PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	EMPOWERING HEALTHCARE PROVIDERS THROUGH SMOKING CESSATION TRAINING IN MALAYSIA: A PRE- AND POST-INTERVENTION EVALUATION ON THE IMPROVEMENT OF KNOWLEDGE, ATTITUDE & SELF-EFFICACY.
AUTHORS	Hasan, Siti Idayu; Mohd Hairi, Farizah; Ahmad Tajuddin, Amani @ Natasha; Amer Nordin, Amer Siddiq

VERSION 1 – REVIEW

REVIEWER	Meagan Graydon VA Maryland Health Care System, USA
REVIEW RETURNED	22-Apr-2019

GENERAL COMMENTS	This manuscript describes the results of pre-/post-evaluation of a full-day training for healthcare providers on smoking cessation. A previously validated measure ProSCiTE was modified and used to measure providers' knowledge, attitudes, and self-efficacy regarding smoking cessation. Participants were all healthcare providers from three government clinics. Although this is an important topic it is already well studied in the current smoking cessation literature. The authors fail to make a compelling argument as to how their current study adds to the existing literature. Additionally, there are several other conceptual omissions in their introduction/rationale and their discussion is poorly written and often overstates the results. I have outlined a number of areas that should be addressed in the revision. • Throughout this article there are extensive examples of missing words or inaccurate grammar. Careful attention should be paid to this during revisions. Although this is not an exhaustive list of the errors in the paper, some examples requiring corrections are listed below: o Page 3, line 10 remove word "about" and on line 12 add "a" between "have" and "lack" o Page 3, line 29 remove "on" o Page 4, line 18 "the annual death could rise"—a word is missing here. The annual death rate or the annual death toll. Please correct. o Page 4, line 41 "tackle serious health problem"—is this a singular health problem? If so, add "the", if not pluralize "problem" o Page 4, line 43 should be corrected to "to be actively involved" o Page 4, line 49 missing "and" after 5As o Page 4, line 53 should either be "not much evidence" or "not many studies" o Page 5, line 12 missing a word, perhaps "provide" in regards to "appropriate counseling…" o Page 5, line 31 "a meta-analysis" or "meta-analyses"

	o Page 6, line 21 capitalize “r” in research o Page 8, line 13 remove “on” o Page 8, line 45 remove “conducted” o Page 13, line 31 “improved” should be “improvements” o Page 13, last sentence starting on line 34 should start with “This study suggests” or “These results suggest” o Page 13, line 50 “attitude” should be plural o Page 14, line 24 “parent” should be “patient” o Page 14, line 38 remove “in” o Page 16, line 16 “they” should be “the “ Abstract: • The abstract provides a succinct and clear overview of the current problem, study, and results. • It would be useful for the reader if the acronyms (e.g., SCOPE) were first spelled out here in the abstract. Introduction: While the authors have outlined relevant pieces for establishing a rationale for the current project, the introduction is lacking depth and details regarding the current research. The arguments made by the authors are vague and would benefit from providing additional details from the referenced studies. Additionally, the proposed study measures changes in knowledge, attitudes, and self-efficacy but these constructs are not discussed in the introduction. The authors fail to provide a rationale for measuring these constructs and how they relate to providing smoking cessation interventions and smoking cessation patient outcomes. Finally, the authors include smoking status in the analyses and discussion but do not provide rationale for this in the introduction. In addition to addressing these broad issues, several specific recommendations are outlined below. • Given the article is referring to healthcare providers, it would be important to establish very early in the introduction what population this prefers to. Is this only doctors or does it include other disciplines as well. Based on this information, it would be important to specify the specific providers included in the research studies that are referenced. Also it would be helpful to clarify for the reader why this is an important population of interest. • In the introduction the authors introduce the clinical practice guidelines but do not sufficiently explain current landscape of application of the 5As by healthcare providers. They indicate that providers reported performance of the first 2As, but fail to explain how often this is done and by which providers. Further, what are the outcomes associated with this intervention? Finally, what are the barriers to implementation of the remaining steps and why are they important? • Please provide a reference regarding the chronically relapsing nature of nicotine dependence as referenced in the first paragraph on page 5. • Page 5, line 16, if available please provided information (e.g. percentage) regarding the frequency that doctors informed patients about the harmful effect of smoking. • Page 5, line 17, what training do providers lack? What is this based on? • Page 5, line 35, please provide further information regarding the trainings references and the “tasks required to help their patients” • Page 5, line 42, please clarify what Article 14 of the WHO Framework is. Also, when using an acronym for the first time, spell out (i.e. World Health Organization).

