**Author’s response to reviews**

**Title:** Barriers to and strategies for addressing the availability, accessibility, acceptability and quality of the sexual, reproductive, maternal, newborn and adolescent health workforce: Addressing the post-2015 agenda

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Reviewer #1: No suggested changes.

Peter Hill (Reviewer 2):

The distribution of countries which held a workshop is broad, but clearly dominated Africa—not unreasonably given the MDG outcomes and the residual agenda that needs to be continued, particularly in sub-Saharan Africa. However, while it in no way invalidates the study, this should be mentioned briefly in the limitations.

Thank you. We agree and have added this.

The title alludes to the post 2015 Agenda, though there is no linkage in the findings or discussion to the multi-dimensional elements of the SDGs that will have a direct impact on SRMNAH—gender equity, education, enhanced communication, employment etc—with the exception of a reference to UHC. Given the timing of the workshops, the definitive SDGs had not been determined, but some reference in the discussion to the SDGs would locate the findings more clearly in the 'post-2015 agenda'.
This is true and we agree and have addressed this now in the Discussion.

Daniel Kojo Arhinful (Reviewer 3)

Information on the range and mean duration of the workshops must also be provided in the methodology section.

The workshops were for one day. This is included in the Abstract and the Methods section.

The authors rightly pointed out that "the wide variation in the number of participants per workshop may have affected the focus and direction of the discussions", as a limitation. They however overlooked another important limitation from the workshop. According to them, on page 5 line 15, "a list of about 25 participants was drawn up in consultation with the Ministry of health" to each workshop. Yet information on line (21) of page 5 also suggests that workshop participants ranged between 6 and 54. The workshop(s) that had as small as 6 participants in such discussions was by all intents and purposes woefully small and inadequate so the small number of participants in some places should also be stated as part of the limitation.

We challenge the assertion that 6 participants is necessarily an inadequate number to achieve the objectives of the workshop – sometimes a smaller number of participants can lead to a more effective discussion. We simply do not know what impact it had, but have acknowledged this issue by adding a sentence in the limitations.

On page 6 line 16 it is stated that "Response were imported into Excel". The value this provided in the analysis should be provided.

We used Excel only as an organising mechanism. We have removed this sentence as it is not a central aspect of the methodology.

The main themes are explained and challenges clearly elaborated, but the paper would benefit more in analytical quality if the proposed strategies and/or solutions also pay attention to what is feasible and practical within specified time frames. For example, for various strategies and solutions proposed, what is practically and operationally feasible in the short to medium term and long term. Such an approach or framework would be more useful to readers because while some of the proposed solutions would require "just" attitudinal change in health worker attitude and mere reallocation of resources, others will require "heavy" investment and so it is analytically useful from a systemic point of view to let this reflect in the analysis. Such an (re)organization will also make the findings of the paper and the strategies/solutions proposed to deal with the challenges sit well with or make programme implementers and policy makers identify with them better.

Thank you. This is a useful observation. We have included a new paragraph in the Discussion that addresses this issue.
The authors will also do well to note that of the four key themes used to explore the challenges and the strategies and solutions, two of them (availability and quality of care) are supply side factors while the other two (accessibility and acceptability) are more demand side factors. This conceptual nuance should have been captured in the analysis since it provides a solid leverage to situate the discussion section which as it stands now is heavily skewed towards issues on the workforce (supply side) of the challenges and strategies/solutions. Indeed a careful reading of the discussion section show that 80% percent or even more of that section is about the health workers or HRH factor and very little about the demand side or consumers of SRMNAH. A bit more attention should thus have been be paid to the challenges/strategies/solutions that concern the services and by extension the people who use the services i.e. accessibility and acceptability factors in the discussion section. I guess the use of the Tanahashi model require that the issues about the SRMNAH services and for that matter the services and service users are given adequate attention in the discussion and conclusion section as well. Indeed the conclusion is very silent on the demand side factors of the framework and that needs to be addressed.

Thank you for this very useful and thoughtful observation. We completely agree and have endeavoured to thread an understanding of demand and supply side factors into the Discussion particularly.

The authors should take a second look and consider whether some of the factors that have been cited as "barriers to accessibility" conceptually belong there or would FIT BETTER as barriers to availability. The particular reference is Page 9 line 2 to line 5 which states that. "A lack of housing for health workers in both rural and urban settings, an uneven distribution of health training institutions, no incentives to go to rural areas and a lack of human resources for health (RH) plan or strategy were all highlighted as significant barriers to accessibility." This is quite problematic when in fact the authors rightly explain the meaning of accessibility to be that "even if there are enough SRMNAH workers, women and newborns may not be able to access their services, e.g. due to being unable to make the journey to a health facility or being unable to afford to pay for care." If the barriers is about what women and newborns encounter why is systemic factors that affect or about health workers being used as barriers of the users even if they are related in a systems thinking paradigm.

On reflection that is correct and we have moved this section. There is also overlap between many of the component of the AAAQ framework and we have acknowledged that now.

Even though this is a qualitative paper it will help the clarity and understanding of readers if a table could be generated that summarizes the problems and to each set of problems the proposed strategies/solutions for dealing with them under the four themes.

We agree and have made a new Box 2 that summarises the issues for easy reference.

If the paper is about "Barriers to and strategies for addressing the availability, accessibility, acceptability and quality of the sexual, reproductive, maternal, newborn and adolescent health workforce..." why should the movement of workforce to the private sector as stated in Page 8 line 11 be captured as loss within a country? The point is true for migration but not the private sector in the country.
We see now how this is not really a loss to the country but as it was highlighted by countries we have included it as a separate sentence in that section.

If information on why the remaining countries did not organize a workshop is known it should be stated as part of the limitations of using workshops as a qualitative method in data collection of such research situations.

We do not know why the remaining countries did not hold a workshop. A sentence explaining this has been added.