Reviewer's report

Title: What happens to ART-eligible patients who do not start ART? Dropout between screening and ART initiation: a cohort study in Karonga, Malawi

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Reviewer: Benson Droti

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Major compulsory revisions:
1. I think this paper needs reorganisation; for example:
   # Introduction: The 3rd and 4th sentences of the introduction actually describe the methods and should therefore be put under methods i.e. 3rd sentence starting with “individuals were eligible for ART in Malawi………” and the 4th sentence starting with “ideally, the group counselling session………”
   # Methods: I think the first paragraph of the methods would fit better under the introduction
   # Second paragraph of Methods: The 1st and 2nd sentences are actually results and should therefore be put under results
   # Conclusion: 1st and 2nd sentences should be put under introduction

2. Methods:
   # The method of this study has not come out clearly. I think it is important for the authors to mention clearly what happens during each visit e.g. what happens during a screening visit; what happens in the subsequent visits; how long were patients’ appointments etc?
   # My understanding is that, all eligible patients (who did not have any contraindications) were actually given appointment to come back to start ART (though the length of these appointments varied from a few days to over a month); what determined that a patient is scheduled to come back after 2 days and another one scheduled to come back after 1 month for example (was it just the length of the waiting list alone?)

3. Results
   # 1st sentence: Definitions of “readiness to start treatment” and “contraindications” should be given. These should in fact be put under methods e.g. the authors could state “ … a patient was not considered ready to start treatment if he/she had …..” “….. A patient had a contraindication if he had e.g. a severe drug reaction with previous treatment, or was pregnant………”

4. Conclusion:
   # The conclusion/recommendation of this study is not clear to me. The objective of this study was to measure extend of loss of ART-eligible individuals between
screening for ART and initiation of ART, and to identify factors associated with this loss. Some of the key findings are a high default rate and a high death rate among eligible patients who were not started on ART. Based on these, it is therefore not clear to me how considering the use of “eligible for ART as a denominator” becomes a conclusion. Using “eligible for ART” is not the focus of this paper, is it? I think the authors would do well to maintain the focus of this paper just by asking simple questions: what did we set to measure; what did we find; based on these findings, what can we conclude; and based on these findings, what recommendations can we make?

# The authors do not need to bring again other people’s work in the conclusions. They can mention other people’s work in introduction/background, methods and discussions. I therefore think, references 14 and 15 that appear in the conclusion should be removed and taken somewhere else.

Discretionary revisions

1. Understanding reasons for defaulting from the patients’ perspectives in such a study is critically important in order to draw a more plausible conclusion. Therefore, in addition to the quantitative study, I think the authors would have achieved more if they had also done a qualitative study to further explore e.g. the reasons for defaulting among patients who are eligible but not started on ART.

2. Did the authors miss anything by focussing only on the patients who dropped out? I know their aim was to determine extend of dropout and find the reasons associated with dropout. But how different was this group that dropped out from the other that did not; how different were the delays for those who dropped out from those who remained in care. For example, the authors found an alarmingly high death rate among patients who were not started on ART immediately. One would naturally ask, was this death rate really high; or one would ask, compared to what? I think the authors need to show: a) how different this death rate is compared to death rate among the peers that were started on ART; b) through a verbal autopsy, what the causes of death were in order to determine whether they were HIV-related deaths. In other words, to what extend can we attribute these deaths to delay in starting treatment or dropout from ART. After finding a positive association between dropout and length of delay to start treatment, the authors would have done even a better job by looking at the group that were started on treatment; did they also have a similar length of delay and if they did, what was their motivation to remain in care etc

3. Discussion

# Paragraph 2, 1st sentence: statement beginning with “MUAC and difficulties in dressing………” I think the issue here is not inability to identify sicker individuals. The patients were already identified as eligible for ART (using the existing criteria) and scheduled to come back for (possibly) ART preparation and then initiation. The patients did not come back and the question then should be why? Even then, further validation of such a tool (difficulties in dressing in particular) needs to be done before making such a recommendation.

4. Annex:
# Figure 1 and table: (If possible) I would love figure 1 and the tables to be inserted into the body of the paper under the results.

**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