Author's response to reviews

Title: Perceptions of Sudanese women in their reproductive years towards HIV/AIDS and Prevention of Mother to Child Transmission HIV services

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Author's response to reviews: see over
Dear Dr. Kathleen Deering,

We were delighted to receive the second round of review for our manuscript (MS: 9776761014228302) which gives us the opportunity to revise the manuscript. Herewith we submit the revised version of our manuscript entitled “Perceptions of Sudanese women in their reproductive years towards HIV/AIDS and Prevention of Mother to Child Transmission HIV services.”

We believe that we further improved the contribution of this manuscript to the literature by following to the reviewers’ comments. We also shared the manuscript with a copyeditor for proofreading as advised by the editor.

Detailed responses to the reviewers’ comments are described below.

We remain committed should you have any further suggestions for improvements of our manuscript.

On behalf of authors,

Sincerely,

Ibrahim E Elsheikh

Sudanese Public Health Association (SPHA)

Maastricht University/CAPHRI
Reviewer's report

Title: Perceptions of Sudanese women in their reproductive age towards HIV/AIDS and Prevention of Mother to Child Transmission HIV services

Version: Date: 25 April 2015

Reviewer: Annabelle Gourlay

Reviewer's report:

Thank you for the opportunity to re-review this manuscript and to the authors who have made some useful clarifications and revisions to this manuscript.

Nonetheless, I believe there are still some enhancements that could be made, or that were not completely addressed following the initial review, as outlined below.

Furthermore, although the grammar and spelling has been improved, it is still poor in places and I strongly recommend if this article is published that the English language throughout the article is checked thoroughly again.

Many thanks for your constructive comments and feedback during this second round of review.

We have shared the manuscript with a copyeditor for proofreading and we are delighted to provide responses to the comments as shown below:

Major compulsory

1. Abstract paragraph 2 - I would still recommend that the theories used are mentioned in the abstract, either in the methods or referred to and used to organise the results paragraph. ‘Being pregnant was given preference’ is a bit unclear or the English sounds odd, so the authors could state the number of pregnant women included instead.

One sentence about theories was added to the abstract under methods section. Being pregnant was given preferences; here we were trying to convey that, during the recruitment preference was given to women who were pregnant at the time of data collection. I.e. priority of recruitment (inside households) was given to a woman who is pregnant unless she opted out. Number of pregnant women who participated, we mentioned this under methods in the manuscript and now we also added that in Abstract. Because of the limited number of words in Abstract we just mentioned the names of the theories. We elaborated more about the theories used in the
Ten focus group discussions (FGDs) with women in their reproductive age were conducted at community settings in Khartoum (N=121). The recruitment eligibility includes; living near or around a PMTCT site and being in the age range of 18 – 40 years. Out of 121 women participated, 72 (61%) were pregnant. Pre-defined themes were addressed in the theory-based interview scheme, which was derived from multiple socio-cognitive theories; i.e., Extended Parallel Process Model, Reasoned Action Approach and the socio-psychological view on stigma. Emerging themes were incorporated during data analysis.

The study reveals that most of the women felt susceptible to HIV infection with perceived high severity; however, this perception has not translated into positive attitudes towards the importance of HIV testing during pregnancy. Because of anticipated stigma, women are not likely to disclose their HIV status. Further research should focus on gaining a more in-depth understanding of the psycho-social determinants and processes underlying the factors identified above. In addition, the adequate implementation of Provider Initiated Testing and Counseling (PITC) should be critically assessed in future research about PMTCT in Sudan.

Sudan has adopted option B+ for the PMTCT treatment protocol since 2012 (10). In option B+; women receive (depending on cluster of differentiation count); Triple ARVs starting as soon as diagnosed, continued for life.
4. Background line 101 – the authors have clarified that there has been little research in Sudan on PMTCT but I am still not sure from the modifications and authors’ letter whether there has been ANY research at all in Sudan on PMTCT. If there are no papers on PMTCT in Sudan please make this clearer as this will really strengthen the importance of this paper. Otherwise, please briefly summarise any small amount of research that has been done and what is not known.

Yes, it is true; very little research was done on PMTCT in Sudan. And according to our review only two papers were published one is about knowledge and attitude and is entitled: *Knowledge and Attitude toward HIV Voluntary Counseling and Testing Services among Pregnant Women Attending an Antenatal Clinic in Sudan. Mariam M. Mahmoud, et al* Journal of Medical Virology 79:469–473 (2007. The other one is descriptive study about the status of HIV (not focused on specific determinants): *The current status of maternal HIV infection in Sudan: time for action? Zahir OE Babiker, et al, Sudan Med J 2010;46(3).* Both articles were cited in our manuscript. There might be other small researches which weren’t published. We have added few sentences about this in line 96 as follows:

Very limited research studies were done about PMTCT in Sudan. According to our review, only a couple of papers were published, which are cited in our paper. We are unaware, however, of any un-published research.

