sentence that reads: Lewin’s theory was identified once the themes started to emerge from the data. We then returned to the data to confirm usefulness of the framework in explaining the data. Methods section, line 367-369, page 16.

We agree, and have added more information about the interview guide under a new sub-sub-section ‘interview guide’. Methods section, line 321-336, page 14-15. This is described as follows:

Interview guide
The first author developed the interview guide in English, under the supervision of the third author (NC). The research team used their personal experiences in qualitative research, knowledge of HP in the South African context, together with literature were used to guide development of the instrument. The interview guide was pre-testing to a single HP expert at the principal investigator’s institution (this interview was retained and used in other parts of the broader research, not reported in this paper). No changes were made after the pre-test. However, the instrument was adjusted depending on participants’ job location level and role. This resulted in six variations of the tool evolving for the study (national to facility). Topics covered by the instrument broadly included:

- Pre-questions - about the position of the participant’s role;
- Introductory questions - how HP is implemented within the DoH;
- HP policy questions - the vision and strategy of HP within the DoH;
- HP successes and challenges questions – facilitators and barriers to implementation;
- rPHC questions – the role of HP and health promoters in PHC revitalization; and
- Closing questions – participant perceptive about the future of HP in South Africa.

Data processing
15. Data processing is more than transcription. It is important to provide information on who did the transcripts and how data verification was done, e.g. did you go back to the
participants and showed them the transcripts to see if that is what they meant. Many times it is impossible to do that, but you can use summaries during the interviews to do that reality check, but you need to state if you did this. How was data quality analysis done, e.g. another researcher could listen to every fifth interview and check the transcripts. I would also suggest you move the paragraph on how you identified quotations here.

We did not go back to the participants to show them their transcripts to see if that is what they meant. However, we did check each interview against its original audio recording for correctness as well as comparing transcripts against field notes taken during each interview conducted.

We added the words ‘processing and’ to the previous Data analysis sub-title. We now have a new sub-section called ‘Data processing and analysis’. Methods section. Line 338-378, pages 15-17. We have added more detail to clarify how data processing and analysis took place, including adding a table that exemplifies our coding audit trail.

- Line 340-348, we added more detail to describe how the data transcription was done, how we checked transcripts for accuracy and how we coded the data. The new added sentences now read as follows:

An independent transcription company transcribed audio-files from the interviews verbatim. TR verified for consistency against their original recording. A random sample of transcripts was shared with all research team members to familiarise themselves with the data. Codes to be developed, discussed and revised were necessary by all the members of the research team during consultative meetings. This was done to elicit similar meanings of codes among each research member. MS Word files of transcripts were imported into MAXQDA 2018 software, which supported coding together with their original audio-files for comparison. TR performed the primary data coding.

- Line 347-348, we added sentence that clarifies how the coding process was reviewed and the rationale: NC was involved in the review of codes and sub-themes.

- Line 351-357, we added more detail to clarify our two broad themes and clearly numbering the categories that emerged. The sentence reads as:

In this paper, two major themes and their categories are described. Firstly, we presented the general purpose and role of HP at PHC level. Under this theme, four main categories emerged (Table 2): (1) purpose of HP practice; (2) settings for HP; (3) HP roles, and (4) types of information used to prioritization HP activities. Of these, sixteen codes emerged. It is important to note that, some participant phases’ cut across a number of codes and sub-themes. Secondly, we described HP and CHWs in the context of rPHC and the WBOT strategy.

Table 1 seems to be missing and table 2 is incorrectly referenced here as displaying the main categories. A table displaying the codes and themes (audit trail) will be an important tool to increase trustworthiness and transparency of your analysis because the reader could probably redo your analysis if provided with the table and the data. The basic information would be, how many codes and categories emerged. The role of the Lewin’s theory during data analysis is not
mentioned. I would think you used it for the deductive coding part, but you mention the role of HPPs in rPHC only.
As stated under 15 above, we added more additional information under the data processing and analysis sub-section. Methods section. Line 338-378, pages 15-17. The new descriptions are detailed below:

- Please see responses to item 15 on the two key themes that emerged and the number of their categories.

