Author’s response to reviews

Title: Building an innovative Chagas disease program for primary care units, in an urban non-endemic city.

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Author’s response to reviews:

First of all, I would like to thank the reviewers for their time and for their valuable comments and suggestions.

Reviewer reports:

Michael Reich (Reviewer 1): This is an important paper about an innovative public-private partnership to provide treatment for Chagas disease in Argentina. Overall the paper seems to have two different purposes: 1) to demonstrate the feasibility of this innovative program, and 2) to describe the healthcare barriers and to explore the implementation process. The authors could explain better how these two purposes are related to each other in the paper. More structured discussion would also be helpful about how the barriers were overcome by the public-private association.

The explanation of how these two purposes are related has been added to parts of the background, methods and discussion. A more structured discussion was also provided, and parts that were considered methods were moved to that section.
Specific comments;

line 16: Abstract: Please explain how you "prove the feasibility"; perhaps it should be "demonstrate" rather than "prove"

prove was changed to demonstrate

lines 72-72: Was Ramon Castillo the Minister of Health? Explain his position.

This position was explained accordingly

Line 79: There is an error here; surely the authors do not mean "1940" since Alma Ata Declaration happened in 1978.

In order to clarify this concept, this statement was changed as follows: “From 1940 onwards and driven in the 80’s by the Alma Ata Declaration, primary care units grew throughout the country”.

Line 89: Again, as noted above: Please explain how you "prove the feasibility"; perhaps it should be "demonstrate" rather than "prove"

This was also changed from prove to demonstrate.

Lines 116-117: Explain what the four dimensions of the Peters D model are, and why the authors selected this model.
This explanation was added as follows in lines 119-128: “The four dimensions described by Peters, D et al. [18] – geographic accessibility, acceptability, availability and financial accessibility – were used and some criteria were adapted to ChD specificities in order to make it more appropriate for the analysis of this project (Table 2). All the criteria shown in Table 2 were listed in a questionnaire. The aim was to explore their existence or lack thereof and the level of implementation (i.e. existence of guidelines but not implemented, policy and macro environment, geographic accessibility, availability and financial accessibility). All the questions were made by the same researcher and double checked with local authorities, health teams and in some aspects with patients from the MPCFs. The aspect acceptability was not explored. This model was selected because of its feasibility for low and middle- income countries and the experience from other countries (18). The baseline was measured during the pilot project and the same items were evaluated at the end of 2017.”

Lines 120-122: Explain briefly what the implementation model is from Damshroder, and why this model was selected and how it was used.

This was added in lines 129-137 as follows: “For the implementation process, the CFIR model from Damschroder LJ et al. [19] was used. This model is composed of five major domains: intervention, characteristics, outer setting, inner setting, characteristics of the individuals involved and the process of implementation. This framework was selected because of its feasibility to be used in complex and multi-level structures. The assessment was performed during the pilot project and during the startup of the project. All the criteria shown in Table 3 were listed in a questionnaire. Questions were made by one researcher to local authorities, local health teams and head directors of local hospitals. The aim was to explore the general context and the intervention characteristics. Minor changes were applied (i.e. some few items were grouped for their evaluation) in order to make it more suitable for the analysis and scope of this project.”

Lines 136-139: Explain how the four dimensions of access barriers were analyzed; what methods were used to assess these access barriers?

This was added together with the explanation of the models used, lines 119-137.
Lines 151-152: How were the characteristics ranked "according to needs for improvement and strategic relevance"? What methods were used for ranking?

This was added to the method section in lines 181-190 as follows: “Many aspects were evaluated and many of them showed the necessity to be scaled-up. The characteristics were ranked according to needs for improvement and strategic relevance for implementation of the ChD program. Specifically, the lack of good roads and adequate public transportation were identified as main access barriers since the traditional type of provision of health services in Argentina requires the movement of patients from one provider to another in order to complete the diagnostic and/or therapeutic process. Structural changes to solve this situation were not within the scope of the project but it was possible to change the way services were provided in order to be able to increase adhesion. Another important barrier identified was the lack of a healthcare network; therefore, it was necessary to work with the hospitals in order to receive those patients that required complex diagnostic procedures or specialized treatments that could not be provided in the first care level. Both of these were a priority because, if not, the ChD program could not have been implemented.”

Line 155: What amount of financial resources was provided by Mundo Sano?

This was added in line 193-194 as follows: “The financial resources eventually provided were scarce (< USD$7000) in order to assure the sustainability of the project once MS was no longer involved.”

Line 175, Table 3: How was this table completed through implementation analysis? What methods were used? Were there any conclusions from the implementation analysis? How is this information related to "feasibility" of implementation?

This information was added to the method section, lines 139-137 and 212-215.

Lines 185-217: This information on what happened in the project belongs earlier in the paper, rather than in the Discussion.

This section was moved to the method section.
Lines 235-237: Mundo Sano made important contributions to this project, by buying equipment and by investing in training; how will this be continued by the municipal government to continue this program and also implement the program in other cities?

This was explained in the discussion since the municipality continues performing the program in La Plata with only occasional funding from MS. Implementation in other cities is being explored but as of today there are no signed framework agreements to move forward.

Lines 258-261: Is continued involvement by MS necessary to assure the program will continue? In what ways, and Why?

This was added to the discussion.

Line 277: Some brief discussion about the sustainability of public-private associations (to assure continued programs for ChD diagnosis and treatment) would be helpful. Can this kind of program be implemented in other countries where MS is not active? What are the necessary conditions for successful implementation?

Some sentences in this regards were added in the discussion and conclusion.

Werner Apt (Reviewer 2): Are the doctors of La Plata permanent? This was added to the method section in line 154.

How is the sustainability of the program ensured?

This is was added to the discussion section of the manuscript.