Reviewer's report

Title: Integration opportunities for HIV and family planning services in Addis Ababa, Ethiopia: an organizational network analysis

Version: 2 Date: 9 October 2013

Reviewer: Louis G Reynolds

Reviewer's report:

1: Major compulsory revision

Provide a clearer description of the networks and of the roles of the dominant types of organization -- civil society, government facilities, and private facilities -- in primary care and up the referral chain. In particular explain the role of the government hospital as a referral centre and its drainage area locally and nationally. Also clarify the role and extent of the integration of the private hospital within the public health system.

Clearly state whether private providers are private for-profit private providers as distinct from private not-for-profit providers, and whether the NGOs and FBOs included here are among the latter.

Rationale:
I found that the discussion lacks clarity. It raises many questions.

The first 2 paragraphs under Results on PP 8 & 9 --

"In Kolfe Keranyo, there were 26 organizations meeting the criteria for inclusion in our network analysis; in Kirkos, there were 25. All of them were successfully interviewed for our study. Although the numbers of organizations were similar in the two sub-cities, the types of organizations were different (Table 1).

Four out of five in Kirkos were civil society organizations: 14 were NGOs and 6 were faith-based. The only government organizations were 3 health centers. In contrast, the organizations in Kolfe Keranyo were more equally distributed among the government, civil society, and private sectors."

-- do not sufficiently describe the nature and mix of organizations, the key differences between them, and the nature of referrals between them - in particular the level of care provided and whether clients were referred "horizontally" (eg a healthy patient from a HIV treatment centre to a family planning centre), or "vertically" (eg to a higher level of care because of the nature and severity of illness).

Kirkos has no hospital and a tiny private sector with only 2 clinics. Sick patients from there would have to be referred to outside centres offering higher levels of care or specialised care. Kolfe Keranyo has 3 hospitals and a much larger private
component with 10 clinics and 2 hospitals. It also has a government hospital -- is this a specialist referral hospital, and if so, how extensive is its drainage area and does it include Kirkos? What role do the 2 private hospitals play in the health system? Are they accessible to poor people in the community, or do they and their associated clinics exist “outside” the system, catering mainly for those who can pay for services?

2: Major compulsory revision:

Provide clarity on the use of only the median to describe client numbers, and/or provide data on the total numbers seen in each sub-city and, if possible, the range seen by the different types of organization. If possible, provide some analysis on why there should be such a big difference in numbers between sub-cities and whether this relates to properties of the network, the organizations, or of the broader community (or maybe something else).

NB I am pretty certain that the authors can deal with these statistics questions without referring to a statistician.

If the data came from the questionnaire, state how the data were collected by organizations and made available to the interviewers. In particular comment on how well the hospitals’ information systems work and how they collect data on referrals including self-referrals and where they come from. If these data did not emerge from the questionnaire, include the source in the methods section.

Explain the large number of patients seen at the government hospital, whether they were referred through the network and how their referral there forms part of this study.

(Discretionary): Clarify the extent of self-referral and, if possible, comment on the extent to which clients were seen more than once.

Rationale:
I don’t get a clear picture of the number of people served by the networks and organizations and whether these data emerged from the methods section - ie the questionnaire. Were all the 150,000 government hospital clients mentioned referred through the Kolfe Keranyo network and did this figure come from the questionnaire? This translates to almost 5,000 cases a day, which is very unlikely to come from 6 NGOs, 1 FBO, 3 government health centres and 3 government health posts in one sub-city (unless I’m very much mistaken). The referring organisations would have to refer more than 350 clients a day on average. Could some of these clients have come from Kirkos, perhaps self-referred, or even from other areas within Addis Ababa or the greater Ethiopia?

Does the hospital have a good information system capable of accurately reflecting the source of all referrals?

Why does there seem to be such a vast disparity in patient (client) numbers between the 2 sub-cities? Is this related to the nature of the network or perhaps something in the community?
Greater referral numbers would increase the number of clients seen by organizations, but this is unlikely to account for a more than 6-fold difference in numbers between 2 areas so similar in health status and demography and socioeconomic conditions. The same applies to repeat visits and re-referrals of individuals.