- Line 361-363, we added a new sentence outlines the sub-categories of the second key theme:

Six key categories are emerged under this theme: (1) role overlap; (2) CHW programme; (3) anxiety among HPPs; (4) working parallel; (5) training of CHWs by HPPs; and (6) working together.

- Line 367-373, we added more detail that explain Lewin’s theory was used in data analysis and presentation of findings (see response to item 14). The new sentence reads:

Therefore, the three-step change domains were used to deductively analyze, and present our findings, particularly under the second key theme of rPHC to unpack the ‘what’ and ‘how’ of HP and CHWs at coalface. However, in-between key themes 1 and 2 an intersecting sub-category emerged - introduction of policy. Therefore, 23 sub-themes emerged in this paper.

- Line 377, we added a table with examples of our some of our coding audit trail:

<table>
<thead>
<tr>
<th>CATEGORIZATION</th>
<th>PARTICIPANT PHASES</th>
<th>CODES</th>
<th>CATEGORIES</th>
<th>THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My role is to assist the community in preventing diseases … (BP011HPP)</td>
<td>Disease prevention</td>
<td>Role of HP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. We network with other institutions, NGO’s and stakeholders … (BP001SD)</td>
<td>Stakeholder engagement</td>
<td>Purpose of HP practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Health promotion goes around in schools and crèches … (AP015FM)</td>
<td>Schools</td>
<td>Settings for HP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. If there is a malaria outbreak, clinic stats show us that and we intervene…. (AP006SD)</td>
<td>Clinic stats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Aspects of what CHWs do is HP, they give health education …. (ND002)</td>
<td>CHWs vs. HPPs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Working as part of one team
HP, CHWs and the WBOT rPHC strategy

6. If there is something new we’ve learnt, my job is to train them (AP014HPP) Train/capacitate
7. When they encounter some challenges...we go and see what the problem is...(BP007HPP) Collaboration

Data analysis
17. I suggest you also state who did the primary coding and who was involved in the review of codes and categories. This also increases trustworthiness.

Line 347-348, we added who conducted the primary data analysis and who was primarily responsible for reviewing the codes and sub-categories: TR performed the primary data coding. NC was involved in the review of codes and sub-themes.

Results
18. The quotes are often hidden in the narrative and thus difficult to identify. I suggest, to use either " or italics, not both, and indent all quotes, like you have done for some of them. I would also suggest, to reduce the number of quotes.

We thank the reviewer for the comment. The re-resubmission manuscript uses italics to highlight the quote of participants. All inverted commas have been deleted from the draft manuscript. Results section, line 380-659, pages 17-30.

Quotes that illustrate the theme - roles of HP at PHC are not included in this paper to reduce the overall number of quotes.

19. I have noted that your sub-headings are not equal to the main categories. I think this is a consequence of not using the Lewis theory for analysis. I am not sure why you decided to report your results under different sub-headings. Like this, it is unclear what the role of the categories in your analysis is. Your results should reflect your analysis to make sure that, they are not your interpretations what can be found in the data. I suggest, to review your approach and report using the categories as sub-headings. I would suggest, to use the Lewis theory during the discussion. I am suggesting this also, because some of the quotes do not match the Lewis headings, e.g the quote in 404 - 410 rather belongs to stage II as well as the quote from 414 - 421.

We have decided to keep the Lewin’s headings to structure the findings, as they help to describe how events unfolded in terms of health promoters and the introduction of policy and the CHWs. As mentioned above Lewin was not used to develop the codebook, but was used to help arrange our findings in a meaningful way that tells a complete story of health promoters amid introduction of policy and WBOT rPHC strategy.

The role of the ‘categories’, particularly under Stage 1, Unfreezing the status quo – Results section, line 400-415, pages 19. These present the summaries of what participants viewed the role of HP and health promoters to be at local level. Without this description, it is impossible to
know what the role of health promoters is before we can describe the events that unfold after CHWs with similar roles to health promoters are introduced amid health system strengthening efforts.

- Line 1009, we have rephrased the title of the Table 3, which is now Table 4 to: ‘Summary of HP practice and general roles and responsibilities of health promoters at PHC level.

- Line 573-579 (previously Line 404-410); the quote illustrates how some HPPs are “not refreezing to their ‘new’ roles”. Nevertheless, continuing to do what they have always done before the formalization of CHWs. Therefore, working parallel with the new rPHC strategy of WBOTs.