	• Page 5, line 57, please spell out UMCAS as it is the first time it is referenced in the article text. • In regards to the aim of the study, please outline any pre-specified hypotheses. Methods • The section on Development of SCOPE training is fairly cumbersome to follow. Please review this paragraph in regards to content and flow. Consider shortening this paragraph and more succinctly describing the development and content of training. • In the study participants paragraph, please provide sample size numbers for each type of provider included in this study. • It would be helpful to also know how participants were recruited for this research study and whether participation was voluntary or mandatory. • Please provided further clarification regarding how the evaluation tool, ProSCiTE was modified for the purpose of this study. Also please explain how this might impact the reliability and validity of this instrument. • It would be useful if a sample item for each domain of the ProSCiTE were included. • Provide additional information on how this measure was scored (e.g., total score, individual item scores) to facilitate interpretation of results related to this measure. Results • The data provided in the healthcare providers section is confusing. If there are different training requirements for healthcare providers in Malaysia, then this should be explained. For example, the authors said that nearly half of the providers were doctors but that half of the sample had bachelor's degrees. Wouldn't we expect that given the sample, that nearly half of the sample would have doctorate degrees (which are not currently included in Table 1)? • In Table 1, please clarify what diploma mean. Also, indicate the reason for the asterisk for smoking status. • In general, the findings from the statistical analyses could be streamlined. For example, individual scores do not need to be repeated. Instead tables can be referenced. Additionally, consider including the test statistic in the sentence when describe the results, rather than in a separate sentence. • Review BMA format of reporting test statistics and table formatting. • Clarify that the first statistic (t= 15.31) is in reference to the total knowledge score. • Table 2 and 3, make formatting (e.g., numbers for variables, capitalizing first letter) consistent in the entire table. • Page 11, lines 3 and 4 remove "client." Authors have consistently used "patient" throughout article. It is important to use consistent. Please review the article for additional instances and correct to patient. • Tables 3 and 4, instead of including each item verbatim, it would make the tables more reader friendly if the items were shorten to only include the main content in each item (e.g. Table 4 Item 1 "Know questions to ask"). • Given the available data on smoking status for the healthcare providers, it would have useful to analyze the relationship between this characteristic and ratings on knowledge, attitudes, and self-efficacy, as previous research has demonstrated such relationships.

	• Also, I am curious how data might vary by provider type. Are some providers more or less knowledgeable or confident or have different attitudes based on training? Discussion • Page 13, line 16 “can result in significant integration of 5A’s,” this is a significant overstatement of the results. The researchers only included pre-post data on knowledge, attitudes, and self-efficacy. This study did not include any assessment of behaviors or follow-up assessments, therefore conclusions cannot be drawn regarding implementation. Care should be taken to not overstate the implications of a pre-post study. • Page 13, line 30 “health care” should be changed to “healthcare” to be consistent with language used in the rest of the article. • Page 13, last line in second paragraph—the only conclusion that can be drawn from these results is that healthcare providers have improved knowledge. The authors did not provide any research that outlines what is “good” versus “bad” knowledge related to smoking cessation. • Page 13, line 50—sentence starting with “In terms of attitude” is confusing. Please rewrite to improve clarity. • Page 14, middle paragraph—this paragraph should be split up as it addresses both attitudes and skill/confidence and then talks about attitudes again. Use separate paragraphs to discuss findings related to attitudes and confidence. Additionally, in regards to confidence results, this does not equate skill. The authors did not include any results that assessed the providers’ skills (e.g., behaviors) and therefore cannot make implications related to skill. • Page 14, line 21, the authors cannot state their research supports the importance of identifying and advising patients, as they did not explore the impact of attitudes on outcomes. That is, do we even know that these attitudes influence behaviors? • Page 14, sentence starting with However on line 23. Move this sentence to the separate limitations paragraph. • Page 14, line 56 remove “huge”, this is again an overstatement. • Page 16, line 13—I don’t believe analyzed is the appropriate word here. Are the authors referring to interpretation? They did not explain that they handled analyses different because it was self-report data. But perhaps the readers may want to limit interpretation because it is self-report. Also, if saying providers tend to over-report then this needs to be accompanied by a reference to support such a claim. However, if over-reporting is simply a possibility then use the word “may”. • Although the authors begin a discussion of implementation and systems-level factors, this needs significant clarification and expansion. Also, discuss the future directions of this current research as it relates to this. • There are several other limitations of the present study. Authors should discuss the limitations of using pre-/post-data without any follow-up data, no data on behaviors, implementation of interventions, or smoking cessation outcomes. Additionally, given the heterogeneity of healthcare provider type, the authors should explain the implications of this as it relates to their findings and generalizability. References • Review all references for BMA format as numerous errors were identified.

