Author’s response to reviews

Title: Distribution and quality of emergency obstetric care service delivery in the Democratic Republic of the Congo: It is time to improve regulatory mechanisms

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Author’s response to reviews:
Reviewer reports:

Reviewer #1: REPH-D-18-00337

Title: Distribution and quality of emergency obstetric and neonatal care service delivery in the Democratic Republic of the Congo: How can be improved the regulating mechanisms?

General:
Thanks for presenting the results of a relevant survey in DRC. The paper needs some work to improve the quality of the message and readability. The most important area to concentrate on is the Methodology which lacks important information.

Comment1: The title: The subheading: How can be improved the regulating mechanisms? Is out of scope of the study.
Answer1: we agreed to change the manuscript title into: Distribution and quality of emergency obstetric and neonatal care service delivery in the Democratic Republic of the Congo: It is time to improve regulatory mechanisms

Comment2: The stated Objective: ... to identify ways to improve the distribution and quality of emergency obstetric and neonatal care in the Democratic Republic of the Congo [Pg.7, L55-60] does not seem in line with the study.

Answer2: we have made changes in the objective of the study:” The aim of this study was to assess the distribution and quality of emergency obstetric and neonatal care in the Democratic Republic of the Congo. Then we have recommended to officials from the ministry of health to improve regulatory mechanisms in the health sector:

“The noted poor regulation of the health system seems to be one of the main causes of the unwanted and currently observed situation. It calls to strengthen the regulatory role of the MOH in insuring equity, providing funds, standards and guidelines, and controlling their implementation by health providers”.

Comment3: Terminology: It is advised to be consistent with the use of standard terminology. Your current Ref. No. 23 can be used to guide the right terminologies. You need to use EmOC rather than EmONC since newborn signal functions per se have not been described. You may need to read also the publication by Gabrysch et al 2012 that defined emergency obstetric care signal functions.

Answer3: we totally agreed with this comment and then changed EmONC into EmOC

METHODOLOY:

Comment4: Revise the reference to EmONC as interventions rather than the standard terminology of signal functions

Answer4: ok

Comment5: On Line 28-29, Pg 10 (index number 3) mentions the seven interventions offered at childbirth while actually this should not be necessarily at childbirth. Moreover, in reference No.23 this should be offered within last 3 months if a health facility is to be classified as BEmOC or CEmOC.
Answer5: To avoid confusion, we removed the word "at childbirth». Although we know that the EmOC functions should be available in the health facility within last 3 months, in this study, we limited ourselves to verify the existence of the EmOC functions during the survey.

Comment6: Revise the wrong labelling of facilities as BEmONC and CEmONC without timing reference [Pg. 10, L28-47.

Answer6: In this study, facilities were assessed as “BEmONC or CEmONC when they offered all signal functions at the time of the survey.

Comment7: Overall, the index of availability needs more detailed explanations: Index no.1 The presence of a delivery room infrastructure does not mean that evacuation of products of conception or Cesarean section can be done in that facility; Index no.2: Staff: having a member of staff assigned to Reproductive Health services says very little about the provision of EmOC services. The staff could just be providing Family planning services. Index 3: Much has already been said on this. When are these services provided? During the day of survey or at a specified period? Index 4: Was this meant for assisted vaginal birth alone or for all the 9 EmOC signal functions?

Answer7:

1. Infrastructure: prerequisite of a specific room dedicated to assisted deliveries (a delivery room);
2. Staff: requirement of a staff member assigned to reproductive health activities, such as assisted deliveries, family planning etc;
3. For this criteria, we did not have the means to check if the health facility offered all the EmOC signal functions or not at least three months before the investigators' visit. So we checked it on the day of the interview. We reformulated the sentence as “Offering at the time of the survey, seven interventions defined as basic EmOC, or nine interventions defined for comprehensive EmOC”
4. The fourth criteria concerned only the assisted vaginal birth

Comment8: Wrong inclusion of unqualified terms "assisted deliveries" "Neonatal resuscitation" and "uterine evacuation after childbirth" as standard EmOC signal functions, Pg 10, L33-34.
Answer8: All the wrong words have been removed in the mean text. Correct terms are: assisted vaginal delivery; remove retained products of conception and basic neonatal resuscitation.

Comment9: Statement of index of EmONC availability No.4, pg 10, L44-47 which states: Service use: Service utilisation based on service statistics that at least one assisted delivery recorded during the six months preceding the survey. It is quite unclear why assisted vaginal delivery which is not a normal delivery procedure has been taken as the benchmark of service utilisation and the other 8 EmOC functions have not been considered. This is not in line with the standard WHO assessment of availability of EmOC services in facilities.

Answer9: The criterion 4 complements criterion 3 which has already included all EmOC functions. We just wanted to know if the service of the maternity was used as this will give to health workers the opportunity to apply EmOC functions. Criterion 4 was therefore obtained through a documentary review which revealed whether the maternity of the facility was attended or not by women who needed obstetric care.

