Author's response to reviews

Title: Feasibility and acceptability of point of care HIV testing in community outreach and GUM drop-in services in the North West of England: A programmatic evaluation

Authors:

Peter MacPherson (p.macpherson@liv.ac.uk)
Anu Chawla (Anu.Chawla@rlbuht.nhs.uk)
Kathy Jones (Kathy.Jones@rlbuht.nhs.uk)
Emer Coffey (Emer.Coffey@liverpoolpct.nhs.uk)
Vida Spaine (vida@liverpool.ac.uk)
Ian Harrison (Ian.Harrison@liverpoolpct.nhs.uk)
Pauline Jelliman (pauline.jelliman@liverpoolpct.nhs.uk)
Penelope Phillips-Howard (P.Phillips-Howard@ljmu.ac.uk)
Caryl Beynon (C.M.Beynon@ljmu.ac.uk)
Miriam Taegtmeyer (miriamt@liverpool.ac.uk)

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Author's response to reviews: see over
Dear Editor

Re: MS: 7994406595066068 – Feasibility and acceptability of point of care HIV testing in community outreach and GUM drop-in services in the North West of England: A programmatic evaluation

I write on behalf of my co-authors to thank you for the further comments from the Associate Editor. In accordance with your email, we have responded to the comments made and questions raised, and these are addressed in detail below.

We would once again like to express our gratitude for the timely and helpful reviews provided.

Yours Sincerely,

Dr Peter MacPherson MBChB MPH
(On behalf of the authors)

Response to Associate Editor’s Comments

1. “See Rev. 1 comment 11 and Rev. 2 comment 1: in the revised paper and in the authors’ response to the reviewers, it is still not clear how authors have constructed their (risk behaviour) variables and there still are comments on how missing values are presented.”

   i. “Having made some calculations, it appears to me that the variables used to construct risk category are overlapping. In 46 cases there seems to be overlap. Thus a person can be e.g. IDU but also say MSM, or African. Also, in the way the data are presented now, it is not clear that the proportion males that is MSM is higher in LCSH (44%) than in community sites (34%). It should be clearly mentioned that persons can belong to multiple risk categories and the overlap needs to be described. Alternatively, (provided that you feel it has meaning for testing practice) it might be more clear to use nonoverlapping categories in the paper and table. Doing so, risk category variable needs to be constructed based on a hierarchical classification (eg. IDU when IDU and MSM is reported, or some other classification). Again, it should be clearly mentioned how the variable is composed (in which hierarchical order).”

We acknowledge that the data on risk categories could have been presented in a clearer fashion and thank the Editor for these comments. We have carefully
reanalyzed the risk exposure data: 43 participants were found to be in more than one risk category (and of these, two participants had more than two risk categories). We have constructed non-overlapping hierarchical risk categories for single and multiple exposures to more clearly describe the patterns of risk exposure between the sites. Additionally, overall summary categories (non-mutually exclusive) are also presented. We feel that this allows the reader to readily appreciate the differences in client groups testing between the sites.

We have revised Paragraph 2 of Page 7 (Statistical Methods) to describe the construction of the hierarchical categories. We have substantially revised Paragraph 2 of Page 9 (Results section) to clearly describe risk categories, and highlight where participants belong to more than one risk category. Additionally, Table 2 has been updated to show hierarchical classifications of risk categories.

Further, we have removed baseline characteristics of participants completing the Liverpool Gets Testing Campaign Questionnaire from Table 2 to ensure clarity in the table and avoid confusion with varying denominators.

ii. “Authors are very careful to mention all denominators in the text and in that way present missing values, but thereby confusing the reader somewhat. Since behavioural data was available for 97% of participants, the among of missing data can be considered relatively neglectable (no bias is assumed). Authors are asked to mention the 97% in their manuscript, keep the nominators and denominators in table 2, and omit all numbers in the results section, page 9 is a duplication of the table. Since by general rule, all duplications should be avoided, only notable findings of table 2 can be highlighted in the results (thereby not providing numbers as they already are stated in the table).”

We have removed unnecessary denominators from the body of the text. Additionally, the proportion of participants with missing data is now stated in the text. As noted above, we have substantially revised Table 2, and data on participant baseline characteristics and results from Liverpool Gets Tested Campaign Questionnaire are now presented in the body of the text.

2. “Please omit the 95% CI’s in table 2, providing p-values is sufficient”

We have omitted confidence intervals. However, we note that in Reviewer 1’s comments on first submission (Comment 12), we were asked to provide confidence intervals for differences.

3. “Table 3, Intraquartile range, do you mean interquartile range?”

Yes. This has been corrected.

4. “When describing the high acceptability of POCT and placing it in broader context, authors are asked to reflect on the fact that in this study was based on a preselection of ‘most likely’
feasible sites. Further, do you think it is likely or not that POCT might have scared of possible testers.”

We agree that pre-selection of sites may have influenced the degree to which individuals were accepting of POCT. A sentence has been added to Page 16, Paragraph 2. Further, it is also possible that the availability of POCT may have discouraged some potential testers. This was not assessed in this study and so we have added to the discussion to suggest that further examination of the attitudes of individuals who refuse HIV testing towards different modes of HIV testing (including POCT) is required.

5. “Please provide some thoughts on the difference in ‘would recommend POCT to others’ between community based sites and LCSH”

We agree that this is an interesting difference and most likely reflects differences in the characteristics of the participants testing at the GUM clinic and in the community. Additionally, the context within which POCT was offered (busy, anxiety-filled GUM clinic appointment vs. POCT offered in a familiar and supportive location) may be important. We have expanded the discussion to reflect this.

6. “Please add to methods section describing focus groups, 25 service providers from 6 (?) selected sites”

We have further elucidated the focus group discussion methods.

7. “Statistical methods, ‘prevalence of risk behaviour’ needs to be replaced by ‘proportion of clients classified in a risk category’. (African eg is not risk behaviour). Actually, the distinction is being made on the basis of potential HIV risk (transmission or risk category). Throughout the paper, the term risk behaviour should be omitted and replaced.”

We agree that there is an important distinction between risk behavior and risk category. The manuscript has been updated accordingly to emphasize that it is risk category that is being discussed.

8. “I count only for 16 of 17 HIV positives information on risk category, is this correct, for one person missing information?”

One of the participants diagnosed HIV-positive had no risk exposure by our definition. This has been clarified in the results.

9. “Page 10, the information provided on risk categories for the Liverpool gets tested Campaign could be moved to table 2. Similar as comment 1ii, it is clearer to the reader to have the numbers in the table and highlights (no duplications) in the results text.”

The detailed description of risk categories for the Liverpool Gets Tested Campaign has been removed from the body of the text and placed in Table 2. Greater emphasis has been placed
on describing the characteristics of those completing questionnaires compared to the overall study population.