Author’s response to reviews

Title: Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia

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Author’s response to reviews:

July 27, 2014
Mr Ian Dominique Trinidad
Editorial Office
BioMed Central

Dear Mr Ian,

Thank you very much for sending us your and the reviewers’ comments on our manuscript [Deressa et al; MS: 7114311651249285 - Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia].

We hope that the revised manuscript now addresses all of your and the reviewers’ comments. Please find attached the point-by-point response to these comments as well as the revised manuscript with highlighted changes. We have also ensured that our revised manuscript conforms to the Journal style.

If you have any further queries, please do not hesitate to contact us at the contact addresses given below.

Looking forward to hearing from you soon.

With Best Wishes,

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SPECIFIC CHANGES MADE TO THE MANUSCRIPT

[Deressa et al; MS: 7114311651249285 - Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia].

A. Editorial comments:
1. We would be grateful if you could address the comments in a revised manuscript and provide a cover letter giving a point-by-point response to the concerns.
   • Thanks a lot. We have resized the MS as per the comments of the reviewers and provided cover letter explaining a point-by-point response to the comments.
2. Please also ensure that your revised manuscript conforms to the journal style
   • We have also ensured that our revised MS conforms to the style of the Journal.

B. Reviewer #1: made a total of four comments

Title: Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia

Version: 2Date: 2 May 2014

Reviewer: Emanuel Mwendo

Reviewer’s report:

Review comments on the paper: Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia, by Deressa et al.

Thank you so much for the opportunity to review this paper. The paper reads well and is addressing important public health issue that is pertinent at the moment as most countries are scaling up PMTCT services and even adopting new strategies such as PMTCT option B+. The paper reads very well, and the authors articulated well the ideas and presentation of the study findings and the implication of their findings. There are however, some few things that need to be clarified on the methods and results section. I will highlight some of these issues in the comments below:

Methods:
It was unclear how the hospitals were selected? i.e. out of how many hospitals in
Addis Ababa.

- Thank you. Although there are 11 public hospitals in Addis Ababa, the two hospitals (Ghandi and Zewditu) were purposively selected for this study. Ghandi Memorial provides maternal health services and Zewditu Memorial Hospital was a model hospital where HCT services were initially piloted and implemented in Addis Ababa. The PMTCT services of these hospitals were stronger also at the time of the study. This is detailed in the revised MS (lines 140-144 and 169-173).

Participants for FGD were purposively selected; it will be useful to describe what were the criteria of selecting these participants. I am wondering if all providers participated in the IDIs, if not useful to describe the group of those recruited.

- Thank you

- Each FGD was conducted with a group of six to eight pregnant women purposively selected from those attending ANC clinic of the health facility at the end of the session. All participants were pregnant women who expressed their willingness to participate in the study.

- In-depth interviews were conducted with purposively selected providers working with ANC/PMTCT in the clinic (nurses, midwives, clinicians). In some health facilities, there were both ANC as well as PMTCT focal persons, but in few one person could be working on both. Overall, 22 IDIs were conducted.

Health facilities were sampled, however, in the analysis it is not mentioned whether the survey analysis procedures were used or not?

- Thank you. In this study we sampled the health centers and purposively selected the hospitals. However, the quantitative study participants were selected consequently and the qualitative participants purposively. Since the analysis is more of descriptive aiming to identify barriers, we did not do analysis based multilevel modeling or cluster sampling analysis.

Results:

Well presented, however tables may need some refining, for example the total column does not provide any meaningful information.

- Thank you. We believe that our Tables could have been presented well. Even if we used X2 and p-values to show the differences between health centers and hospitals data, our primary aim was not to compare the difference between the clients of hospitals and health centers. Our aim was just to identify the main barriers among hospital and health center clients separately and as a whole for all clients. We are still interested to have the column total just to get the aggregate figure and maintained it in the revised MS. If you insist us to remove it, please let us know.

Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests

C. Reviewer #2: made a total of 11 general and specific comments

Title: Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia

Version: 2 Date: 19 May 2014

Reviewer: Rose Zulliger

Reviewer's report:
This manuscript by Deressa and colleagues utilized mixed methods to describe factors associated with utilization of HIV counseling and testing services during pregnancy in Addis Ababa, Ethiopia. Overall, this manuscript is technically sound and provides interesting evidence on PMTCT within this large urban area, but it would benefit from provision of additional details on qualitative methodology and better integration of qualitative findings. I commend the authors on their effective use of mixed methods to provide a more holistic understanding of PMTCT experiences.

- Major Compulsory Revisions
  • Line 193-4: The quantitative methods are well-characterized, but there is very little detail provided on the qualitative analysis. Please expand on how data were coded and the timing of qualitative interviews were conducted relative to quantitative surveys. Also, one of the strengths of FGDs is their ability to shed light on community norms and perspectives. Was there any disagreement amongst participants about HIV knowledge or barriers? If yes, please describe in the results. Please provide additional detail on how the nature of the FGDs may have affected participant responses.
  • Thank you.
  • Both quantitative and qualitative studies were conducted simultaneously. It would have been better to start with the qualitative to be followed by the quantitative study. However, we conducted both simultaneously as both the quan and qual tools were previously used for similar purposes and we adopted them for our study. In addition, the duration of the study was so limited mainly due to shortage of budget and logistic constraints.
  • Qualitative data were transcribed and translated into English. Then they were thematically coded based on the major thematic areas of the study (Knowledge
about MTCT; Knowledge about HCT; ANC utilization; barriers hindering PMTCT utilization; Discussions with partners/husbands; partners HIV testing status; Satisfaction with ANC services and healthcare providers; waiting time; cost of services; etc. This is incorporated in the revised MS (lines 219-223).

- The major issues identified by this study about the knowledge of FGD participants about HIV knowledge or barriers was that the majority knew that the virus can be transmitted from mother to her infant, but most did not know how it is transmitted. There were also FGD participants who did not know how about MTCT. There were also participants with misconceptions. All these are already incorporated in the MS through the presentation of the qualitative findings.

- Some FGD participants explained that they were happy with ANC/PMTCT services while others were not.

- Of course we did not come across any major disagreement between the FGD participants about the knowledge or barriers.

- Line 567-577: Surveys were administered by nurses and were implemented within a health center. This may have led to social desirability bias and should be noted as an additional study limitation. Also- the non-random, consecutive sampling strategy may have introduced selection bias.

- Thank you. These limitation are now included in the revised MS (lines 616-619).

- This study included some women who were HIV-positive who presumably have quite different perspectives on PMTCT. Thus, please specify the HIV status of participants with their quotes. Also- if such information exists, it would be helpful to include results and discuss how the perceived barriers to PMTCT services differ by HIV status. What barriers did HIV-positive women mention to accessing ART? Currently, the focus is more specifically on barriers to HCT rather than more comprehensively looking at barriers to PMTCT services.

- Thank you. The main focus of this study was to identify barriers to HCT rather than looking into detail barriers among HIV-positive women. Since that was not our primary aim, we did not try to classify women into HIV positive or negative. Identifying and interviewing such HIV positive women might have been a challenge or not easy as it is difficult due to confidentiality issues and problem of disclosure. Therefore, we have recommended further research to study the uptake of antiretroviral prophylaxis or treatment among HIV positive pregnant women.

- Minor Essential Revisions

- The authors should consistently use either the term ARV or ART, but not both. Also- the acronym ARV is defined twice (line 72 and 93).

- Thank you, we now removed the second definition of ARV. With the consistent use of ARV or ART, we now used ARV throughout the MS and dropped ART.
• Line 210: Please define SD the first time it is used.
• Thank you. Now defined in the revised MS.

• Overall, the manuscript is well-written, but there are a number of awkward sentences. Please re-read the manuscript to address these issues. E.g. line 402- “In contrast to the government health facilities, most FGD participants agreed the availability of quality ANC service in private health facilities.”
• Thank you very much. We have now modified the sentence in the revised MS. We have made significant changes in this section.

