Author's response to reviews

Title: Assessing the accessibility of HIV care package among tuberculosis patients in the Northwest Region, Cameroon.

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POINT BY POINT RESPONSE TO REVIEWERS’ COMMENTS

REVIEWER 1.

1. The manuscript has been sent for language review.

1a. Comment 1a has been addressed and rephrased into “the Government drafted the first National Strategic Plan against AIDS 2000-2005 ....” on page 2, paragraph 1.

2. Outlines of the structures of both the National TB and AIDS control programmes have been described on page 2, paragraphs 1 and 2.

2a. The National burden of TB (prevalent and incident cases), case notification rate (CNR) for 2007, and the trend of the CNR from 2000 to 2007 based on the 2009 Global TB Control Report have been provided on page 3, paragraph 1.

2b. The National TB treatment outcomes for the 2006 cohort of smear-positive patients have been provided on page 3, paragraph 1.

2c. The last demographic and health survey was conducted in 2003 and the results published in 2004. The next exercise is planned for 2010. The only official national HIV-seroprevalence data available is therefore from the 2004 survey. The 2008 data for persons eligible for ART and on ART has been provided on page 2, paragraph 1.

2d. The most recent national HIV-seroprevalence data among TB patients has been provided 2006 and 2007 (the study period) on page 3, paragraph 1.

2e. The data source for the National Demographic and Health Survey 2004 has also been included.
3. This study assesses the uptake of PITC, ART and CPT services and factors that influenced the uptake of these services among TB patients in selected treatment facilities within the Northwest Region between January 2006 to December 2007 when TB/HIV collaborative activities went operational nationwide and in the region. This study period was chosen because although collaborative TB/HIV activities were adopted in 2004, 2005 was spent redesigning the TB registers to capture HIV testing, uptake of ART/CPT which were made available to all TB diagnostic and treatment centres as from January 2006. Staffs were also trained on TB diagnosis and treatment, record keeping and reporting. The objectives and justification of the study have been stated on page 4, paragraph 1.

4. The purposeful selection of 4 out of 10 health facilities providing comprehensive TB/HIV care services took into consideration i) their accessibility ii) heavy patient load compared to the other centres ii) the diversity of patients served since they cover both rural and urban populations iv) similarity in the services provided since they act as referral centres in the region and v) possibility to evaluate the services between public and faith-based settings because of perceived differences amongst the population with regards to the quality of patient care, user friendliness and cost in accessing treatment and care. We recognise the selection bias this might have caused and this is acknowledged as a limitation in the discussion.

5a. Table 1 has been included.

5b. Comparisons are made between public and faith-based health facilities, the rationale is because of perceived differences amongst the population with regards to the quality of patient care, user friendliness and cost in accessing treatment between these two settings. This has been included on page 4, paragraph 3.

5c. P-values have been included in the tables and significant results highlighted to facilitate interpretation.

5e. The different TB types have been separated into smear-positive, smear-negative and extra pulmonary TB and comparisons made across them as potential predictors.
6. The key message in the collaborative TB/HIV activities is that despite the fact HIV testing among TB patients is increasing, there should be linkage in the number of patients who are enrolled on ART and CPT. Moreover pre-HIV therapeutic/diagnostic services including CD4 testing need to be made free of charge to all TB patients to improve ART eligibility. These are important messages for policy-makers in many countries in Africa and these are presented in the conclusion.
Major Compulsory Revisions.

Tables 2-4 have been redone with comparisons made between public and faith-based hospitals, sex, age groups and area of residence, category and types of TB with regards to the outcomes (HIV testing and status, ART and CPT uptakes). The objectives of the study and the rationale for comparing public and faith-based hospitals have been provided on page 4, paragraphs 1 and 3 respectively. The outcomes of interest across have been compared across various groups including the ORs, confidence intervals and p-values have been included in the tables and the variables reflect the actual proportion of the uptakes.

The significant factors in the tables have been highlighted and although some new finding were observed after the table were re-done, there were no significant changes in the main conclusions. These findings have been revised in both the abstract, results and discussion sections and the facts clearly represented.

Minor Essential Revisions.

All the tables (1-4) have been re-numbered and labelled properly.

The global/African TB data for 2007 from the Global TB Control Report, 2009 has been included in paragraph 1 of the introduction. The global HIV data including those among TB patients for 2007 has also been included in paragraph 1 of the introduction.

The statement in paragraph 1 of the discussion has been rephrased to “Testing rates were slightly higher in the public hospital compared to the faith-based hospitals....”

The statement on page 10, paragraph 1 which begins with “Setbacks....” has been re-worded to “Limitations...”
EDITORIAL POINTS

1. A title page has been included with the relevant information.

2. Informed consent for the study has been documented on page 6, paragraph 3 under “Ethical approval” subheading in the methods section.

3. Keywords have been removed from the Abstract.

4. The manuscript has been sent to a professional copyediting service.

5. The manuscript has also been formatted to conform to the journal style.