Reviewer's report

Title: Removing financial barriers to access reproductive, maternal and newborn health services: The challenges and policy implications for Human Resources for Health

Version: 1 Date: 8 February 2013

Reviewer: Delanyo Dovlo

Confidential comments to editor:

Title: Removing financial barriers to access reproductive, maternal and newborn health services: The challenges and policy implications for Human Resources for Health

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General Comments:

- Well written, well-argued document on a difficult topic given the lack of data on HRH and finances as well as information on the policy processes that developed these responses.
- It has implications for the focus on Universal Health Coverage and the equity implications therein and also there is useful inter-country similarities and operational differences. Perhaps detailed case studies may be a more useful tool?
- My own take away is (i) need for recommendation on certain information and data types that will inform HRH policy interactions (ii) countries need advice on a more micro level research to understand some of the dynamics as clearly, national aggregated data is difficult to get and almost impossible to analyse on a comparative basis.
- Information on service availability assessments etc may be a good source of more information on equality of service quality and HR availability across different fee situations. (SARA: Service Availability and Readiness Assessment;
SPA: Service Provision Assessments)
- Some staffing norm availability and utilization in the countries will be useful to understanding the article’s premises
- There is need for further commentary on policy making processes and whether countries did make deliberate effort (can be got from key informants) to integrate fee changes and HR policy in any country?
- Article gives impression that staff motivation is only in salary terms as there is not much discussions on the value of local fees as creating management flexibility and ease of doing business/reducing bureaucracy (Avoiding minor shortages etc...)
Some Specifics in document:
- abstract was excellent and an effective summary of document
- Introduction:
  o Is there any influence from informal fees in these issues?
  o In Ghana where fee removal initially started with 4 regions, movement across region lines for free services occurred and may contribute to some increases seen.
  o Expectations (perhaps structure of future micro work) (i) RMNH workforce situation; (ii) projection of shortfalls or needs etc (iii) fees and Exemptions situation analysis (iv) demand for services status and trends (v) Policy and strategy implications for HRH
- Background
  o No specific comments
- Methods
  o Well presented.
  o It was not very clear to me what data was sought and how data absence and poor quality affected the study – i.e., what form or type of data was actually needed?
- Literature Review:
  o It’s unclear what the literature said on geographical access issues in relation to fee removal and uptake as the discussion seemed to assume equal distribution of service delivery points?
  o Some further explanations needed – page “11” – 95% of HC income came from user fees? What does this mean – that no government subsidy is received in any form including salaries; medicines; vaccines etc?
o How were replacement funds used differently from user fees revenue?

- Results

o The study is a quite difficult proposition given the lack of data and difficulties of comparability between countries.

o Financing policy and utilization:
  # Nepal defines unequal access and change in post fee removal uptake well through the HDI frame. Any way of estimating unequal access for the other countries’?
  # Nepal: what is Aama?
  # I’m not sure the use of % to describe the changes in high and low HDI districts uptake clarifies the story: the movement from 6 to 21% is a 3 fold rise but still a low proportion of the population.
  # Similar availability and access clarification needed for the other countries as well I think. Especially in case of Zambia with variable uptake results across the country.

- Geographical distribution:

  o The article is understandably unclear on definition of skilled attendant and use or non-use of auxiliaries. Some more discussion of this or illustrative example would have helped.

  o Would have perhaps been more informative to have a country by country result for each question area as done for the fee removal section

  o Interesting and informative figures and graphs

  o Perhaps more discussion of private-public distribution differences between countries will be helpful.

  o Last sentence on NGO/FBO workforce distribution and public sector in Ghana and Nepal is unclear.

- Delivery workload

  o Again difficult given the definition of SBA . I understand in Asia (Nepal?) doctor/nurse ratios are 1:1 or higher, unlike in Africa with high nurse-doctor ratios. Is this the case for Nepal? How does that affect the comparisons of access to doctors?

  o Nurse, doctor availability is often for a broad range of services and often midwives may practice in non-MNCH functions but the rates are a good average indicator anyway

- Remuneration and terms/conditions
Again difficult to compare as acknowledged despite brave attempt.

The work on salary comparisons and linkage to GNI gave a good comparative picture and perhaps purchasing power parity and linkage to country poverty line may be other helpful markers

- DISCUSSION:
  - Concept of “effective care” is an important one to be elaborated
  - A “means tested” changes in utilization apart from Nepal, are poorer areas and people using the free services more?
  - Is there any information at all on changes child and maternal mortality or morbidity?
  - I think the recognition of the non-coordination of policy is a major issue that merits more detail review and discussion
  - Many African economies are growing and with it private services? Any discussion on how these may affect the study questions?

- Conclusions:
  - My own takes from reading the article include:
    # There is and fragmented parallel policy making without considering implications elsewhere in the health system – are there examples where this works better in LDC situations? how can we integrate HRH strategy/planning into other cross health systems reforms/changes?
    # A very good point made for effective Policy monitoring and some suggestions and examples will be useful for readers

- Authors contributions:
  - No mention was made of YC the corresponding author in the line up?