And line 531-535
“The qualitative findings of this study highlighted that only limited number of pregnant women convinces…”
• This sentence is modified and shortened in the revised MS.
• We have also tried to modify and shorten other statements in the revised MS. Overall, we have made significant changes in this section.

• Please indicate whether questions about HIV knowledge and about reasons for non-testing were open-ended or close-ended.
• Thank you
• Questions about knowledge were close-ended such as:
  o Do you know that HIV can be transmitted from a mother to her child? Yes/No
  o When can HIV be transmitted from a mother to her child? (1. During pregnancy, 2. During child birth 3. After child birth during breast feeding)
• For questions on reasons of being tested:
  o The choices include 1. Fear of rejection by my partner/husband, 2. Fear of stigma and discrimination, 3. fear of being tested positive for HIV, 4. Lack of awareness about HCT, 5. Others (mention)_____________________________________________
• Please clarify if wait times and time with counselors were for all types of clinical appointments or specifically for HCT.
• Thank you. The waiting time was only for ANC/HCT, it was not for all types of clinical appointments.

- Discretionary Revisions
• There appear to be some important differences between the participants attending hospitals and health centers. It would be helpful to add in a bit more detail as to why a woman would attend one service over the other in Addis.
• Thank you. In Addis Ababa, most pregnant women attend health centers for
ANC since their accessibility is better compared to hospitals. However, most pregnant women with a history of complications or other problems prefer to visit hospitals for ANC. However, most pregnant women prefer to deliver at hospitals due to the availability of better delivery services at hospitals.

- There are multiple places where there are a series of FGD or IDI quotes with no other text. The article would benefit from more thoughtful integration of qualitative findings.

- Thank you. We have made significant revisions in the presentations of the qualitative findings in the revised MS.

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being Published

- Thank you. We have tried our level best to improve the English writing in the revised MS.

Statistical review: Yes, and I have assessed the statistics in my report.

Declaration of competing interests:

I declare that I have no competing interests

D. Reviewer #3: made a total of 14 general and specific comments

Title: Utilization of PMTCT services and associated factors among pregnant women attending antenatal clinics in Addis Ababa, Ethiopia

Version: 2 Date: 3 June 2014

Reviewer: Sarah Gimbel

Reviewer's report:

Major compulsory revisions: There was limited background literature review to justify this study which attempted to identify factors inhibiting uptake of VCT in health facilities (both health centers and hospitals) in Addis Ababa. A comprehensive review would have demonstrated a very large body of work in this area. In fact a pub med review found multiple articles on barriers to PMTCT uptake in Ethiopia in 2014 alone. Below are 2.

Determinant and outcome of early diagnosis of HIV infection among HIV-exposed infants in southwest Ethiopia.


Identifying factors associated with the uptake of prevention of mother to child HIV transmission programme in Tigray region, Ethiopia: a multilevel modeling
The research question that the authors are pursuing although not novel does contribute to the body of knowledge because it builds on the research that has already been done both in Ethiopia and regionally. These must be cited in the paper.

- Thank you very much for sending us the relevant literatures in Ethiopia. We have revisited our background literature and expanded more. We reviewed the two articles and incorporated about a paragraph in our revised MS (lines 111-121). We also cited the two references and other additional references in the revised MS.

Other issues that need to be dealt with.

1-Justify why Addis was chosen as the study site city

- Thank you. This study was funded by the Addis Ababa Health Bureau and the research was done by the School of Public Health at AAU. The Regional Health Bureau had a problem of understanding why PMTCT services in the City were low despite the high coverage of ANC services. The Health Bureau wants to scale-up the PMTCT services based on reliable information obtained through research.

2-In the background compare cascade flow data to similar countries (neighboring/similar epidemics)--not just in the final conclusions--it seems late to be mentioning this. You obviously had expectations, based on literature review what you would find related to barriers to access--state these a priori and then return to those that are consistent with previous research findings and add those issues that you have identified which are unique or differ from the norm.

- Thank you. This is now well addressed in the revised MS (lines 111-121).

3-In the background it would be stronger to link the low ANC coverage to the low PMTCT coverage--tease out those two related issues a bit more for the reader

- Thank you. This is well modified and incorporated in the revised MS (lines 103-109).