REVIEWER	Maxwell Akanbi Associate Professor of Medicine, College of Medicine, University of Jos, Nigeria Ph.D. Candidate Health Sciences Integrated Ph.D. Program Center for Education in Health Sciences Feinberg School of Medicine Northwestern University, Chicago, IL, USA
REVIEW RETURNED	15-May-2019

GENERAL COMMENTS	Your manuscript titled 'EMPOWERING HEALTHCARE PROVIDERS THROUGH SMOKING CESSATION TRAINING: IMPACT ON KNOWLEDGE, ATTITUDE & SELF-EFFICACY' evaluated the impact of an 8-hour smoking cessation training on knowledge, attitude and self-efficacy among health providers in Malaysia. As you rightly noted, tobacco use remains a major cause of preventable death, and identifying effective interventions to help smokers quit is an important part of the global tobacco control package. Your work contributes to this very important goal. My comments on your manuscript are outlined below: Major comment(s): 1. The assessment of the efficacy of your training was done using a tool called 'ProSCiTE'. I could not access any of the references provided for the tool. Since this is a core part of the paper, it will be helpful if the questionnaire is provided as a supplement. Minor Comment(s) Abstract: 1. A new acronym that was not previously written in full was introduced (SCOPE) 2. Line 25: It appears there is an error in the result presented for the change observed in attitude. Introduction: 1. Information on current smoking prevalence in Malaysia will help readers better understand the need for the smoking target presented (Page 5, Line 51). 2. Page 5, Line 57: 'UMCAS' needs to be written in full since this is the first time it is appearing in the manuscript. Methods: 1. More information concerning the questionnaire is needed. Specifically the number of questions in each domain, the weight assigned to each of the questions and how each section was analyzed 2. Since there are no peer-reviewed publications on ProSCiTE, this is a good opportunity to inform readers/ researchers about how and why ProSCiTE was developed. Results: 1. Table 2: Readers need more information to understand what variables are being used to assess knowledge. Also, some items in Table 2 were numbered, while others were not. 2. All table titles need to be self-explanatory. Discussion: 1. Limitations: While you provided a number of limitations, some important limitations may still exist. An important limitation of an immediate post-training survey is our inability to predict how much of the information will be retained over time. More importantly, the ultimate goal is that trainees utilize the knowledge and skills acquired during the training to assist smokers to quit. It will be helpful if these issues are addressed.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Reviewer's name: Meagan Graydon

Comments	Authors' response
Throughout this article there are extensive examples of missing words or inaccurate grammar. Careful attention should be paid to this during revisions. Although this is not an exhaustive list of the errors in the paper, some examples requiring corrections are listed below: o Page 3, line 10 remove word "about" and on line 12 add "a" between "have" and "lack" o Page 3, line 29 remove "on" o Page 4, line 18 "the annual death could rise"—a word is missing here. The annual death rate or the annual death toll. Please correct.	The missing words and grammar has been revised accordingly throughout the revised manuscript as highlighted.
Comments	Authors' response
o Page 4, line 41 "tackle serious health problem"—is this a singular health problem? If so, add "the", if not pluralize "problem" o Page 4, line 43 should be corrected to "to be actively involved" o Page 4, line 49 missing "and" after 5As o Page 4, line 53 should either be "not much evidence" or "not many studies" o Page 5, line 12 missing a word, perhaps "provide" in regards to "appropriate counseling…" o Page 5, line 31 "a meta-analysis" or "meta-analyses" o Page 6, line 21 capitalize "r" in research o Page 8, line 13 remove "on" o Page 8, line 45 remove "conducted" o Page 13, line 31 "improved" should be "improvements" o Page 13, last sentence starting on line 34 should start with "This study suggests" or "These results suggest" o Page 13, line 50 "attitude" should be plural o Page 14, line 24 "parent" should be "patient" o Page 14, line 38 remove "in"	

o Page 16, line 16 “they” should be “the “	
Abstract: • The abstract provides a succinct and clear overview of the current problem, study, and results. • It would be useful for the reader if the acronyms (e.g., SCOPE) were first spelled out here in the abstract.	The acronym has been written in full before introducing its abbreviated term. ‘Smoking Cessation Organizing, Planning and Execution’ training or abbreviated as SCOPE training.
Introduction: While the authors have outlined relevant pieces for establishing a rationale for the current project, the introduction is lacking depth and details regarding the current research. The arguments made by the authors are vague and would benefit from providing additional details from the referenced studies. Additionally, the proposed study measures changes in knowledge, attitudes, and self-efficacy but these constructs are not discussed in the introduction. The authors fail to provide a	

rationale for measuring these constructs and how they relate to providing smoking	
Comments	Authors' response
cessation interventions and smoking cessation patient outcomes. Finally, the authors include smoking status in the analyses and discussion but do not provide rationale for this in the introduction. In addition to addressing these broad issues, several specific recommendations are outlined below. • Given the article is referring to healthcare providers, it would be important to establish very early in the introduction what population this prefers to. Is this only doctors or does it include other disciplines as well. Based on this information, it would be important to specify the specific	Since majority of the primary care providers play an important role as front liners in promoting smoking cessation and offering support to tobacco users, the SCOPE module has been designed for different disciplines of healthcare providers (e.g., doctors, dentists, pharmacists, nurses, medical assistants) to increase knowledge and best practices in smoking cessation in Malaysia.[38] Evidence suggest that, intervention delivered by any single type of healthcare providers (e.g., doctors, dentists, nurses, psychologists) or multiple healthcare providers improve abstinence rate compared with no intervention without healthcare providers (e.g., self-help).[11] Higher cessation rate will be achieved with more intensive and frequent contacts with healthcare providers.[4]

