Author's response to reviews

Title: The last one heard: The importance of an early stage participatory evaluation for programme implementation

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Author's response to reviews: see over
Dear Sir or Madam:

Please find enclosed our revisions to our submitted manuscript for your continued consideration.

In response to the report of reviewer Joanna Reynolds we have made the following changes:

MAJOR COMPULSORY REVISIONS:

• We moved our paragraph describing the problem to be researched in the context of the Paris Declaration to the opening paragraph. This first paragraph now reads:

  Despite the Paris Declaration on Aid Effectiveness’ recommendations to monitor and evaluate the implementation process, the systematic involvement of project beneficiaries remains low and limited, especially during the formative stages of a project cycle [32, 37]. An overemphasis on measuring clinical outcomes, most of which are aligned to the indicators outlined in the Millennium Development Goals (MDGs), has led to the neglect of other important factors. Namely, the key characteristics and processes through which effective outcomes are achieved, and the opinions of the end-users with regard to how effective they perceive the intervention to be [31].

• We would like to thank the reviewer for raising this. We have reversed the order of the “factors contributing to the low uptake of health practices” to first discuss the lack of community engagement, followed by the dearth of health workers. We have also changed the language of the paragraph to highlight that we are concerned with the uptake of behaviour change practices (which links to levels of engagement), rather than health interventions per se (which as the reviewer rightly points out, might be more to do with strengthening health systems as a whole). To clarify, what is meant by low-coverage is more the “low-uptake” of simple and inexpensive (if not free) behaviour modifications. In addition to substituting low-coverage with low-uptake, we have also clarified the types of health behaviours we are referring to. Lastly, in regards to the reviewer’s comment on the term ‘accountability’ we have attempted to clarify this adding the term ‘ownership’. We take in the reviewer’s point that this is a highly contended argument in the literature however, we feel that presenting both sides of this argument is beyond the scope of this paper. We have therefore acknowledged that this debate exists by adding the words, “some argue” and have incorporated more on this debate in our discussion section.
• We have clarified that for the purpose of this research we use the terms participation and engagement synonymously. As for the clarification of “health behaviours” please see aforementioned section.

• We agree that there are debates on the importance of community participation in health programmes, but feel that delving too much into these is beyond the scope of this paper and does not fit within the Programme Principles and the principles of Alma-Ata, to which we align our notions of best practice. We have changed our wording to better reflect this issue however, and the sentence now reads as:
  
  Though several challenges for its practice exist (Cited Rafkin 2009), community participation is often recognised as best practice in health programmes and has been linked to increasing ownership and quality of services, which can subsequently impact on the success of activities [28-30].

• We have more clearly defined “users” and “non-users” under our Study Participants section by adding the following:

  Women were considered “users” of 7-11 if they had been visited at least once by a trained CHW. Contrastingly, a “non-user” was defined as a woman who had not been visited by a CHW trained as part of the 7-11 strategy despite living in the programme target areas.

Given that this study was conducted at an early stage, dropouts had not been reported to date.

• We removed the term “reduce researcher influence”.

• This was an oversight on our part and we appreciate the reviewer pointing out that the top-down approaches used in our data analysis were in fact deductive.

• After reading the reviewer’s comments we came to the realisation that the heading given to this section was rather ambiguous. This section was intended to refer more to the lack of understanding on the roles and responsibilities of the community health workers, rather than knowledge and awareness of the programme itself. We have amended the heading of this paragraph to read, “Lack of understanding of the roles and responsibilities of the CHWs among participants”. Moreover, we have elaborated on the misunderstandings both users and non-users had regarding the roles and responsibilities of the CHWs active as part of AIM-Health:

  Both users and non-users were familiar with the AIM-Health programme active in their communities and due to the high visibility of this programme, came to expect that CHWs would visit the households of pregnant women. However, participants frequently had misinformation, or a lack of information, on the roles and responsibilities of the CHWs. This included misunderstanding that the CHWs were acting as volunteers and that they receive no financial compensation for their work; the expectation that CHWs could dispense medication as part of their remit; and for non-users, where to report a non-active CHW in their community. The research team was frequently asked to explain the role of CHWs, and the programme itself.

Lastly, we clarified how both users and non-users were made aware of the programme itself.

• Thank you for this and we have added to the first paragraph of the Discussion to show what our results add. We have included that changes to the programme were made based on our findings, as well we have added an additional sub-heading...
‘Implementation implications’ at the end of the Discussion to better demonstrate this.

- We find this comment very helpful and agree with your observations. We have expanded the Discussion (please see first two paragraphs) to bring in more literature on evaluations and to demonstrate what our findings add to this. We have also addressed the issue of timing regarding evaluations.

- We have attempted to address this issue further, but feel that going much deeper into the issues around ownership and sustainability does not contribute more to the focus of the paper which is why such evaluations are important to conduct.