5. Background - In their response letter the authors mention the year that an opt-out testing policy was implemented (in antenatal clinics for all pregnant women?) in Sudan – this would be very useful to state in the background.

The revised paragraph in the background lines 77 - 82. Now reads as follows:

In Sudan, PMTCT services began in 2005 by a pilot in a few states. In 2007, there were seven sites; this was scaled up to more than 27 sites in 2010 (9) and to 227 in 2013 (10). The opt-out strategy was piloted in Sudan in 2007 and adopted in 2009; in 2012 the PITC was introduced. Although PMTCT services are provided through tertiary, secondary and primary levels of healthcare, full implementation of the standard PMTCT package is limited to the tertiary level (10).

6. Methods – I could not find the year the study fieldwork was conducted.
This filed work was done in November 2013. The year was added.

Ten focus group discussions (FGDs) with women in their reproductive age were conducted at community settings in Sudan’s capital, Khartoum in 2013.

7. Results – the authors have made some improvements to the structure of the results, although I still feel that the structure could be more closely aligned to their framework presented in table 1 – e.g. is perceived importance of HIV testing during pregnancy part of ‘attitudes/ subjective norms/ behavioural control’?

Although the authors have mentioned all the theories they considered in constructing their interview guide, they did not really elaborate on these theories in their background, so this may be why it then becomes a bit challenging to the reader to link the results back to each theory.

We actually followed the structure that we have outlined in table 1. However, we grouped the themes in main four categories to facilitate the formulation of the results.

“We have used the theories to shape the interview guide. It might indeed be that there is overlap between certain theories, but the aim of this study was not to validate these theories. It might indeed by, that perceived importance affects behavioural beliefs underlying attitude, but future research is needed to disentangle that.

8. Discussion lines 361-363 – The authors gave some useful information in their response letter which could be included in the text of the manuscript, for example what they feel are their study strengths, and they also mention in the response letter that they acknowledge the limitation of using notes instead of tapes although this also had other benefits – this information would be useful to the reader of the manuscript. The authors also mention in their response letter that access to PMTCT services is limited to big hospitals, but I did not see that stated anywhere in the manuscript. This would also be useful context to add.

The issue of the fact the PMTCT services are limited to big hospital was added into the background section line 82. The points about strengths and limitation were captured and reflected. The updated paragraph line 373 is now reads as:

Our study has a reasonable sample size despite the sensitivity of the topic and the uniqueness of the respondents. A limitation of this study is that it has been conducted among women in Khartoum capital (and peripheral neighborhoods) only, which might endanger the generalizability of the findings. However, Khartoum capital city typically represents a wide
spectrum of people originating from all other regions of Sudan. The use of notes instead of tapes could also be a limitation; however, this has brought a lot of advantages in getting genuine information from the women who participated freely.

9. Discussion final paragraph - The authors have added some recommendations but they are still a little vague (e.g. functionality and practicality of PITC) or lacking discussion of how this might be achieved. For example, do the authors have any suggestions of how the implementation of PITC in ANC in Sudan could be improved? Based on their response letter, I think the authors accidentally omitted ‘such as stigma and psychosocial determinants’ from line 372. Other relevant literature could again be reflected on and referenced. Since this research was done among women at community settings we don’t have interviewed the health care providers to get more insights about the key issues affecting the full implementation of the PITC. Here we are reflecting on women’s views. We are having another paper in which we are addressing the PITC in a comprehensive way. Nevertheless, we have amended the sentence to read as follows:

It is recommended that for any HIV/AIDS program, a holistic approach that tackles all aspects of the program should be adopted. In addition, the adequate implementation of PITC should be critically assessed in future research about PMTCT in Sudan.

For the phrase ‘such as stigma and psychosocial determinants’ from line 372, we omitted it intentionally as we thought this a redundancy because stigma and psychosocial determinants could fell under the holistic approach that we have recommended.

Minor essential revisions
10. Abstract line 44 – I still find the English a bit odd here – perhaps something like ‘most women believed that HIV/AIDS is a serious and fatal condition’ might read better. (minor issues not for publication)
Amended, now reads as follows;
Most women believed that HIV/AIDS is a serious and fatal condition for them and also for their children.

