Author's response to reviews

Title: Facilitators and barriers to cotrimoxazole prophylaxis among HIV exposed babies: a qualitative study from Harare, Zimbabwe

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Response to reviewers’ comments for MS 1582465868162528

Thank you for reviewing our paper and for the useful comments given. We take great pleasure in submitting responses to the reviewer comments as follows:

Reviewer: Celia Dana Claire DC Christie-Samuels

1. Page 79, para 1, line 78-79: The study objectives indicate that the whole package of service for HIV-exposed infants along the PMTCT cascade was examined, however there is no mention of PCR testing in early infancy (was this not yet available)? Would that also include immunizations? Breast feeding and attention to infant nutrition? Maternal adherence to ARV’s considering there is breastfeeding? Should this part of the objective be reworded?

Response:
The qualitative study that is described in the manuscript was nested in a wider mixed-methods study that was aimed at exploring barriers to uptake of services along the PMTCT continuum of care; however in this paper we have only focused on the qualitative study that explored adherence to cotrimoxazole prophylaxis. We have now clarified this in the text on page 5, lines 87-89.

2. Although this is listed as a “qualitative study” and therefore the numbers of reported participants is less important than the stories and/or themes, the way in which the data is reported is not wholly reflective of a qualitative study such throughout. There are many areas where the paper reports quantitative data (eg.,line 102 - 16 were married; line 116 - all women desired baby’s health; line 147 –all were devastated; line 178 – six husbands were positively supportive; line 196 – five men had taken small steps; 208 – five husbands were proposed to CTX-p, line 220 – two women stopped taking cotrimoxazole; etc) and in other areas where this is not done (see a-k, as follows). Would it be better to increase consistency and change this to a “mixed methods” “Qualitative and quantitative” study by spelling out the actual number of cases involved in each instance, as follows?
   a. Page 6, line 102: “Most” (how many?)
   b. Page 7, para 1, line 125: “they” (how many)
   c. Page 7, para 3, lines 130-132: How many?
   d. Page 7, para 5, line 136: Perceived ineffectiveness (how many?)
   e. Page 7, last para line 141: women (how many); line 142, Most, (how many?)
Response: We wish to clarify that the study reported in this manuscript is a qualitative study that was conducted among twenty participants. The approach to sampling, data collection and analysis was according to qualitative study conventions where we seek to have an in-depth understanding of people’s social contexts. The sampling process was not designed to give a representative sample, so it would be inappropriate to include numbers and/or proportions in each case. Where we have included numbers in the text, it is with a view to showing patterns in the findings, e.g. whether a view was expressed by the majority or minority of participants, and is not intended for statistical inference.

In lines 118-119 we have now clarified that the numbers quoted in that specific paragraph are meant to give the reader an idea of the characteristics of interviewed women.

3. Page 4, para 2, line 74: Perhaps it might help if prior reasons for poor uptake of HEI could be elucidated from the literature, whether here or elsewhere in the manuscript? (pre refs 10,11,12).
Response: Thank you. On page 5, lines 76-85, we have now added findings from the literature on barriers to retention of infants along the cascade, and specified the dearth in literature on challenges faced among caregivers whose infants are retained in regular follow-up at health facilities.

4. Page 5, par 2, line 87: Any reason why not all babies received NVP prophylaxis?
Babies whose mothers were on ARVs for their own health were not prescribed nevirapine prophylaxis after the age of six weeks, according to the WHO guidelines. We have now clarified this in lines 99-100.

5. Page 5, para 2, line 91: Any particular program that was used to aid data analysis, or coding?
Data handling and analysis was done using NVIVO 10, and we have now clarified this in line 105-6.

Page 5, para 3, line 92: Do we know what the response rate was, ie how many women refused to participate?
Out of 35 HIV positive women who were identified during the survey, 20 agreed to regular follow-up (and were therefore interviewed at 4-5 months for this qualitative study), four were lost to follow-up and 11 refused regular follow-up. We have now provided this information in lines 107-110.

Page 18, Table 1: Need to spell out meaning of ANC, VCT, PMTCT etc when they are first used.
Thank you. We have now written these out in full in the table 1.

Reviewer: Christopher Gill
1. Intro – the author notes that HIV exposed/uninfected children may suffer various immune deficits which Dr. Sibanda attributes to maternal health, poverty, and as a source of exposure to the infant.
To note simply that there is growing recognition that such infants may suffer from more innate immune deficiencies, not just acquired by the post-natal environment, but due to alterations in T cell function in utero. It may be worth expanding this point, since it speaks to the rationale for Ctx prophylaxis even if early HIV infection can be excluded.

Thank you; on page 4, lines 54-57, we have now expanded the point to include the additional vulnerability as a result of altered innate immune development.

2. Intro – it is stated that barriers to CTx ‘at various steps of the PMTCT cascade.’ will be assessed. That was a slight disconnect with the result section, which wasn’t structured clearly with that theme in mind. Perhaps this point could be clarified, or the results section organized in such a way as to make this more transparent?