In the introduction the authors introduce the clinical practice guidelines but do not sufficiently explain current landscape of application of the 5As by healthcare providers. They indicate that providers reported performance of the first 2As, but fail to explain how often this is done and by which providers. Further, what are the outcomes associated with this intervention?	Increasing the implementation of CPG by various healthcare providers is likely to lead to more smokers exposed to evidencebased treatments, more smokers quitting and reduce the prevalence of smoking and smoking-related disease.11 Despite many evidence that shows the effectiveness of brief interventions even in a busy clinical environment, yet dissemination is very slow and there are still many healthcare providers who do not follow the CPG.13 Healthcare providers reported they performed the first two ‘’A’’s which are ‘’Ask’’ and ‘’Advise’’.14 However, not many evidences report on the performance on the three remaining steps which are ‘’Assess’’, ‘’Assist’’ and ‘’Arrange’’.15 According to the National Ambulatory Medical Care Survey between 2001 – 2004, 32% of patient charts did not include their smoking status, more than 80% of smokers did not receive assistance and only 0.3% and 1.8% received Nicotine Replacement Therapy (NRT) and bupropion treatments, respectively.16 Only 19.8% of current smokers received any cessation assistance
Comments	Authors’ response

	either counselling, medication or both. Even at preventive care visit, only 28.9% received cessation assistance.17 Like many other countries, Malaysia is also facing challenges in tobacco control. The trend of smoking prevalence captured by Global Adult Tobacco Survey 2011 and 2015 showed slight decrease in overall (from 23.1% to 22.8%) and among male (from 43.9% to 43.0%) prevalence of current smokers. However, the prevalence of smoking among women has increased (from 1.0% to 1.4%). Additionally, under smokeless tobacco there is a high increase and is suspected to be due to the use of electronic cigarettes.18 19 In addition, the increase in smoking prevalence among girls as documented by the Global Youth Tobacco Survey in 2003 and 2009 should also be noted. Based on the recent Malaysian National Health and Morbidity Survey 2011, 67.6% of the current smokers who visited healthcare services in the past 12 months was asked about their smoking status and 52.6% was advised to quit smoking by healthcare providers.19 In 2015, 75.4% of the current smokers who visited healthcare services in the past 12 months was advised to quit smoking by healthcare providers.18 Unfortunately, no evidence on healthcare providers performing the three remaining steps has been documented. Although in many countries, more than half of the current smokers want to quit smoking, and one-third had made at least three quit attempts, less than half of smokers succeed in quitting smoking before the age of 60[18-22]. A number of barriers to intervene smokers has been discussed in the previous literatures including lack of knowledge, negative healthcare providers' attitude, low self-efficacy, lack of training,[23] competing priorities and believing that counselling was not an appropriate service,[24] barriers of time, manpower and finance, lack of skills, concern for the clinician-patient relationship and perception of insufficient patient motivation, intervention rate are low.[25] Smoking among healthcare providers also has been prevalent in many countries and those who smoked were less likely to advise patients
Finally, what are the barriers to implementation of the remaining steps and why are they important?	

Comments	Authors' response

	to stop smoking.[26] Healthcare providers also claimed that they lack knowledge in smoking cessation counselling techniques and confidence in smoking cessation program.[27] The most significant barrier in providing smoking cessation intervention reported by previous study is due to limited training of healthcare providers.[3 8 28] Thus, to ensure successful and effective intervention, healthcare providers require knowledge, good attitude and intervention skill to help smokers to overcome the ambivalence to change and guide them to provide appropriate counselling and pharmacotherapy treatments.[15]
Please provide a reference regarding the chronically relapsing nature of nicotine dependence as referenced in the first paragraph on page 5.	The reference has been added accordingly
Page 5, line 16, if available please provided information (e.g. percentage) regarding the frequency that doctors informed patients about the harmful effect of smoking.	According to the National Ambulatory Medical Care Survey between 2001 – 2004, 32% of patient charts did not include their smoking status, more than 80% of smokers did not receive assistance and only 0.3% and 1.8% received Nicotine Replacement Therapy (NRT) and bupropion treatments, respectively.[16] Only 19.8% of current smokers received any cessation assistance either counselling, medication or both. Even at preventive care visit, only 28.9% received cessation assistance.[17] Like many other countries, Malaysia is also facing challenges in tobacco control. The trend of smoking prevalence captured by Global Adult Tobacco Survey 2011 and 2015 showed slight decrease in overall (from 23.1% to 22.8%) and among male (from 43.9% to 43.0%) prevalence of current smokers. However, the prevalence of smoking among women has increased (from 1.0% to 1.4%). Additionally, under smokeless tobacco there is a high increase and is suspected to be due to the use of electronic cigarettes.[18 19] In addition, the increase in smoking prevalence among girls as documented by the Global Youth Tobacco Survey in 2003 and 2009 should also be noted. Based on the recent Malaysian National Health and Morbidity Survey 2011, 67.6% of the current smokers