11. Background line 71 – out of all new HIV infection cases in what year? 2014?
In 2010. The year was added to the paragraph as follows:

In Sudan the HIV epidemic is driven by heterosexual transmission and according to a review conducted in 2010 it is estimated that out of all new HIV infection cases, 59% occurred in women in their reproductive years (15-49 years). PMTCT services are therefore a high priority. Effective delivery of PMTCT services is highly rewarding as it can reduce the risk of MTCT of HIV infection and ultimately eliminate new HIV cases among children (7).

12. Background lines 83-85 and 91-93 – grammar revisions needed (minor issues not for publication). Revise to read as follows:

Sudan has adopted option B+ for the PMTCT treatment protocol since 2012 (10). In option B+, women receive (depending on cluster of differentiation count) Triple Antiretrovirals (ARVs) starting as soon as they are diagnosed, continuing for life (11). In 2013, only 7% of pregnant women took an HIV test, mainly due to inefficient implementation of Provider Initiated Testing and Counseling (PITC), which can be attributed to health system factors such as the reluctance of healthcare providers to provide HIV testing for pregnant women, lack of accountability and weak integration of HIV testing as part of the routine tests for pregnant women (10). Incomplete implementation of the opt-out strategy regarding HIV testing, limited training of health care providers and delay in shifting from vertical to integrated programs were also mentioned among key factors affecting the scale up of PMTCT services (9) (7)

13. Background line 97 – indented? Do you mean identified? (minor issues not for publication).

Yes, we meant “identified”. We have corrected the spelling.

14. Methods line 129 and 130 – ‘They’ – I would clarify that you are referring (presumably) to the facilitators. (minor issues not for publication)

Yes, we are referring to the facilitators.

15. Methods – line 140 – useful additions to the methods have been made, but can you provide a brief sentence on how random sampling was done – ie what was the sampling frame?

Purposive and simple random techniques were used to select the respondents. Purposive sampling was used to select the 3 districts, 10 communities and the 121 women from houses
based on the eligibility criteria. The sampling frame was the total number of the households in the ten communities which were located near or around the five PMTCT sites. The houses in a selected community were selected by first identifying the center of the community. After locating the center of the community, the community agent/volunteer span a pen to pick one direction (where the mouth of the pen pointed). The first house in the direction was entered and all the eligible women who accepted to participate were enrolled. From the first house, the next house entered was the house which gate faces the exit gate of the completed house. This process was followed till all the 121 women were selected from the 10 communities.

The paragraph in the manuscript was revised to read as follows:

Recruitment of participants

Purposive and simple random techniques were used to select the respondents. Whereas women were purposively selected, the communities and households were randomly identified. Ten communities from three localities in Khartoum state (Khartoum, Omdurman and Bahri) were purposively selected based on the fact that they were around the main five PMTCT sites in greater Khartoum. The sampling frame was the total households in the ten communities that were located near or around the five PMTCT sites. Consecutive numbers were assigned to each household and then 121 households were randomly selected. Women in their reproductive years were recruited \((N = 121)\) by community agents/volunteers upon entering the randomly selected houses. Inside the household, all eligible women were recruited. This process was followed until all the 121 women were selected. Most of the women who were approached accepted. The recruitment eligibility included living near or around a PMTCT site and being in the age range of 18–40 years. Those who were pregnant were given preference. HIV status was not part of the selection criteria. Women were told in advance that the discussions would be about HIV and AIDS. Most of the actual participants fell mainly into two age bands of 20–29 and 30–38 years. Women of similar ages participated in the same FGD. Of the 121 women who participated, 72 (61%) were pregnant.

16.Methods line 146 – ‘attention was paid to the age factor’ – suggest just removing this and saying women of similar ages participated in the same FGDs. Yes, amended as follows: During the group discussion women with similar ages participated in the same FGD.
Can you make this even clearer by saying what age bands the groups were? Eg. 20-25; 26-30 etc? (minor issues not for publication)

Amended. Now it reads as follows:

Most of the actual participants fell mainly into two age bands of 20–29 and 30–38 years. were pregnant.

17.Methods line 156 – ‘Interviews were held.’– I think you mean Discussions? (minor issues not for publication)

Yes, we meant discussions. Amended in the manuscript.

18.Methods line 187 – manually analyzed by who? How many people - 2?

Manually, as in by hand without a computer - I find this unclear because you said the notes were typed up and transferred onto a computer so it is not obvious.

By manually we meant that the analysis was done on the computer, but not through dedicated software for qualitative analyses. The initial one was done by the facilitators and then the principal investigator compiled the analysis following detailed discussions with the facilitators of the FGDs.

19.Methods line 188-189 – I think you mean only a few new issues arose that were not part of the pre-defined themes?

Yes, we have amended the paragraph which now reads as follows:

_Only few issues arose – husband’s infidelity and mistrust in laboratory results – and these were linked to the pre-defined themes during the analysis_