

## **Author's response to reviews**

**Title:** Documenting the experiences of health workers expected to implement guidelines during an intervention study in Kenyan hospitals.

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**Version:** 3 **Date:** 19 March 2009

**Author's response to reviews:** see over

## **Manuscript: Documenting the experiences of health workers expected to implement guidelines during an intervention study in Kenyan hospitals.**

**Authors:** Jacinta Nzinga, Patrick Mbindyo, Lairumbi Mbaabu, Ann Wairira, Mike English

### **Editorial Review**

Basically, the main issue is the framework you used to inform your interviews and frame the findings. In the introduction, you start off with the Theory of Planned Behaviour (TPB, a perfectly rational place to start) but then leap onto saying that use this theory 'with other insights from the literature.' I then moved on to the Methods section to see just how you integrated TPB with other theories under 'tools for data collection' but could not find any explicit pathway describing why and how you selected theories/frameworks, identified their key constructs and dealt with duplicating constructs, etc. For an example of how this might be done (albeit with probably more time, resources and psychologists you had at your disposal), take a look at the Michie paper you cite. The resulting framework is, I found, confusing and makes it hard both to form a coherent picture of the barriers to guideline implementation and to allow a rational basis for selecting / tailoring the interventions. For example, there is conceptually a big overlap between 'negative attitudes and beliefs', 'low outcome expectancy' and 'reluctance to accept new practices'. 'Motivation' is included as a construct, without any clear reference to how it fits into the pathway within TPB (i.e. resulting from attitude, social norm and perceived behavioural control). Figure 1 misrepresents TPB - this theory applies to individuals and has been applied to teams - but it is wrong to say that each of the three key constructs that determine motivation operate on different levels (individual, social and organisational). 'Inertia of previous practice' crops up as a sub-heading in this section, which I presume refers to 'reluctance to accept new practices' but makes me suspect that this framework was made up on the hoof. These and other constructs appear poorly defined, if at all, e.g. I was uncertain whether 'incompatible healthcare worker norms' referred to incompatibility of social norms with guideline recommendations or incompatibility between the healthcare workers.

**[Authors]** – *We are grateful for the expert advice from the editors and in particular for identifying for us the Ferlie 2001 paper that we found helpful and that clearly resonated with the work we are attempting to describe. In response we have tried to make it clear now that our aims were largely descriptive and based on a broad consideration of how we were attempting to change clinical practice through the intervention. This is definitely the focus of the piece rather than any attempt to inform or reframe theory. We have also re-labelled the results headings and hope that they provide greater clarity. In all this has been an extremely extensive revision.*

The discussion also seemed poorly structured, starting with an account of the methods rather than summary of key findings and integration into existing knowledge. There is no critical account of the methods, and it is unclear how the findings should guide guideline implementation.

**[Authors]** – *As a result of a major re-think and revision of this paper the discussion has been completely restructured. We hope the editor's concerns have been addressed.*

I'm sorry to be so negative about this paper. Despite what the reviewer has said, I found it conceptually flawed and unclear.

In trying to think through a way forward, I am not going to reject it outright. You might want to take a second run at it and, for example, explicitly and retrospectively apply something like the Michie framework (explaining that you did this retrospectively). You could even consider applying the Ferlie and Shortell multi-level framework I referred to when providing feedback to an accompanying paper. If you substantially revised this paper, I'd try to ensure that it went to a second reviewer with an interest in behavioural frameworks. However, I could give no guarantee that it would be favourably received. The other option would be for you to withdraw this paper.

**[Authors]** – *We hope the revisions are an improvement and provide a way forward for this paper.*

## **Reviewer #1**

Thanks for letting me read this interesting report of new work in an under-researched area. The paper, in my view, is on the long side - a frequent issue in qualitative work. With some more work this paper will make a very useful addition to the literature in this field.

**[Authors]** – *In response to the major revisions suggested by the editors the manuscript has changed considerably. Below we indicate that in undertaking this rewrite we have also taken account of the reviewer's comments. However, as the changes to the manuscript were so extensive we have not reproduced the text illustrating the changes in our response below.*

### **Major revisions**

- I personally think "barriers" to behaviour change is a major issue - I would like to be helped where they are in the conceptual frameworks used in Figs 1 and 2 (e.g. common ones lack of drugs, equipment, etc, or did that not apply?)

**[Authors]** – *Due to the extensive revisions we have now removed Figs 1 & 2.*

- I would like to know which qualitative method was used for data analysis - e.g. content analysis (manifest?, latent?), grounded theory etc? Also what was the relation between the authors with regard to coding - who did what? how were differences reconciled?

**[Authors]** – *We have carefully described the approach to analysis which would be classified as a form of content analysis*

- at times I am not clear on what was stated, observed, and interpreted, respectively. Similarly at times it is not clear what is a result and what is an element of discussion - they now appear mixed in the results section

**[Authors]** – *Throughout we have tried to make it clear now where observations have contributed to our results and interpretation*

- I think the previous point could be helped by putting the relevant quote just after the paragraph it refers to - at times there are now several paragraphs in one results subsection but the often many quotes are all at the end of the section

**[Authors]** – *We have reformatted to follow this suggestion*

- I would like to ask for more correspondence between the conclusions in the abstract and at end of article

**[Authors]** – *The abstract and in particular the conclusion has been revised*

**Minor revisions**

- "developing countries" is a term that includes both Somalia and Singapore. I recommend using terms like Low income countries vs High-income countries (instead of "developed" countries)

**[Authors]** – *We have attempted to use the terms low and high income countries throughout*

- there are some improvements to be made in English here and there and in getting details right in Referencing (e.g. No 1, 10 and 23 etc)

**[Authors]** – *Corrections have been made to the English*

- Some of the barrier names do not conform with the subheadings, which makes my life as a reader unnecessarily hard...

**[Authors]** – *The sub-headings have been altered for clarity*