Comments	Authors' response

	who visited healthcare services in the past 12 months was asked about their smoking status and 52.6% was advised to quit smoking by healthcare providers.[19] In 2015, 75.4% of the current smokers who visited healthcare services in the past 12 months was advised to quit smoking by healthcare providers.[18] Unfortunately, no evidence on healthcare providers performing the three remaining steps has been documented.
Page 5, line 17, what training do providers lack? What is this based on?	According to the 4th Edition of Tobacco Atlas, doctors often informed patients about the harmful effect of smoking but they lack in smoking cessation behavioural and pharmacotherapy intervention training to help their patients to stop using tobacco products.[29]
Page 5, line 35, please provide further information regarding the trainings references and the "tasks required to help their patients"	Meta-analyses by Cochrane Collaboration also showed healthcare providers who received specific training had higher probability of performing smoking cessation intervention to help their patients to stop smoking compared to their untrained controls counterparts.[3 8] Unfortunately, evidence suggest that very minimal number of healthcare providers have received even minimal training on smoking cessation treatment.[35]
• Page 5, line 42, please clarify what Article 14 of the WHO Framework is. Also, when using an acronym for the first time, spell out (i.e. World Health Organization).	Article 14 of the World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) states that "each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence".[36] Acronym has been revised accordingly.
• Page 5, line 57, please spell out UMCAS as it is the first time it is referenced in the article text.	

Comments	Authors' response
• In regards to the aim of the study, please outline any pre-specified hypotheses.	Thus, the purpose of this study was to assess the pre- and post-training results from a series of eight-hour SCOPE training on smoking cessation. We hypothesized that the training would increase smoking cessation-related knowledge, attitude and self-efficacy for all type of healthcare providers including doctors, pharmacists, medical assistants and nurses.
Methods	

• The section on Development of SCOPE training is fairly cumbersome to follow. Please review this paragraph in regards to content and flow. Consider shortening this paragraph and more succinctly describing the development and content of training.	The paragraph has been revised
• In the study participants paragraph, please provide sample size numbers for each type of provider included in this study.	The healthcare providers consist of medical doctors (n=98), medical assistants (n=44), pharmacists (n=42) and nurses (n=34).
• It would be helpful to also know how participants were recruited for this research study and whether participation was voluntary or mandatory.	A representative sample from each health clinic was randomly selected from the list of healthcare providers provided by the State Health Departments. The eligible healthcare providers were invited and scheduled for this study. The participation in this study was on voluntary basis.
• Please provided further clarification regarding how the evaluation tool, ProSCiTE was modified for the purpose of this study. Also please explain how this might impact the reliability and validity of this instrument.	The details of the tool has been added in the ''evaluation tool'' section. The tool originally consists of 5 part (knowledge, attitude, self-efficacy, behaviour and barrier) and was not modified. However, since this is short term evaluation of before and immediately after the training, we cannot measure the behaviour and barrier changes. Therefore, we excluded the behaviour and barrier component for this study. The tool was included in the supplementary file as suggested
• It would be useful if a sample item for each domain of the ProSCiTE were included. • Provide additional information on how this measure was scored (e.g., total score, individual	The information has been added in the ''evaluation tool'' section.
Comments	Authors' response
item scores) to facilitate interpretation of results related to this measure.	
Results	

The data provided in the healthcare providers section is confusing. If there are different training requirements for healthcare providers in Malaysia, then this should be explained. For example, the authors said that nearly half of the providers were doctors but that half of the sample had bachelor's degrees. Wouldn't we expect that given the sample, that nearly half of the sample would have doctorate degrees (which are not currently included in Table 1)?	We have revised table 1 and added education level for each discipline of healthcare providers. As the SCOPE training is a basic smoking cessation training targeted for all healthcare providers, the sample was heterogenous. The minimum qualification for pharmacists and doctors was a bachelor's degree while for nurse and medical assistant was a diploma.
• In Table 1, please clarify what diploma mean. Also, indicate the reason for the asterisk for smoking status.	In the Malaysian context, diploma is a qualification obtained during tertiary education and minimum qualification to be employed as a nurse or a medical assistant in the government sector. It is of a level below the bachelor's degree qualification. Asterisk for smoking status means only 215 participants responded to this question.
• In general, the findings from the statistical analyses could be streamlined. For example, individual scores do not need to be repeated. Instead tables can be referenced. Additionally, consider including the test statistic in the sentence when describe the results, rather than in a separate sentence.	Thank you very much for suggestion. The results has been revised accordingly The statistical report has been revised
• Review BMA format of reporting test statistics and table formatting. • Clarify that the first statistic (t= 15.31) is in reference to the total knowledge score.	The big value of t for knowledge score is due to heterogenous population. Different types of healthcare providers have different levels of knowledge at baseline. However, SCOPE training seems to benefit all discipline of healthcare providers as seen in post training score.
• Table 2 and 3, make formatting (e.g., numbers for variables, capitalizing first letter) consistent in the entire table. • Page 11, lines 3 and 4 remove "client." Authors have consistently used "patient"	Formatted accordingly.
Comments	Authors' response

