To Whom It May Concern:

Thank you very much to the reviewers and editorial staff for their kind and supportive comments. We are grateful for the opportunity to address these comments and improve our manuscript. Please find a point-by-point description of how we addressed these comments below.

Sincerely,

Dale Barnhart

***Reviewer one:*** *This is a well-written paper on a pertinent topic with a study design that speaks to the saying that 'simplicity is the ultimate sophistication'. My only comment is that the authors should have explored the differences in knowledge by gender a little bit more in the discussion. Are there differences in education attainment by gender for the particular study demographics in Rwanda? Does the predominance of women in the study population (2/3) have anything to do with this?*

We thank Reviewer #1 for this extremely positive response.

We have added the following text to line 268 in the Discussion section to better explain both the imbalance in gender in our study and the differences in knowledge between men and women:

**“We observed a significant difference in baseline knowledge levels comparing men and women. Although educational attainment for Rwandan men and women under the age of 25 is very similar, among Rwandans over 45, women are over 1.5 times more likely to have never received formal education [27]. Because increased age is a strong risk factor for hepatitis C in Rwanda, our study population was largely composed of older individuals who would have been most affected by this educational disparity. We believe the predominance of women in our study primarily reflects a structural gender imbalance in the Rwandan population, which is pronounced in older age groups [27], because previous research in this setting has demonstrated similar linkage to care rates among men and women [21].**

***Reviewer two:*** *Which were the methods and criteria of inclusion in this study considering that in only 90 days more than 330 patients were included in the study (more than 4 patients/day even if we consider that the study was conducted in 16 health care centers).*

Thank you for the opportunity to clarify our recruitment methods. As briefly mentioned in the study stetting, this research took place in the context of a mobile clinic outreach program, which was designed to help decentralized care. During this campaign, up to ten patients per day were scheduled to attend the clinic so that they could receive same-day testing, clinical assessments, and DAA initiation. We have expanded our description of this program in the following bolded text of the “Study Settings” section on line 106:

“In particular, PIH/IMB in partnership with Ministry of Health facility staff, supported linkage to care for patients with chronic hepatitis C who were eligible for DAA treatment, defined as having a detectable viral load (hepatitis C RNA ≥15 IU/mL) by implementing a novel mobile hepatitis clinic as described in detail elsewhere [21]. **Briefly, this mobile clinic approach was designed to facilitate access to hepatitis treatment by decentralizing hepatitis care to primary-level health centers. Up to ten hepatitis C patients were invited to their closest health center on a given mobile clinic day and offered same-day pre-initiation laboratory exams, patient education, clinical consultation, and DAA treatment initiation at their nearest health centers. Although this delivery approach was novel**, the care provided to patients followed Rwanda’s national hepatitis guidelines and included clinician-provided patient education.”

***Reviewer two:*** *Which was the general population considered as baseline?*

The Rwandan general population hepatitis screening campaigns are open to all Rwandans of the age of 15 and over. We have clarified this by adding the following bolded text of line 102:

“In 2019 and 2020, PIH/IMB supported government-operated mass screening campaigns in Kirehe and Kayonza**. These screening campaigns were open to all Rwandans aged 15 years and above.**”

***Reviewer two:*** *Which was the diagnosed Hepatitis C population at baseline?*

We have added the following bolded text to the Study Population section on line 124:

“We enrolled patients aged ≥ 18 years diagnosed with chronic hepatitis C and initiating on DAA treatment for the first time at 16 primary-level health centers**. Our participants had been diagnosed with hepatitis C through previous national screening campaigns and were identified from patients attending a hepatitis mobile clinic campaign** occurring from July 2020 to September 2020.”

***Reviewer two:*** *How easy is the access for a rural population at medical health care services in pandemic conditions?*

At the time of the mobile clinic campaign, within-district travel restrictions had been removed, which means that access to health-center level care had returned to normal. We have clarified this in the following bolded text of our study population on line 126.

“Our participants had been diagnosed with hepatitis C through previous national screening campaigns and were identified from patients attending a hepatitis mobile clinic campaign occurring from July 2020 to September 2020. **During this time, within-district COVID-19-related travel restrictions had been lifted, which meant that neither travel from the communities to the local health center hosting the mobile clinic services nor provision of routine clinical care were impacted by COVID-19 related travel restrictions.**”

Notably, some between-district travel restrictions did go into effect during the data collection process (this is described in existing text on line 141). While these restrictions did affect our data collection activities, they did not impact the patients’ ability to access care at health centers.

***Reviewer two:*** *Which is the degree of adherence and compliance to therapy of this population?*

We have added the following bolded text to our results on line 241. This data was previously listed in Table 3, but not highlighted in the written results section.

**“Generally, self-reported treatment adherence was high with only 38 (11.7%) reporting very poor, poor, or fair adherence, 68 (20.9%) reporting good adherence, 136 (41.9%) reporting very good adherence, and 83 (25.5%) reporting excellent adherence.** However, neither post-treatment initiation knowledge nor change in knowledge were significantly associated with treatment adherence in the adjusted models, although post-treatment initiation knowledge was significantly associated with having good or very-good adherence compared to very poor, poor, or fair in the unadjusted model.”