



SDI Review Form 1.6

Journal Name:	International STD Research & Reviews
Manuscript Number:	MS: 2013_ISRR_5867
Title of the Manuscript:	Scaling Up Community ART Groups in Mozambique
Type of the Article	

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
<u>Compulsory</u> REVISION comments	As noted in the next section, the paper needs to give a larger sense of the future evolution of the CAGs, to increase the added value of this paper over previously published papers.	We updated the statistics for the provincial roll out. Moreover we refer to the early results of the of a pilot site of the national roll presented recently in Kuala Lumpur. More results of the national CAG roll out data will be available when a formal evaluation will be effectuated.
<u>Minor</u> REVISION comments	Line 37: these LTF estimates are not consistent with that reported by the cited review. Please revise. Line 41: compromised by the current provider-centered biomedical model" This is going a bit far. Given that still today 1 in 4 people are presenting with a CD4 <100, there is certainly a clear need for doctors and hospitals in the AIDS response.	Meta-analyses: <i>Median attrition at 12, 24 and 36 months was 22.6% (range 7%-45%), 25% (range 11%-32%) and 29.5% (range 13%-36.1%) respectively. After pooling data in a random-effects meta-analysis, retention declined from 86.1% at 6 months to 80.2% at 12 months, 76.8% at 24 months and 72.3% at 36 months. Adjusting for variable follow-up time in a sensitivity analysis, 24 month retention was 70.0% (range: 66.7%-73.3%), while 36 month retention was 64.6% (range: 57.5%-72.1%).</i> → We referred to the latter figures. This phrase was deleted.



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	Line 47: “With these perspectives in mind, in 2011, the Mozambique Ministry of Health began reshaping” This is confusing – if the model was piloted in 2008, then the ‘reshaping’ began in 2008 not 2011. Line 59 “From 2003 to 2011,” Please add months. Line 84: “These strategies, however, are unlikely to adequately address the challenges of an ever-growing ART population” My understanding of the CAG model is not only to manage increasing patient numbers but also because stable healthy patients don’t need to go to clinics so regularly (irrespective of numbers) Line 185: “30 (2,3%)” Do not use commas for decimal places – that is French, not English. Line 272: This section ends abruptly. What were the actual outcomes of the 30 pilot sites? What is the future roll out perspective for CAGs? Page 321: “However, the eligibility criteria that requires patients to be clinically stable and to have been on ART	Resuming the text this phrase was deleted. Months were added. We rephrased. <i>These strategies, however, are unlikely to adequately address the challenges of an ever-growing ART population in a country that has goal of providing universal access to ART for PLWHA by 2015. It is imperative to develop out-of-clinic approaches to facilitate ART refill for healthy patients.</i> We have adjusted (2.3%). We added information on the early results of the national roll out. The future roll out perspective will depend on the evaluation of the pilot sites. <i>Early results show that the CAG strategy was well accepted. Treatment outcomes of CAG members compared favorably with outcomes of patients in conventional care. Moreover patients of neighboring districts began to ask to be allowed to form CAG. The rigorous evaluation of the national pilot will guide the future development of this community based ART model.</i> We have adjusted and refer to long term attrition (after 2 years on ART) reported in the meta
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	for 6 months before being able to join the program limit the comparison due to survivorship bias.” There are published studies that report rates of LTF after 1 year on ART; these could be used as indirect comparisons (rather than simply concluding that the results are excellent but flawed).	analyses of Fox & Rosen. <i>A meta-analysis of attrition in sub-Saharan countries documented an attrition of 5 per 100 person-years among patients more than two years on ART [2]. The latter can be considered as a threshold for attrition among stable patients. The outcomes among members in CAG, with 2.2 attritions per 100 person-years, compare favorably. However, the eligibility criteria that require patients to be clinically stable and to have been on ART for 6 months before being able to join the program limit the comparison due to survivorship bias.</i>
<u>Optional/General</u> comments	None	