throughout article. It is important to use consistent. Please review the article for additional instances and correct to patient.	Clients has been removed accordingly.
• Tables 3 and 4, instead of including each item verbatim, it would make the tables more reader friendly if the items were shorten to only include the main content in each item (e.g. Table 4 Item 1 “Know questions to ask”).	All these questions were used to assess attitude and self-efficacy throughout the study.
• Given the available data on smoking status for the healthcare providers, it would have useful to analyze the relationship between this characteristic and ratings on knowledge, attitudes, and self-efficacy, as previous research has demonstrated such relationships.	Thank you very much for the suggestion. We really appreciate the idea. However, this relationship has been established in our pilot study paper which is currently under review.
• Also, I am curious how data might vary by provider type. Are some providers more or less knowledgeable or confident or have different attitudes based on training?	We have added one figure comparing the changes of each measures for each discipline of healthcare providers (Figure 1)
Page 13, line 16 “can result in significant integration of 5A’s,” this is a significant overstatement of the results. The researchers only included pre-post data on knowledge, attitudes, and self-efficacy. This study did not include any assessment of behaviors or follow-up assessments, therefore conclusions cannot be drawn regarding implementation. Care should be taken to not overstate the implications of a pre-post study.	The findings from this study suggest that training healthcare providers in smoking cessation is effective in the short term. They have better knowledge, positive attitude and they are more confident when assisting smokers to quit smoking using the 5A’s smoking cessation intervention approach.
• Page 13, line 30 “health care” should be changed to “healthcare” to be consistent with language used in the rest of the article.	The words have been changed accordingly.
• Page 13, last line in second paragraph— the only conclusion that can be drawn from these results is that healthcare providers have improved knowledge. The authors did not provide any research that outlines what is “good” versus “bad” knowledge related to smoking cessation.	This line has been removed.
• Page 13, line 50—sentence starting with “In terms of attitude” is confusing. Please rewrite to improve clarity.	The ever smokers among these professionals would most likely not advocate their patients for smoking cessation despite agreeing that smoking is harmful to health and would not advise young adults to start smoking.

Comments	Authors' response

• Page 14, middle paragraph—this paragraph should be split up as it addresses both attitudes and skill/confidence and then talks about attitudes again. Use separate paragraphs to discuss findings related to attitudes and confidence. Additionally, in regards to confidence results, this does not equate skill. The authors did not include any results that assessed the providers' skills (e.g., behaviors) and therefore cannot make implications related to skill.	The paragraph has been rearranged accordingly.
• Page 14, line 21, the authors cannot state their research supports the importance of identifying and advising patients, as they did not explore the impact of attitudes on outcomes. That is, do we even know that these attitudes influence behaviours?	This evidence supports healthcare providers are aware on the importance of identifying and advising patients on the harmful effect of second-hand smoke.
Page 14, sentence starting with However on line 23. Move this sentence to the separate limitations paragraph.	Sentence has been moved to limitation section.
• Page 14, line 56 remove "huge", this is again an overstatement.	The word has been removed
• Page 16, line 13—I don't believe analyzed is the appropriate word here. Are the authors referring to interpretation? They did not explain that they handled analyses different because it was self-report data. But perhaps the readers may want to limit interpretation because it is self-report. Also, if saying providers tend to over-report then this needs to be accompanied by a reference to support such a claim. However, if over-reporting is simply a possibility then use the word "may".	Data must be carefully interpreted as there is the possibility of healthcare providers tend to over-report the frequency of smoking cessation intervention.[49]
• Although the authors begin a discussion of implementation and systems-level factors, this needs significant clarification and expansion. Also, discuss the future directions of this current research as it relates to this.	Discussion has been revised accordingly
• There are several other limitations of the present study. Authors should discuss the limitations of using pre-/post-data without any follow-up data, no data on behaviors,	The nature of pre- and post-study lacks control group for the intervention and without long term follow up does not indicate causal relationship between the impact of the training on the actual

Comments	Authors' response
implementation of interventions, or smoking cessation outcomes. Additionally, given the heterogeneity of healthcare provider type, the authors should explain the implications of this as it relates to their findings and generalizability.	healthcare providers' behaviour and smoking cessation outcome. Future study should consider having a control group, preferably in a larger sample to improve the significance of this study.
References • Review all references for BMA format as numerous errors were identified.	All references have been revised according to BMA format.

