Author’s response to reviews

Title: Maternal and reproductive health financing in Burundi: public-sector contribution levels and trends from 2010 to 2012.

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Author’s response to reviews: see over
Dear Editorial Team and Reviewers:

On behalf of my colleagues, I would like to re-submit for further consideration our manuscript entitled “Maternal and Reproductive health financing in Burundi: levels and trends of public-sector contribution from 2010 to 2012.”

In the previous revision round (#2), Reviewer 1 (Preeti Patel) had mentioned that she was happy with the revised manuscript and had no further recommendations while Reviewer 2 (Josephine Borghi) had mentioned that her previous comments had been addressed and that clarifications were provided, but that inherent limitations remained with the study. In this revision round #3, Reviewers 1 & 2 provided no additional comments while the Editor asked for a copyediting of the article and further clarifications regarding the table included in this letter.

In this revision round, the following actions were taken to address the comments mentioned by the Editor:

- A professional editor was hired to review the language and style of the article,
- The table responding to the Reviewer 2’s comments was reviewed and completed. Some of the limitations mentioned derived from a lack of proper explanations from our side. For these, we provided further clarifications in the manuscript. Other limitations had already been mentioned in the Limitations section, and were further clarified.

We agree with Reviewer 2 that our dataset’s limitations – which we unfortunately can’t improve – somehow limit the impact of the study’s results. However, we believe that despite these limitations, this manuscript is of great interest to the readership of BMC Health Services Research for the following reasons:

- Information on the reproductive health (RH) expenditures spent by countries most affected by maternal and child deaths is extremely scarce. As the 2015 MDG target is getting closer, this article provides key information on the levels of RH expenditures in Burundi, one of the 75 priority countries.
- In post-conflict countries like Burundi, financial information is often scarce and complicated to collect and analyze. Our study provide useful information regarding how reproductive health sub-account methodology can be adapted for countries with poor information systems. Our estimation strategy, based on unit costs and utilization data at provider level is an innovative way to allocate non-earmarked expenditures, which could be easily replicated in other settings with similar data limitations.
- Finally, our study is the first reproductive health expenditures tracking exercise ever implemented in Burundi. Besides, the last general health expenditures estimation study (NHA) dates back to 2007. Although our results are somehow limited due to our restricted...
dataset, they still presents up-to-date and original information which could be useful to
governments and international donors in Burundi and in the Central African region.

As Reviewers 1 and 2 disagree about the importance of this study, it now falls to the Editorial Team
to decide whether it should be published in BMC Health Services Research. For the reasons
mentioned above, we are convinced this manuscript has its place for publication in your journal. We
look forward to receiving your decision.

Thank you for considering our work. Please let us know if you have any questions about the
manuscript.