- Line 583-591 (previously Line 414-421); the quote illustrates the challenges of CHWs face fully refreezing into their HP activities given that they are led by clinical staff, nurses and the implications of HP in rPHC.

20. I would like to suggest, to state the most important findings in the beginning. You have done this very well in the abstract. Then name the main categories again and elaborate on each category. You have done the latter in detail. I suggest you mention the findings that really inform your main findings and the hypothesis you state later. To me, the main finding is the way HPPs assigned meaning to their new role, despite the lack of guidelines. I think you should elaborate a bit more on that either under the category called purpose of HP practice or under HP roles and type of information used to prioritize HP activities. Pages 19 to 21 elaborate nicely on that with good quotes.

As mentioned above we have decided to retain Lewin’s framework to structure the findings, as it helps to describe the process of change, how change is not comfortable and how individuals interpret the change. This cannot omit how they feel about the introduced change and their adaptation to the new expectations. Without the fuller story that provide pieces to the jigsaw puzzle, a reader may find it difficult to contextualize the findings of the study.

21. I would suggest, to use a table for the demographic details of the participants and only shortly refer to it for readability and word count issues.

This is an insightful suggestion, and we have used a Table for the participants’ characteristics and deleted most of the paragraph, Results section, line 398-399, page 18.

- Line 398, we have added the Table illustrated as below:

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>CLASSIFICATION</th>
<th>FREQUENCY (N)</th>
<th>PROPORTION (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Female</td>
<td>32</td>
<td>78.1</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>9</td>
<td>22.0</td>
</tr>
<tr>
<td>Age in years</td>
<td>&lt;25</td>
<td>25-34</td>
<td>35-44</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
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<td>2.4</td>
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<table>
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<th>Race</th>
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<th>Indian</th>
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<tr>
<td></td>
<td>39</td>
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<tr>
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<td>95.1</td>
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<table>
<thead>
<tr>
<th>Highest level of education</th>
<th>Some secondary</th>
<th>High school</th>
<th>Certificate</th>
<th>Diploma</th>
<th>Bachelor degree</th>
<th>Post graduate</th>
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<td>36.6</td>
<td>22.0</td>
<td>19.5</td>
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<table>
<thead>
<tr>
<th>Job title</th>
<th>Health promoter</th>
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<th>HP coordinator</th>
<th>HP liaison officer</th>
<th>Facility manager</th>
<th>Other</th>
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<td>2</td>
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<td>7</td>
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<td>12.2</td>
<td>24.4</td>
<td>9.8</td>
<td>4.9</td>
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<th>Job location</th>
<th>National</th>
<th>Province</th>
<th>District</th>
<th>Sub-district</th>
<th>PHC/facility</th>
<th>Other</th>
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<td>9</td>
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<tr>
<td></td>
<td>14.7</td>
<td>4.9</td>
<td>7.3</td>
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<td>2.9</td>
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<table>
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<th>Years worked at current job location</th>
<th>≤4</th>
<th>5-6</th>
<th>6+</th>
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</tr>
<tr>
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<td>7.8</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years worked as current job title</th>
<th>≤4</th>
<th>5-6</th>
<th>6+</th>
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<tbody>
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Discussion
22. Your discussion is nice, there are only some minor editing issues. I would suggest, to use the word "findings" instead of "data", because your data are the transcripts only. But you have analyzed these, and the product of this analysis are your findings or results.

We agree, and have corrected the use of the word ‘data’ with that of ‘findings’ throughout our Discussion section. These changes are highlighted on the following sentences:

- Line 696
- Line 704
- Line 711

23. I suggest you emphasize more on the challenge of putting evidence into practice. There is a lot of literature on why guidelines are not implemented and you have added a very important part to the puzzle with your research.

Thank you for this comment, which we have rephrased and added in the Discussion section, line 692-694, page 32. It reads:

Research shows that policy and guidelines are not always adequately implemented (7-9). This study adds an important piece to the puzzle, by highlighting the challenges faced by front line workers in implementing guidelines that provide insufficient ‘guidance’.

24. 529: I suggest, to use fill instead of fulfill.