Reviewer 2

Reviewer's name: Maxwell Akanbi

The assessment of the efficacy of your training was done using a tool called 'ProSCiTE'. I could not access any of the references provided for the tool. Since this is a core part of the paper, it will be helpful if the questionnaire is provided as a supplement.	ProSCiTE was designed and developed for the SCOPE evaluation and has been presented in conference. The validation paper is still under review. The questionnaire has been attached as a supplement document.
Abstract: 1. A new acronym that was not previously written in full was introduced (SCOPE) 2. Line 25: It appears there is an error in the result presented for the change observed in attitude.	Acronym has been spelled out accordingly. The error has been corrected accordingly.
Introduction: 1. Information on current smoking prevalence in Malaysia will help readers better understand the need for the smoking target presented (Page 5, Line 51). 2. Page 5, Line 57: 'UMCAS' needs to be written in full since this is the first time it is appearing in the manuscript.	The prevalence of smoking has been added in paragraph 3 of the introduction. The word has been written accordingly.
Methods:	

1. More information concerning the questionnaire is needed. Specifically the number of questions in each domain, the weight assigned to each of the questions and how each section was analyzed 2. Since there are no peer-reviewed publications on ProSCiTE, this is a good opportunity to inform readers/ researchers	The questionnaire details have been added in ''evaluation tool'' section. However, we have submitted a separate paper for validation of questionnaire and it is still under review.
about how and why ProSCiTE was developed.	Siti Idayu Hasan, Farizah Mohd Hairi & Amer Siddiq Amer Nordin. Construct Validity and Internal Consistency Reliabitlity of Providers Smoking Cessation Evaluation (ProSCiTE) Tool, 12th Asia Pacific Conference on Tobacco or Health (APACT), 13-15 Sept 2018, Bali, Indonesia Siti Idayu Hasan, Farizah Mohd Hairi, Mahmoud Danaee & Amer Siddiq Amer Nordin, Content validity for the questionnaire on Knowledge, Attitude and Behaviour (KAB) towards smoking cessation intervention among health care providers. Poster presented at Society for Research on Nicotine and Tobacco 23rd Annual Meeting, 8-11 March 2017, Florence, Italy.
Results: 1. Table 2: Readers need more information to understand what variables are being used to assess knowledge. Also, some items in Table 2 were numbered, while others were not. 2. All table titles need to be selfexplanatory.	All tables were revised and updated according to comments made.

Discussion: 1. Limitations: While you provided a number of limitations, some important limitations may still exist. An important limitation of an immediate post-training survey is our inability to predict how much of the information will be retained over time. More importantly, the ultimate goal is that trainees utilize the knowledge and skills acquired during the training to assist smokers to quit. It will be helpful if these issues are addressed.	The nature of pre- and post-study lacks control group for the intervention and without long term follow up does not indicate causal relationship between the impact of the training on the actual healthcare providers' behaviour and smoking cessation outcome. Future study should consider having a control group, preferably in a larger sample to improve the significance of this study. This study also could explore more in terms of their attitude towards smoking cessation advice, where in depth questions or qualitative approach would help answer this section on attitude. Even though knowledge has been greatly improved in this study, the duration of the information retained is not measured as no follow-up study was done. Evidence showed that knowledge can be maintained beyond three-month follow up period except for brief advice component, which decreased at three months.[47] Thus, continuing professional course for smoking cessation should be done frequently.

VERSION 2 – REVIEW

REVIEWER	Meagan Graydon VA Maryland Health Care System, USA
REVIEW RETURNED	01-Jul-2019

GENERAL COMMENTS	General Feedback: -Although significant efforts were made to correct the grammar in this manuscript, there were numerous errors that remained. Some of the errors identified are listed below: -Page 4, line 3- "adult" should be plural -Page 4, line 12- "problem" should be plural -Page 4, line 20- should read "a role-play session" or "role-play sessions" -Page 4, line 23- "rate" should be plural -Page 5, line 16- "many" should be "much" -Page 5, line 15- remove "yet" -Page 5, line 20- "many evidences" should be "much evidence" or "many studies" -Page 7, line 2- "study" should be "studies" -Page 8, line 12- "suggest" should be plural -Page 8, line 15- "rate" should be plural -Page 8, line 16- missing "the" in "the goal of role-play" -Page 10, line 22- "was" should be "were" -Page 11, line 19- "explained" should be "informed" -Page 15, line 19- remove "the" in "on the average" -Page 21, line 21- "emphasize" should be "emphasis"

	ABSTRACT: -ProSCiTE should be spelled out first here since this is the first time it is used. The description of acronym in the methods section can be removed once explained here. INTRODUCTION: -I appreciate the additional data regarding the effectiveness of various medical providers intervening with patients who smoke. However, I believe this paragraph is a bit choppy and would benefit from introduction and closing statements as well as efforts to better integrate the various lines of research. -Page 5, line 24- NRT was already defined, can use acronym do not need to spell out again -Bottom paragraph page 5- This paragraph jumps around by first talking about provider interventions to smoking prevalence and back to providers. Consider separating paragraphs or removing unnecessary or redundant information. -Page 8, line 4- SCOPE has already been defined, do not need to spell out acronym again METHODS: -The additional information regarding the development and outline of training is very helpful. However, the authors outline the elements of the interactive lectures and role-play demonstrations but do not explain the content of the practical sessions. Please explain this element of the training. -Page 10, line 19- please spell out acronym SIH -The definitions of knowledge, attitude, and self-efficacy are unnecessary and can be inferred by review of the measure items. RESULTS: -When referencing descriptors of data (e.g., almost two quarters, majority), be sure also include in parentheses the actual data for reader's reference. -You do not need to include the descriptor of the effect size d -Review accurate report of test statistics in text and chart. Be sure that symbols are appropriately italicized. DISCUSSION- -Page 19, bottom paragraph- The study did not examine the relationship between smoking status and outcomes, rather just reported on smoking status frequency. Therefore there are no conclusions that can be drawn on this and should be removed. This can be included as a future direction given that previous research indicates that it may be relevant. -The results of this study continue to be overstated. This study assess attitudes, confidence, and knowledge and does not include data regarding implementation. Therefore there can be no interpretation regarding behavior and any conclusions should be explicitly stated as speculations. Please review your results for appropriate interpretation given the study results. For examples, please see page 21, lines 14-17- "It was also observed that health care providers could provide effective intervention." And also Page 21, line 24 "to help increasing their performance". -A major limitation of this study that was recommended to be included in previous review has yet to be included. Please include that this study does not include implementation data and therefore there is no available data to suggest that changes in attitudes, self-efficacy, and knowledge translates into practice.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 1