Thank you. We have clarified (in the introduction section, lines 87-89) that this small qualitative study that explored barriers to CTX-p was nested within a wider study that investigated barriers along the PMTCT cascade.

3. Methods – please clarify that subjects were interviewed individually, not in groups.

Thank you. In the Methods section, line 98, we have now clarified that participants were interviewed individually.

4. Methods – can you provide the question guide in a table in the paper, or an appendix if it is quite long?

Thank you, because these were qualitative in-depth interviews where conversations and probes were allowed to flow naturally, we feel it is inappropriate to provide the discussion guide as each interview flowed differently according to the nature of participant responses. In addition, as reflective of best methodological practice in qualitative research, the specific nature of the questions should evolve as the data collection proceeds because they are informed by emerging analytical ideas. We therefore feel a summary of key areas of investigation will be more appropriate, and we have now created a table with this summary (table 2), and referenced it in line 103. In case you would still like to see the interview guide that was used, we have also attached it for your information.

5. Results – the tricky part of reporting on qualitative results is understanding how generally held were certain key attitudes. Through most of the results, the authors make an interpretative statement about their data (a theme, if you will), and then back that up with a representative quote. That’s fine, but leaves open whether the quotes were cherry picked to reflect a point of the author’s? Or whether the quotes were representative of similar statements? Presumably you are arguing for the latter, but to strengthen that case it feels insufficient just to state, as you did for example on line 116, “All women desired their baby’s health above all else.” That assertion makes me question, ‘All, really?’ and, ‘Above all else, really?’ Very strong statements, but the only thing backing up the single quote. This seems like a general problem throughout the results, but relatively easily addressed by providing more summary data on the %s of women who made such assertions, and perhaps offering further supportive quotes.

Thank you. In all instances we have selected quotes in order to represent the similar views that were expressed by participants. Because these were in-depth interviews that flowed differently according to participant responses, similar views were expressed differently in different interviews, some expressed more fluently than others.

We have now included more quotes in some cases, lines 140-142; 151-155; and 210-212.
We agree that in some cases we have used very strong language, so we have made changes, for example, in lines 133-135, we have now provided alternative wording (which retains the meaning) for the sentence “All women desired the health of their babies above all else”, to “In all interviews, it was clear that women were anxious about how their HIV infection might affect their babies’ health; they reported being determined to do their best to ensure the baby’s wellbeing”.

As discussed above for the Question 1 of the other reviewer, because this was a qualitative study the sampling process was not designed to give a representative sample, so it would be inappropriate to include numbers and/or proportions in each case. Where we have included numbers in the text, it is with a view to showing patterns in the findings, e.g. whether a view was expressed by the majority or minority of participants, and is not intended for statistical inference.

6. Results – from Line 170, how many husbands/partners? Were they interviewed directly? Or were their attitudes as reported by their wives (which is what lawyers would call ‘hearsay’)? Please clarify.
Sixteen women were married. No, the husbands were not interviewed; their attitudes were reported by their wives. This has now been stated more explicitly in lines 194-196. In the limitations section, lines 384-5, we have now stated that men’s attitudes to adherence were reported by the women, and not by the men themselves.

7. Results – same section. You report a ‘striking dose response’ relationship. The use of such strong language begs strong evidence to support it, but really you don’t present data to back up this assertion. Please do so.
Thank you. We have re-worded the section to remove the strong language, but have maintained the intended meaning: in lines 196-198 we have replaced “striking dose-response relationship” with “When looking at patterns in the women’s responses on level of adherence support they received from their husbands, it was clear that the less engaged in HIV issues a husband was, the less supportive for CTX-p”. The information (on the increase in adherence support according to how engaged a husband was) is based on an analysis that we did as we examined the patterns of adherence support/lack of support that the women reported – so it is not possible to support this relationship using quotes as it is a result of the detailed analysis we did. We have now explicitly stated that this is based on analysis of patterns in participant accounts (in lines 195-201).

As part of the descriptions of each type of husband, however, we have provided the women’s quotes to illustrate the support/lack of support they were getting from their husbands.

8. Results – same section, please provide N of husbands in each category up front.
Thank you. We have now done this in lines 199-201.

9. Results – line 220 – how many women were taking CTx?
Thirteen women were in regular HIV care (some were on ART and others were in regular assessment for ART eligibility). Among the seven women who were not in regular care, two had been stopped from taking CTX-p by their husbands. We have now clarified this in lines 248-250.
10. Discussion – I was in broad agreement with your interpretations. However, you lacked a limitations section and need one. The sample size is small; its hard to be sure your findings were typical; not clear how they were recruited; single point in time; single region surveilled; etc. These are typical problems in qual research, so not a barrier per se, but please at least acknowledge them. Thank you. We have now added a limitations section, lines 381-385.

11. Discussion – I was struck by the fact that stigma WITHIN the married couple (i.e., husband stigmatizing HIV positive wife) was so pronounced. A reminder that stigmatization is not just about the individual and their larger peer community, but even exists within a couple. Sad. Thank you. We have added a sentence about this in the discussion section, lines 349-351, where we talk about stigma.

We look forward to hearing from you.

Yours sincerely

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