Line 712, page 33, we have deleted the word ‘fulfil’ and inserted the word ‘fill’.

25. 532-533: The relationship between HP activities and the duties of facility managers and WBOT leaders is not clear. I would suggest, to use another term than "suffer" which is rather colloquial. Instead, I suggest you explain, how HP activities "suffer".

Line 715-717, page 33; we deleted the word ‘suffer’ and rephrased the sentence as follows:

Our findings suggest CHWs’ HP activities fall by the wayside. Given that, facility managers and WBOT leaders who oversee them have primarily clinical-oriented duties. They are more likely to neglect the non-curative aspects of CHWs in rPHC.

26. 538-541: Why is it relevant under which directorate HP is covered. Please explain, power of practices in implementation sounds really interesting, but you do not give further detail on what this is and how the directorate influences this.
Evidence from one of the other papers from the broader research project shows that HP implementation within the RSA DoH is hindered by a curative-focused health system, which constrains the HP agenda.

Line 726-727, we added a new sentence that describe power over implementation. It reads:

Power dynamics influence change implementation (10). Those directorates with power over resources, for example the HIV Directorate, are more likely to be heard and respected.

27. 545: I suggest, to replace "although" with "in contrast" for the flow.

Line 696, we deleted the word ‘although’ and replaced it with ‘In contrast’

28. 546 I suggest "This different interpretation of a vacuum left by national guidelines…"

Line 732-733, we deleted the words ‘These differential outcomes from’, and replaced them with the words suggested by the reviewer ‘This different interpretation of a vacuum’

29. 547-549: I suggest, to move this statement further up in your discussion, since this is relevant for the rationale of your research.

Line 734-735, we cut the sentence that read: ‘No previous local or regional research could be found that have examined HP or its human resources relative to a PHC reform’ and pasted on line 683-684.

30. 560-561: This phrase is not clear. Who are they and is this at global or RSA level?

Line 746, we deleted the word ‘they’ and replaced in with the words ‘in Mexico…’

Limitations
31. In general, qualitative research is more about transferability than on generalizability, because the methodology doesn't allow this inference. You have conducted 41 interviews, which is a good number, so I would think, that your findings and conclusions can be transferred to other settings provided you give enough information on how you came to them. One limitation I see however, is that you did not conduct focus group discussions. I think that would have been the most obvious choice of method. I concur with you on the limitations regarding the inclusion of CHWs and WBOT leaders and on the observation, which would also have added triangulation to your findings from the interviews.

This an insightful suggestion and we have rephrased the limitation section using the reviewers’ words, line 753-759. It now reads:

There are several limitations to this study. Firstly, the research was conducted in two out of nine provinces. However, with 41 in-depth interviews, our findings and conclusions are transferrable to other parts of South Africa. Secondly, no CHWs/WBOT leaders were interviewed although; facility managers represent a neutral non-HP voice in the study. Lastly, we did not conduct focus
group discussion and observations of HPP’s work at facility or community level, to validate information given and to enable added triangulation of findings.

Closing remarks

32. These suggestions may look like a lot of work, but if you look at the two EQUATOR documents you will find that it can be done. You have done a very nice research and it is worth to be published in a way that makes it as relevant to the readers that it deserves.

We would really like to thank the reviewer again for her very constructive feedback and comments that have assisted in strengthening our paper.

Reviewer #2

General comments

1. The article "Implementing without guidelines: Learning at the coalface A case study of health promoters in an era of community health workers in South Africa" presents the results of a qualitative study that examined the context of changing the approach to health promotion in PHC in South Africa, from the case study of the implementation of Community Health Workers in the context in two provinces of the country. The most important thing is that this type of study provides qualitative evidence of high value for understanding barriers, facilitators and other crucial aspects for the implementation of health programs and policies in contexts of evolution and the search for the consolidation of health systems that intend to strengthen the PHC role, given the factors related to the social determination of health, especially in low- and middle-income countries. The study shares information and insights that can help other health systems to reflect on their challenges and learn from the experience studied to consider this qualitative evidence in their decision-making processes. Although the contexts are different, the phenomena can always maintain verisimilitude, once their different constitutive elements are shared to some extent. Thus, the study presents, in my view, relevance and good general methodological quality.