- A paragraph on our study’s limitations was added to our discussion section.

MINOR ESSENTIAL REVISIONS

- We have made changes to both the Abstract and Background sentences around the involvement of project beneficiaries.
- The sentence which read, “Understanding the components and processes...” now reads:
  Exploring the factors that contribute to the success and/or failure of community members, such as CHWs, engaging in MCH programmes provides an important opportunity for shared learning on what policies and implementation strategies are most effective in the improvement of MCH outcomes at community level.

- The sentence which read, “Moreover, it is anticipated” was changed to:
  Moreover, the implication is that findings can potentially contribute to inform programme implementation for health care policy and decision makers from an early stage so that appropriate, timely changes can be made.

- The language used in interview as well as any note-taking and translation processes were described in our original manuscript. However, we expanded these sections in more detail in the enclosed revised version.

- We have added a second table to describe the distribution of participants across IDIs and FGDs. This can now be found in Table 1. Moreover, the attribution of quotations now specifies which participants were users and which were non-users.

- The 7-11 component of the intervention was further described and can now be found under the “7-11 Timed and Targeted Counseling” heading of the Background.

DISCRETIONARY REVISIONS

- The second quotations in the Results Section (i.e. the implications of problems faced when people don’t have access to CHWs and the impact CHWs can have here) are further elaborated on in the Discussion section.

- We expanded the term “pride” to “pride in health knowledge” to make the theme more specific, however we chose to keep “pride” as that is what the women were displaying when discussing their knowledge.

- We have reflected upon the choice of words by women, ‘doctors’, in the Discussion section. The first paragraph under the subheading Programme challenges, now reads:
  The choice of words that many women used to describe the CHWs such as ‘doctors’ may signify several things, including the trust in the CHWs’ abilities and also, more worryingly, a level of power or authority. Further investigation into whether this term was intended to...
ascribe faith in CHWs, or was developed out of systems of hierarchy and power, and how this may impact relationships, could further compliment this work.

- There were no obvious differences between those who participated in focus groups and in-depth interviews, though we do agree that this would be interesting to explore in such a case.

**In response to the report of reviewer Laura Nichols we have made the following changes:**

**COMPULSORY REVISIONS**

- We appreciate your comments on this and have added additional information on the methodology, specifically relating to participant identification and selection. Women were able to choose if they wanted to participate in either FGD or IDI, depending on which method they felt most comfortable with. As information and invitation letters were given out 7 days prior to actual data collection, women were told a specific time to meet, (either 10am for FGD or 2pm for IDI), as well they were asked upon arrival at site which they preferred. Any pregnant or breastfeeding woman in the study area was eligible, and they were accessed through gatekeepers within the district and self-identified as pregnant and/or breastfeeding. They were also asked their age upon commencing data collection. Please see both the ‘Data collection’ and ‘Study participants’ sub-headings under the Methodology for further clarification.

- Yes, we agree that the relationship with health workers is very important so were quite interested and happy with the findings that women were reporting such strong positive relationships. However, unfortunately as it is with many programmes there does not seem to be enough resources to have many ‘safety checks’ for CHWs. As the CHWs were all from the MoH, and then further trained on the World Vision Programme, there is a designated employee within the MoH for monitoring CHWs; however, that includes thousands of CHWs within the district. That point alone is an argument for more early phase evaluation studies, such as this one, as we identified an area with inactive CHWs. We have also expanded upon this in the ‘Findings’ section, and how both WV and the MoH were alerted to this issue.

- Thank you for this observation, and we have expanded the discussion section to bring in more evaluation theory, linking it to our findings in the paper. Please see the first two paragraphs of the ‘Discussion’ for changes. As well, we have modified the background to include more information on the AIM-Health programme itself, which we hope now better links with the discussion.

**ESSENTIAL REVISIONS**

- Thank you for recognizing this and we agree that it is important to feedback how this research has impacted implementation. We have integrated this throughout the paper more and also added an additional section in the ‘Discussion’ titled ‘Implementation implications’. There are several main ways in which this happened: report dissemination to 9 other project contexts that were not as advanced in the project phase, so that implementers were aware the challenges in this particular context; MoH and World Vision targeting areas with inactive CHWs and for further
training, and then if needed re-selection of CHWs; spousal involvement in both counseling sessions and health centre visits have been expanded upon and feedback from WV staff is that involvement has continually increased; and barriers that were identified throughout the interviews were targeted for programme expansion including the planning of motorcycle ambulances for women, supply of essential materials in hospitals and increased focus on nutrition interventions.

We hope that we have sufficiently addressed the concerns of the reviewers and would once again like to thank the reviewers for their helpful comments and suggestions. We strongly believe this manuscript was enhanced and strengthened as a result of their feedback. Should you have any questions regarding our submission or require any additional information please do no hesitate to contact me.

Thanking you in advance for your continued consideration,

[Signature]

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