Reviewer's report

Title: Home based HIV counseling and testing: factors associated with access to HIV care services in eastern Uganda

Version: 5  Date: 24 June 2015

Reviewer: Eugene Ruzagira

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Major Compulsory Revisions

Background

Paragraph 5: “peer educators were also trained to conduct follow-up visits for HIV positive clients”. Please provide more information about these follow-up visits e.g. purpose, frequency and timing etc.?

Paragraph 6: “At the time of HIV testing, blood was also taken off and saved for CD4 testing at the Joint Clinical Research Centre (JCRC).” Please state if and when CD4 count test results from this testing were provided to the clients.

Paragraph 7: Please clarify if HIV positive persons were referred to facilities that did not provide ART. Did facilities without ART services have capacity provide CD4 count testing and assessments for ART eligibility?

Paragraph 9: “about 64.6% of all HIV positive clients referred from the Kumi HBHCT program reached the [health] facilities. How was this determined e.g. interviewing clients, checking health facility records, reports from peer educators etc.?”

Methods

General: A lot of detail on the categorisation of variables is presented. Most of this may not be necessary as it is presented again in table 1.

Study setting, sentences 4-7: Please consider deleting these details as most may not be relevant? Instead, consider including a little more information about HIV care services e.g. the providers (government or NGO), spread in the district, etc.

Study design: It is not clear why ill individuals would be excluded from this study. Note that such individuals are likely not to have accessed care, and therefore excluding them could lead to overestimating access to care.

Study sample, data collection and analysis

General comment: It appears there were two levels of screening (identification of study participants) i.e. 1) selection of individuals from the HBHCT data base, and 2) face-to-face screening after tracing selected individuals in the community. Please describe these levels separately for better clarity. Which inclusion criteria
were considered at the each level? For example, it would be difficult to know which individual will provide informed consent or who is ill at the first level of screening.

Paragraph 2: “Eight sampled clients were not found in their expected households; among whom, six had transferred.” Please consider moving this statement to the results section.

Paragraph 2: “Two of the eight clients could not be traced at all.” Please consider moving this statement to the results section.

Measurement of variables

Paragraph 1, sentence 1: “The main outcome variable (access to HIV care services) was measured by reported receipt of Cotrimoxazole for prophylaxis by clients registered at the ART clinics in a given facility.” Please clarify if clients who registered at and received cotrimoxazole from facilities that did not provide ART were considered to have accessed care? Did any clients obtain cotrimoxazole from sources other than health centres/hospitals e.g. pharmacies, drug shops etc.? If so, were such clients considered to have linked to care?

Health facility factors: Only distance to the referral site was looked at under this category. Do you have data on other health facility factors e.g. level of health facility, staffing, presence of ART clinic, ownership (government or NGO) etc.? Some of these factors may impact access to care.

Data management and analysis

General comments

• Consider mentioning the variables that were included in the multivariate model apriori (irrespective of their relationship to the outcome at univariate analysis)

Results

General: If data is available, please consider investigating and/or reporting the following?

• Were baseline (at HBHCT) CD4 count test results provided to the participants? If yes, did receipt/non-receipt of CD4 count results affect access to care?

• Relationship between CD4 count (immune status) at time of HIV diagnosis and access to HIV care?

• Relationship between post-HBHCT peer educator follow-up visits and access to HIV care?

Health facility factors and access to HIV care services

Paragraph 1

• Consider presenting this information under a different sub heading e.g. ‘time to access to HIV care’
• When reporting time to access to care, it may be helpful to use time points
(after HIV diagnosis and referral) that make it possible to compare findings in your study with those of other studies e.g. 3, 6 or 12 months

Best fitting model for factors influencing access to HIV care services

Paragraph 2: It seems the variable “Perceived benefit of obtaining information from health facility” is mentioned for the first time here. As for the other variables it may help to mention it in the methods.

Unadjusted and adjusted Odds Ratios of statistically significant variables for access to HIV care services

• Please consider deleting this section as the information presented has already been provided elsewhere

Table 1
Please consider the following
• Delete text above table (not title). The information has been provided under ‘results’ and is also summarised in the table.
• Use row instead of column percentages.
• Consider re-categorising ‘education’. The sub-category ‘ever been to school’ is too broad and may mask effect of education if any e.g. an individual with only 1-2 years of schooling is in the same category with one who has completed >10 years of school.
• Add results presented in table 2 (relation between community related factors and access to HIV care)
• Delete the 3rd column (did not access HIV care)
• Add results for adjusted analysis
• Revise title as appropriate after making above changes

Table 2
• Please consider combining this table with table 1
• Please delete text above table (not title). The information has been provided under ‘results’ and is also summarised in the table.

Table 3
• Please consider combining this table with table 1
• Please delete text above table (not title). The information has been provided under ‘results’ and is also summarised in the table.

Figure 1
• As mentioned above, it may be helpful to use time points (after HIV diagnosis and referral) that make it possible to compare findings in your study with those of other studies. For example, few studies are likely to report access to care within a day of HIV diagnosis.
• The proportion of participants who accessed care within the first week is higher than that for participants who accessed care within the first month. This is confusing since one would expect those that accessed care within the first month to include individuals that accessed care within the first week after HIV diagnosis. Similarly those that accessed care within a day of referral would be included among those that accessed care within the first month of HIV diagnosis.

Discussion

General: Access to HIV care (as defined in this study) was much higher than that reported in similar studies where except for referral to care, no other strategies were employed to ensure referral uptake. What might be the reasons for this?

It is briefly mentioned in the paper that peer educators were trained to conduct follow-up visits for HIV positive clients. Did peer-educator follow-up visits actually happen? If yes, might this intervention have increased access to HIV care?

• Paragraph 1, 2nd sentence: please consider deleting this sentence as it is a repetition of the results

• Paragraph 2, 2nd sentence: The references provided to support the current study’s findings regarding the association between age and access to care are for HIV testing studies (that do not report access to care). Please consider citing studies that have reported access to HIV care

• Paragraph 2, 3rd sentence: Please consider providing a reference for this statement.

• Paragraph 3, 1st sentence: Please consider providing a reference for this statement.

• Paragraph 4, 1st sentence: “Other researchers found similar rural-urban disparities in uptake of HIV testing services.” Please consider citing literature on rural-urban disparities in access to HIV care rather than literature on HIV testing services.

Also as mentioned above it would have been helpful to explore other health facility factors e.g. level of health facility, staffing, presence of ART clinic, drug supplies, etc. that may be influenced by the rurality/urbanicity of facility location.

• Study limitations, 3rd paragraph: persons aged <18 years were not part of the study population. Therefore, the study would not be expected to report patterns of access to care in this population.

It may be worth explaining why persons aged <18 years were not excluded from the dataset before sampling for the current study.

• Conclusion, 1st paragraph: The information in the paragraph has been presented elsewhere in the discussion and the results. Please consider deleting this paragraph.

Minor Essential Revisions
Methods, Data management and analysis

General comments
• Consider removing reference to ‘quantitative data’ since no other type of data was analysed in the study.

Discretionary Revisions

**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