Reviewer's report

Title: Use of task-shifting to rapidly scale-up HIV treatment services: experiences from Lusaka, Zambia

Version: 2 Date: 10 October 2008

Reviewer: Lisa Hirschhorn

Reviewer's report:

The authors have done a very thorough job of responding to most of the comments and criticisms. The manuscript represents a more in depth and valuable description of the program process of supportive task shifting. Unfortunately as the authors state, the limitations of the data preclude a strong evaluation of the quality provided. The program overall maintained or improved care, but without knowing the relative percent of care provided by traditionally trained providers versus task shifted ones, understanding what improvement, no conclusions about the quality of care provided by these expanded providers can be made.

As such, I would agree with the first reviewer from round 1 that this be published as a program description

Major revision

Line 217, the authors write: Although task-shifting can help alleviate the human resource shortages in Africa, one major concern has been reduced clinical care quality. To address this issue, we conducted a review of quarterly clinic performance reports in order to assess whether clinic performance had improved after the introduction of mentoring and quality assurance activities. When we examined clinical performance according to time of site establishment, we noted general improvements according to a number of basic clinical care indicators (FIGURE 3). This improvement occurred in the face of significant increases in clinic volumes from 12,500 patients to 44,580 on ART

The improvement in quality in the setting of rapid and impressive scale-up is certainly of interest. However as the authors state, they do not have the ability to measure the quality of care provided by task shifted versus standard providers . Therefore a statement should be added to again reiterate that while no major drop in clinic-level quality was seen (and improvement was seen) after the clinic-level interventions (QA and mentoring), that conclusions about clinical care quality at the provider level could not be made

Minor revisions:

The authors write “we believe such an approach is cost-effective in Lusaka” (286)- what evidence do they have to support this statement?

In the prior review, a description and results of QA for the peers was suggested.
The authors provided a description of the QA, but no results are given. Were they any available?

Other comments:
The authors state “insurmountable methodological difficulties” preclude an evaluation of quality as provided, yet describe providing oversight of clinic encounters and reference a program which has described quality in peer-delivered services in Uganda. I would encourage them to consider developing an approach to evaluate the quality and effectiveness of care delivered through task shifted providers at the provider rather than clinic level.

**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.

**Declaration of competing interests:**

I declare that I have no competing interests