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Title	Missed opportunities for the prevention of vertical HIV transmission in Canada, 1997–2016
Authors	Ari Bitnun, MD MSc, Terry Lee PhD, Jason Brophy MD MSc, Lindy M. Samson MD MSc, Fatima Kakkar MD MPH, Wendy Vaudry MD, Ben Tan MD, Deborah M. Money MD, Joel Singer PhD, Laura Sauvé MD MPH, Ariane Alimenti MD; for the Canadian Perinatal HIV Surveillance Program
Reviewer 1	Fiona Smaill
Institution	Department of Pathology and Molecular Medicine, McMaster University, Hamilton, Ont.
General comments (author response in bold)	1. The trend comparisons over time are divided in three - evenly. Is this an "appropriate" way to divide the time periods, e.g. were there different guidelines and options in place for treatment/screening at different points? **See response to editorial comment 7.** 2. Provide a rationale for the geographic grouping. I could not clearly see what the MIT rates were for each province and think this could be helpful even if the numbers are small. **This was discussed at length by the team when we did the original analysis. We have modified the analysis with region separated into the following categories: BC +Yukon territory; Alberta; Saskatchewan; Manitoba; Ontario; Quebec; Atlantic Provinces. The Atlantic Provinces were pooled as the numbers are small. Yukon was added to BC for the same reason. Due to the very small numbers from the Yukon, we have indicated <5 cases in the footnotes to tables 1, 2 and 3 (due to confidentiality concerns). There were no cases from the Northwest Territories or Nunavut.** 3. Re the discussion: "The lower uptake among women who inject drugs, indigenous women and women who live outside of the Western region may reflect insufficient resources to provide services tailored to these women's specific needs. Limited healthcare outreach capacity, especially to rural locations, and inability to track women who move from place to place may be of particular significance. HIV stigma, drug addiction, coexisting mental health illness, and lack of trust in the healthcare system are also likely important contributing factors. 7,9,14-17 The availability of women centric, integrated HIV and antenatal multidisciplinary clinics in which multiple services and providers can be accessed in a "one stop" model may also contribute to regional differences." It would be good if the data presented could be used to inform these statements rather than just saying: "may". **We have completely revised the paragraph in question as suggested by the editor (to cut back on editorializing). See response to editor comment 9.** 4. Who would take responsibility for treating each VT as a sentinel event? **We have included a sentence suggesting a public health role, but also indicted the importance of collaboration between public health, care providers and community (last sentence of the third paragraph of discussion). The two relevant sentences currently read as follows: "Treating each VT event as a sentinel health event, whereby system failures are identified and corrected was associated with a reduction in VT rate from 4.3% to 0% in Philadelphia, and could potentially be helpful in Canada.18 Applying such a strategy will require adequate resources for Public Health, close collaboration between public health and frontline healthcare providers, and perhaps most importantly, strong community engagement."** 5. Is there any possibility that some of the "incomplete" ART regimens reflect settings where the maternal IV ZDV and infant ZDV were deemed unnecessary because of maternal control of virus (although this is not keeping with current guidelines)? **Current American and Canadian guidelines recommend infant receive zidovudine for minimum of 4 weeks even if maternal management is optimal. It is possible some physicians did not prescribe IV zidovudine in labor based on U.S. guidelines. However, as this is a Canadian study we believe it was appropriate to evaluate uptake according to our own guidelines. In addition, the main focus of the analysis is on antenatal cART as this is most relevant for prevention of vertical HIV transmission.**