We would like to thank the reviewer for his comments, and opinion that the study is relevant, amid the global PHC revitalization movement. We really appreciate how he has summarized the aims of the paper and its finding above, elements of which fit in the broader research goal, which we had not thought of. We will therefore integrate his summary and ideas in the boarder research report and presentations of this work. All the reviewers’ suggested comments have been addressed as described below:

2. This article is a resubmission resulting from a first round of review, in which I did not participate, so I can assume that this version has been improved, which facilitated my work of reading and reviewing, while it was possible to identify that the article reached a good level quality, as already mentioned.
We thank the reviewer for this feedback. The re-submission was not after peer-assessment. It addressed comments from the Editors, required from the authors before the manuscript could be sent out for peer-review.

3. However, specifically regarding the need to clarify the methodological aspects of the study, I confess that I missed more details about the data analysis process, especially in the subsection "Data analysis" in which the authors present information about the technical procedures of the analysis (software, aggregation techniques, etc.), but do not mention whether there is an interpretive / descriptive theory / approach behind the results presented. In fact, as this is a primary qualitative study, I think it is even more important to make the research as transparent as possible, including to increase confidence in the results presented.

Please see responses to item 15-17 in response to the first reviewer’s comments.

4. So, I think it's important to clarify about the qualitative approach (eg ethnography, grounded theory, case study, phenomenology, narrative research, other) and guiding theory, as well as identifying the research paradigm (eg postpositivist, constructivist / interpretivist), if possible.

We have added a new paragraph under the Methods section, line 191-200, pages 8-9. The new sub-section reads as follows:

Content analysis approach was used to underpin the study. The study was conducted from a relativist perspective, using the social constructivism theory to guide understand a social reality. The paper presents findings of a qualitative study that examined the context of changing the approach to HP in PHC in South Africa, from the case study of the implementation of CHWs. Interpretivists believe that reality can only be understood through people’s subjective lens and interpretation of lived experiences (11). We assumed that there are multiple perspectives of health promoters roles of at PHC level (12). Thus, we recruited participants using a whole system view (national to facility-level). The research feeds on health promoters and managers’ (HP and facility) beliefs, values, reasons and how they provide meaning to the role of HPPs in rPHC (11, 12).

Other minor issues

1) Apparently, Table 2 is inserted in a different call than what was indicated in the text (line 265);

Table 5 (previously Table 2) is larger than A4 size and had to be placed at the end of the manuscript as per submission guidelines of BMC. The table summarizes the general roles and responsibilities of health promoters at PHC level as described by the study participants in their text phases. These views were analyzed and summarized in a table format vs. presenting the quotes, as they were not the major aim of this paper. However, provided context for what the roles of health promoters are.
We acknowledge that this may have been a bit confusing. For clarity, we have deleted the words ‘(see Table 2)’. Results section, line 411-413, page 19. We have added a new sentence that reads: Table 5 summarizes the roles and responsibilities of health promoters at PHC level.

All Tables in the manuscript have been re-numbered.

2) The Figure 1 has ‘poor’ quality / graphic definition, I think it could be improved;

We agree and have deleted the previous version of Figure 1; and replaced it with a new redesigned one, attached below. Background section, line 160, page 7 (Figure 1 is supplied separate to the manuscript).

Figure 1: Lewin’s three-step change model, Adapted (13)

3) The STROBE check-list for observational studies is perhaps not the most suitable for reporting qualitative studies, I suggest considering COREQ (https://www.equator-network.org/reporting-guidelines/coreq/) for verification and inclusion as supplementary material (for authors' consideration).

We thank the reviewer for this great suggestion. We agree and have added a completed version of the COREQ checklist as supplementary material to the re-submission indicating on which page number each item is found on our manuscript.

References

7. Sakyi DEK. A retrospective content analysis of studies on factors constraining the implementation of health sector reform in Ghana. The International journal of health planning and management. 2008;23(3):259-85.
9. Erasmus E, Orgill M, Schneider H, Gilson L. Mapping the existing body of health policy implementation research in lower income settings: what is covered and what are the gaps? Health policy and planning. 2014;29(suppl_3):iii35-iii50.