Reviewer's name: Meagan Graydon

Comments	Authors' response
General Feedback: -Although significant efforts were made to correct the grammar in this manuscript, there were numerous errors that remained. Some of the errors identified are listed below: -Page 4, line 3- "adult" should be plural -Page 4, line 12- "problem" should be plural -Page 4, line 20- should read "a role-play session" or "role-play sessions" -Page 4, line 23- "rate" should be plural -Page 5, line 16- "many" should be "much" -Page 5, line 15- remove "yet" -Page 5, line 20- "many evidences" should be "much evidence" or "many studies" -Page 7, line 2- "study" should be "studies" -Page 8, line 12- "suggest" should be plural -Page 8, line 15- "rate" should be plural -Page 8, line 16- missing "the" in "the goal of role-play" -Page 10, line 22- "was" should be "were" -Page 11, line 19- "explained" should be "informed" -Page 15, line 19- remove "the" in "on the average" -Page 21, line 21- "emphasize" should be "emphasis"	The grammar has been revised accordingly throughout the revised manuscript as highlighted.
ABSTRACT:	

-ProSCiTE should be spelled out first here since this is the first time it is used. The description of acronym in the methods section can be removed once explained here.	Providers' Smoking Cessation Training Evaluation was spelled out as recommended and removed in the method section
Comments	Authors' response
INTRODUCTION: -I appreciate the additional data regarding the effectiveness of various medical providers intervening with patients who smoke. However, I believe this paragraph is a bit choppy and would benefit from introduction and closing statements as well as efforts to better integrate the various lines of research. -Page 5, line 24- NRT was already defined, can use acronym do not need to spell out again -Bottom paragraph page 5- This paragraph jumps around by first talking about provider interventions to smoking prevalence and back to providers. Consider separating paragraphs or removing unnecessary or redundant information. -Page 8, line 4- SCOPE has already been defined, do not need to spell out acronym again	-The introduction has been revised as suggested. -The full name has been removed -The paragraph has been rearranged accordingly -The full name of SCOPE has been removed in this section
METHODS:	

-The additional information regarding the development and outline of training is very helpful. However, the authors outline the elements of the interactive lectures and role-play demonstrations but do not explain the content of the practical sessions. Please explain this element of the training. -Page 10, line 19- please spell out acronym SIH -The definitions of knowledge, attitude, and self-efficacy are unnecessary and can be inferred by review of the measure items.	-The content of the practical sessions has been added in the method section. -Siti Idayu Hasan (SIH) was spelled out. -All the definitions have been removed from the method section.
RESULTS: -When referencing descriptors of data (e.g., almost two quarters, majority), be sure also include in parentheses the actual data for reader's reference. -You do not need to include the descriptor of the effect size d -Review accurate report of test statistics in text and chart. Be sure that symbols are appropriately italicized	-The actual data has been added for each descriptor as suggested. -This part has been revised accordingly -This part has been revised accordingly
DISCUSSION- -Page 19, bottom paragraph- The study did not examine the relationship between smoking status and outcomes,	-This part has been removed and included in future research
Comments	Authors' response

rather just reported on smoking status frequency. Therefore there are no conclusions that can be drawn on this and should be removed. This can be included as a future direction given that previous research indicates that it may be relevant.	
-The results of this study continue to be overstated. This study assess attitudes, confidence, and knowledge and does not include data regarding implementation. Therefore there can be no interpretation regarding behavior and any conclusions should be explicitly stated as speculations. Please review your results for appropriate interpretation given the study results. For examples, please see page 21, lines 14-17- "It was also observed that health care providers could provide effective intervention." And also Page 21, line 24 "to help increasing their performance". -A major limitation of this study that was recommended to be included in previous review has yet to be included. Please include that this study does not include implementation data and therefore there is no available data to suggest that changes in attitudes, selfefficacy, and knowledge translates into practice.	-This part has been revised accordingly -The part has been addressed in limitation section as suggested.