Is the median a valid way to express client numbers without looking at the distribution of numbers among network members? A median of 219 patients per month in Kirkos translates to fewer than a dozen a day (assuming a 5-day working week) seen by at least half the centres. In the context of a large disease burden and high service needs this seems very small.

Could the low median in Kirkos be due to more than half the organizations being very small with limited capacity? Or are there barriers to care? Geography does not seem to be a barrier, but are there other barriers? For example, family planning and contraception may be highly contentious issues to some community members as well as staff working in service delivery areas.

Could some people in Kirkos simply decide to attend integrated HIV-family planning services in Kolfe Keranyo or elsewhere closer by? How do community members and community-based organizations perceive these service providers, and are there issues related to quality of care, and how do they respond if they perceive these as inadequate?

Are limitations of the work clearly stated?

No. The distinct possibility that significant and substantial numbers of referrals could have occurred from Kirkos to hospitals in Kolfe Kanyo, particularly to the government hospital or even the private hospital has not been considered. Nor has the possible role of community actors in influencing referrals or simply self-referring been considered.

Both these concerns can be addressed in the above compulsory revisions.

7. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?

Yes.

8. Do the title and abstract accurately convey what has been found?

Yes.

Is the writing acceptable?

There are some areas where the style and grammar can be improved at the discretion of the authors.
1. First para is a little clumsy and unclear to me:

“The specialization is driven in large part by the corresponding specialization of funding sources, be they departments in a ministry of health, non-governmental organizations (NGOs), or foundations. The specialization of the funders is driven, in turn, by the desire for accountability for the funds given, the count-ability of services provided, and the marketability of a particular organizational mission”.

I think this and the para that follows are concerned with how the special interests and agendas of donors tend to fragment delivery leading to vertical interventions, especially when the recipients of funds are not well organized and networked. Whether or not I’m correct in this their argument doesn’t come across clearly. Also: does ‘count-ability’ mean ‘measurability’? And what does ‘marketability’ mean in this context?

2. The following para: How is specialization of organizations “manifested in geographical dispersion”? Does this not refer to another form of fragmentation? Please clarify what this means.

3. Third para:

A comment: About organizations coming to see themselves as “a network”: instead of each organization concerning itself about possibly being subsumed into or even bring taken over by a network (as sometimes happens in South Africa), it might be easier to see itself as an integral part of a broader network of providers that has the potential of coordinating efforts to meet the needs of the community in a holistic way, without losing its own identity. This formulation also fits better with the way it is expressed on P 9.

4. Reorder paragraphs to keep background with Background, and methods in Methods. Here are suggestions:

[A] Move the first para under Method on P5 to the Background section in 2 pieces: (1) The first 2 sentences

[‘Addis Ababa, the capital city of Ethiopia, has a population of about four million ... and 'The national prevalence of HIV is estimated at 1.5%, but residents of Addis Ababa ...' and 'Unintended pregnancies are still quite common ...'

to the start of Background, and (2) Edit the final sentence [Something like ‘In response to these health needs the burden of HIV and the recognition that better coordination and networking between the broad range of service providers is necessary to address it effectively, the Ethiopian Ministry of health &c...- see footnote 1] and move it to just above “We conducted ....

[B] The 1st para on P6 also contains information about the contextual background rather than about the methods, but it could maybe be integrated into the methods more smoothly.
The sentence

We included organizations that provided HIV care and support and/or family planning services to women living with HIV between the ages 18-49 living in one of the two sub-cities should read ‘… both sub-cities ...’ or ‘… each of the two sub-cities …” or simply ‘… each sub-city ...’.

Page 7

Suggestion: “Both (instead of 'each') spoke fluent Amharic and English”.

General comment

I have a sense that the communities in these 2 sub-cities are largely absent from consideration or at least from this report. How do they themselves impact on these referral patterns, or are they largely passive? To me this seems to underlie many of the unclear aspects of the discussion. It may be an issue that his highly relevant to to the conduct of ONAs among organizations and networks that are strongly community based. Where is the interface between the community and the service provider -- in the home, the neighbourhood, a social movement or other community-based structure?

This is important work with the potential of improving health in economically marginalized communities. Indeed, this project promises to do so if the networks act constructively on their undertakings after the workshop.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.