Reviewer's report

Title: Barriers and facilitators of adherence to TB treatment in patients on concomitant TB and HIV treatment: a qualitative study

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Reviewer: Ann Kurth

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This qualitative study from an experienced team of clinical researchers in Ethiopia is amongst that first from the region to assess issues of dual medication adherence among HIV-positive TB patients. It adds to what is known about common barriers and facilitators of ART adherence in low-income country settings (a meta-analysis of which has been published). The authors appropriately cite preceding work on ART adherence in Ethiopia, and study limitations. The paper would benefit substantially from 1) making the analytic process more transparent, and 2) presenting the data in a more cohesive fashion.

Suggestions for edits are below by categories of responsiveness.

Minor Essential Revisions recommended:

ABSTRACT - In Methods state the number of people involved in the interviews (apparently n= 15 co-infected patients, and 9 providers) and focus groups (n = 2, conducted with patients only). The Conclusion recommends food distribution (prescriptions?) as a helpful intervention but no mention of this as a barrier is outlined in the Results paragraph, so should be mentioned there first.

TABLES: These demographic data could be summarized in text, or at a minimum put into a single table with respective subject group rows/columns.

Major Revisions recommended:

Participants section:
- It appears that interviews were done in two rounds. It is not clear that this was a pre-planned methodology; if it was, that should be stated (i.e., we set out to develop and then validate the interview topic guide). Also unclear whether analysis of the first round of interviews was done, developing a coding matrix that was then applied and assessed for validation of "preliminary findings" prior to next round of interview data capture. Also is not stated why focus groups were carried out with patients only, since interviews were done with both patients and providers.

- The sampling frame is unclear. How many TB and ART clinics were subjects drawn from? Were letters distributed to all patients at these clinics (given that only 1 subject was said to refuse enrollment, were only 16 invite letters actually distributed)? How were providers invited to participate?
- Last sentence before the 'Data Collection' paragraph: The issue here is not really recall bias (which is usually influenced by differential disease state coloring one's recall of exposures, but rather time telescoping of events. Selecting only patients who had completed or discontinued treatment in last 6 months - were equal numbers of these patients invited, given the goal of understanding both adherent and non-adherent patient issues?

Data Collection: Should explicate that the topic guide asked about experiences of both TB and ART medicines, if that was how it was asked. Were only TB medication intake factors explored, or both TB-HIV regimens? (This goes back directly to original goal of the study). How were health provider perceptions and issues included in the topic guide, as would seem relevant to patients as well as they were an interviewed group.

Analysis: Methods are not very transparent (e.g., were first set of interviews fully analyzed before focus groups were done?) Was a member check (presentation of findings back to the subjects, or modified member check done?

RESULTS: Data descriptions are inconsistently presented, mixing patient and provider data intermittently, usually only to quote a provider who agreed with a previous patient quote. If the two groups were studied because it was felt they would have different or inter-dependent issues, then consider summarizing patient themes, then provider themes, then discuss where there was cross-over or cross-purposes of beliefs and findings.

The subject headers don't really correspond to the original theoretical framework (6 categories plus regimen & health service delivery issues).

A seemingly important finding is that pts appear to decide which drug is more important to take (based on perceived disease severity), and discontinue some meds accordingly. Yet in the Discussion section it is stated that no patients brought this up.

Forgetfulness has been identified inmost studies as a primary reason for ART non-adherence, so might be worth speculating why wasn't seen as a major reason in this pt population.

Food issues - (p. 11) state how many of the patients raised this as a major concern, since it is shown as a major recommendation of the authors. Did pts see lack of food as an impediment to taking the meds, or was it seen as a consequence of successful treatment (restored appetite), or both? If so, when would food prescriptions (as recommended by the authors) best be implemented?

Timing of ART vs. TB tx: Describe what is current standard of care/government guidelines re: this in Ethiopia.

DISCUSSION
p. 18 – It’s stated that no patients raised concerns about TB-HIV disease
interaction reducing TB curability but a patient is quoted on p. 8 saying exactly
this.

Important in the Discussion section to mention that WHO/UNAIDS 1998 Policy
statement on preventive therapy against TB in people living with HIV will be
updated. Clinical dilemmas and patient impact (e.g., IRIS) around treatment
initiation for TB-HIV are lightly mentioned but critical to discussing how to support
patient adherence by minimizing side effects and adverse reactions. This also
has health service implication in terms of co-delivery of meds in both clinic types,
etc.

Adherence counseling para p. 18: If the authors are recommending an integrated
counseling approach for co-infected patients, especially those on concomitant
treatment, what elements should be covered?

p. 19 – Sigma findings should be in Results, not Discussion section. Define
enacted vs. felt stigma.

Food – How exactly is it recommended that HIV NGOs integrate their food
provision work with TB clinics/pts.

Data triangulation mentioned at top of p. 21 should have been explicated as a
goal in the methods section.

REFS: Important to highlight that Cochrane reviews have found DOT to be
ineffective/cite.

TABLES: Add a table outlining the themes identified in the qualitative data, and
how they fit (or didn't) with the originally-conceived 6 theoretical domains of
interest plus regimen and health service related factors (from bottom of p. 6).

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

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a
statistician.