Best regards,

On behalf of all co-authors,

Claire Chaumont
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<th>Comments (Reviewer 2)</th>
<th>Response</th>
<th>In the text</th>
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<td>The limited time frame for analysis, the period 2010-2012 is too short to be able to say anything about time trends, and this time period does not overlap with the initiation of the reforms and initiatives that the paper hypotheses may have affected financing levels (these started in 2006).</td>
<td>We acknowledge this limited time frame of three years is a serious limitation for interpreting the study's results. Within this time frame, which was limited to only 3 years for both data availability and budget’s reasons, we decided to focus on the years 2010-2012, because they correspond to the transitional period between the National Plan for Health Development I &amp; II (respectively 2006-2010 and 2011-2015) as well as the mid-term of the National Health Policy 2005-2015. As such, we think that, despite the limited data availability, this time period was the best to observe changes in terms of the funding mix and funding levels of reproductive health.</td>
<td>This limitation is acknowledged in the Limitations Section (p. 17, lines 364 to 366)</td>
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<td>The study focuses on government financing as an agent rather than a source. As previously mentioned this does not enable the researchers to isolate the government contribution to health financing as it includes donor funding provided to the government as general budget support and sector level support. The latter is determined by donor prioritization of health rather than government prioritization.</td>
<td>The study includes donor funding provided to the government as general budget support. However, it does not include donor funding provided for the health sector, even when this funding is managed by the government. The government has full discretion on how to allocate and prioritize its budget – including the general budget support coming from donors – which is why we decided to keep this specific type of donor funding in this analysis but to exclude sector level support.</td>
<td>This aspect was further clarified in the Methods section (p.8, lines 148 to 151)</td>
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<td>The paper does not say anything about the government share of financing relative to external or household out of pocket payments, or the levels of government financing (as a source); yet the removal of user fees and introduction of performance based financing were also pushed by and part financed by donors. Any variation in funding levels could very well be a result of</td>
<td>We wish to clarify the following point: as no sector-level donor funding was included in this analysis, the variation in funding levels presented in the results can’t be explained by greater donor investment. It could potentially be explained by an increased in general budget donor funding. However, even if general support funding had indeed been used to support the removal of user fees, this allocation decision would have had been decided entirely by the government itself, and as such, could still be considered as a sign of government’s commitment to RH. However, we acknowledge the lack of</td>
<td>This first point was further developed in the Methods section (p. 8 lines 148 to 151). This limitation is also acknowledged in the Limitation section (p.17, lines 366 to 370).</td>
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<td>The paper defines reproductive health very narrowly as maternal health and family planning; yet it is unclear how this corresponds to the focus of the policies under study.</td>
<td>The study focuses on these two main activities, because these are the only RH activities implemented in the public sector in Burundi. National documents clearly highlight them as priority for the RH strategy (cf. Table 2). Other RH activities, such as sexual education for adolescents, prevention of gendered-based violence or cancers and sterility treatments are mentioned in strategic documents but their implementation is not monitored (no output indicators collected at national level correspond to these activities), and it is unclear whether they are actually implemented or not.</td>
<td>This was further clarified in the Methods section (p. 8, lines 138 to 141)</td>
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| It is still unclear why the authors need to allocate provider level expenditures given that they appear to have information on the use of reproductive health services and the unit cost of these services. It is unclear which maternal services were included in the assessment. | Hospitals and clinics' budgets combine public funding, coming both from the PBF mechanism and from national budgets, as well as revenues from medicines and out-of-pocket payments. First, we re-estimated total expenditures for each type of providers using unit costs and utilization data, out of which we isolated total expenditures related to RH. The allocation factors obtained were used to reallocate only the public funding coming from national budgets. Other sources of revenues, such as from selling medicines or services’ fees were not included in the analysis. | This was further clarified in the Methods section (p.10 lines 188 to 189) |

| The presentation of results should be done on a per capita basis only, as you need to adjust for population changes. When this is done there is no evidence of a change in financing levels. | Results are first presented by financing agents, health providers and health functions, as this is standard practice for RH sub-accounts. However, we also present results per capita (per delivery and per women in childbearing age) and emphasize in the Discussion section how public expenditures per capita stagnated over the period. | Results section (p.14 lines 278 to 284) |

<p>| The first paragraph of the discussion is misleading (as it does not report on per capita figures) and makes claims about the effect of policies on RH public expenditures increased as a share of total public health expenditures between 2010 and 2012. Therefore, even considering population growth, we argue that RH financing has increased with regard to other health | Results section (p.16 lines 328 to 331) |</p>
<table>
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<tr>
<th>Financing which are simply not supported by the data.</th>
<th>Activities. Besides, we argue that RH public expenditures are aligned with strategic documents in terms of expenditures distribution across health providers and health functions. Both claims are correctly supported by our data. However, we do not argue that public RH expenditures per capita have increased – as pointed out later in the discussion – which would indeed be an unfair statement.</th>
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<td>The review of the literature provided in the discussion is very confusing as comparing different years, different parameters.</td>
<td>Unfortunately, data on RH expenditures in Sub-Saharan Africa is extremely scarce. Besides, even when countries implement a RH sub-account exercise, this analysis is often not replicated across time. Finally, information is often reported for total RH expenditures and does not always differentiate RH funding by funding sources. This makes comparison of public RH expenditures across countries extremely challenging, which is why our cross-country comparison arguably lacks standardization. However, we consider it is important to report data from neighboring countries, even if such data should be used with caution.</td>
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<td><strong>Editorial</strong></td>
<td>We recommend that you copyedit the paper to improve the style of written English. A professional editor was hired to review the article</td>
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