4-you mention in the background that ~16% of births occur with skilled attendants and that the reason is ease of access. One I would cite that and also hone in on existing literature that demonstrates what other causes are leading to this low coverage. certainly this is multifactorial.

- Thank you. This is now well addressed in the revised MS (lines 110-121).
5-HCT or VCT?? pick one acronym please
• Now we have consistently used HCT.

6-the methods section needs grammatical revision, also elements/terms are unclear -- for example ANC coverage cannot be estimated at 100%, 32 health facilities (out of how many?).
• Thank you. We have removed this sentence and modified it in the revised MS (line 148).

7- the sample size and sampling procedures needs justification--why 50% estimated?
• Thank you. The sample size calculation was based on the available data for Addis Ababa. We assumed the proportion of HIV positive pregnant women who received ARV. The data for Addis Ababa in 2010/11 was 46% (line 154).
• All pregnant women who attended the ANC clinic of the selected health facility were invited for exit interview. The selection of clients for the interview was based on consecutive sampling until the sample size allocated for the facility was completed. Sample size allocation of pregnant women for exit interview was based on proportional to the flow of the number of clients, considering the ANC attendants at the health facility in the past month. We made consecutive sampling of pregnant women due to shortage of time. All health providers working in the provision of PMTCT services at the selected health institutions were also included in the study.

8-also what was the time frame for data collection?
• Thank you. The data collection was done for two weeks from 15-30 April 2010 (line 189).

9-where the items used in the questionnaire from existing, validated scales? especially for patient satisfaction which is notoriously hard to measure well.
• Thank you. Both quantitative and qualitative questionnaires were adapted from the UNAIDS best practice collection after considerable modifications were made to assess potential service barriers (lines 205-206). They were translated into Amharic for administration by 12 trained female nurses recruited from health facilities not included in the study and qualitative researchers for qualitative questionnaire.

10-the sample of interviewees was noted as being purposively selected--what was the purpose? to get a varied sample? to just select managers? other? it isn’t clear.
• Thank you. The selection of all study participants (pregnant women and providers of PMTCT services were not at random. There were few health workers providing PMTCT services at each institution and all were interviewed using key informant interviews. The selection of pregnant women for the
quantitative interviews and FGDs was also not at random. We explained the limitation of this approach in the discussion section.

11-under data analysis it was unclear where the supervisors were from--the MOH? the university? an NGO?

• Thank you. We indicated in the revised manuscript that they were faculty members of the University with PMTCT experience (lines 189-191). The field work was organized in three survey teams, and each team was responsible for the overall coordination and implementation of the quantitative and qualitative data collections at health facilities. Each team was composed of one field coordinator and supervisor, four nurses paired with four assistants (each pair assigned to one health facility) and one driver.

12-why was the data analyzed in English instead of Ahmaric?

• Thank you. This situation is very common in Ethiopia. Data collection is usually done using a questionnaire translated to the local language. The quantitative data are entered into the computer program using the English questionnaires and codes. Qualitative data collected using the local language and transcribed verbatim, and translated into English for analysis.

13-no info on how interviewees questionnaires were safeguarded/kept secure/confidential?

• Thank you. We have now included this part in the revised MS (lines 231-234).

14--the findings need to synthesized under clear, succinct headings. It would be easier for the reader to grasp the findings of the paper. these headings should link to one another and make a comprehensive argument. perhaps a figure could be used to better illustrate the findings (drivers of poor uptake of PMTCT)

• Thank you. We have further divided the results section by inserting additional sub-headings such as: HCT status of partners/husbands; Waiting time by pregnant women for ANC/PMTCT services; Barriers to ANC/PMTCT services. We now think that it gives a smooth flow of information for the readers.

Minor revisions: Please improve the writing. In many places the writing could be shortened and clarified. Also, a good English grammar check is needed

• Thank you. We tried our best to improve the English for the revised version and also modified or shortened many sentences.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being Published

• Thank you. We have tried our level best to improve the English writing in the revised MS.
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:
I declare I have no competing interests

Best regards!