Comment10: The Methodology should give details on how the NHIS is used and how quality of data is controlled in DRC.

Answer10: We did not add a specific paragraph on the control of the quality of the NHIS data or how data are used. We think this might be part of another search. However, what we can say is that the quality of the NHIS data and their use was deplorable in 2014; since then, the DRC has subscribed to the DIHS2 platform and significant improvements are reported.

Comment11: It is also extremely important to give description on what facility level is BEmOC or CEmOC permitted in DRC.

Answer11: The section “health system organization in the DRC” has been updated.

Comment12: Data collection and Analysis: delete sentence, Pg.12; L10-13 on Odds ratios because this kind of analysis does not apply to this study design.

Answer12: for this cross sectional study, we effectively used Odd ratio test to perform analysis.

RESULTS
Comment13: The results that 76.9% of facilities offered Reproductive Health Services is contrary to a statement in the Methodology on Pg. 8, L10-31 which shows that there was cross-checking to ensure the facilities were currently functional.

Answer13: To be enrolled in this study, all health facilities had to be functional. The functionality was attested only by the fact that it provided the data on vaccinations, deliveries, antimalarial care, anti-tuberculosis care, etc.) to the NHIS. So we say that of all these health facilities, only 76.9% offered Reproductive Health Services.

Comment14: The statement on Pg. 12-13 "...shows that skilled childbirth service was the most available (74.8 %) of the seven basic interventions package of EmNOC, followed by uterine evacuation after childbirth (71.0 %), manual removal of the placenta (68.4 %) and neonatal resuscitation (68.0 %)" should be rewritten because skilled childbirth is not a recognisable EmOC signal function. Uterine evacuation after childbirth and neonatal resuscitation should be qualified in this section and throughout the document as already pointed out above.

Answer14: The entire document has been updated using conventional terms (about EmOC signal functions).

Comment15: It should be clearly stated in the Methodology and well presented in the results how availability of EmOC services was measured. Is it that the service was available on the day of survey, is it in past 3 or 6 months? Were these directly observed or only electronic case reports were used?

Answer15: Cfr answer 7, point 3.

Comment16: "Of all health facilities, 9.1 % offered basic EmONC as defined by the index of availability, which represents up to 16.0 % of facilities with Reproductive Health Services." Pg 13, L10-19. These results cannot be interpreted without clear explanations of the indices of availability.

Answer16: The results in figure 1 are focused on the availability of basic EmOC which should combine 4 criterions highlighted in methodology section. This figure shows that only 9.1% (about 142 health facilities) met all above criterion in the same time.

Comment16: "...Cesarean sections and blood transfusions were provided in a few health centres (6.5 % and 9.0 % respectively) and health posts (2.3 % and 2.3 % respectively)". Pg.13, L29-34 It is difficult to interpret these results if the methodology does not say which level of facility is expected to do what.
Answer 17: The section “health system organization in the DRC” has been updated. In the DR Congo, the BEmOC is organized in health centres while CEmOC should be organized only in hospitals. We added above results in the paper with the aim to formulate recommendation regarding the DRC health system regulation with needs to be improved.

Comment 18: The analysis therefore should strictly consider: Calculating % of facilities that are entitled to give the service which actually provided.

Answer 18: cfr answer to comment 17 above.

Comment 19: It is even more important that such %ages consider a sub-analysis of those facilities that actually attended cases of the nature that needed the specified EmOC functions during a specified period. It will be useless to calculate and present % of health posts that performed evacuation of products of conception while in fact just few of them received abortion cases during the period in question.

Answer 19: what you are doing as a comment is quite correct but the results presented here represent a part of the results of the study which analyzed both the availability as well as the reactivity of services that covered almost all health aspects (surgery, diabetes care, high blood pressure, family planning, etc.). Information on the number of structures that have actually experienced evacuation of products of conception or others EmOC functions has not been systematically collected. Here we just wanted to ensure the reactivity of the FOSA in the event of obstetric emergencies.

Comment 20: Table 1: Gives the number of facilities providing BEmOC and CEmOC. For Kinshasa province this number is 28+11=39 out of the total 147 health facilities. Table 2 assesses the basic operational capacity of health facilities to provide EmOC and for Kinshasa province 91 facilities in total were assessed. Why not all the 147 facilities assessed for their capacities? This number should have been 39 facilities with EmOC services available because a facility without EmOC services available is not expected to provide quality BEmOC services. Where the 91 facilities come from in Table 2? There is need to reanalyze data or give sufficient explanations in these two tables since the case of Kinshasa applies to all other provinces.

Answer 20: A part of Table 1 detailed the results presented in figure 1 in which 9.1% of facilities met all criterions to be basic EmOC. Table 1 shows that the Kinshasa province had the high number (28/147=19.0%) of facilities offering “basic EmOC”. Kinshasa also had the high number of facilities offering CEmOC functions. (Of the 28 facilities with Basic EmOC, 11 which represent 7.5% of 147 facilities offered comprehensive EmOC.

Table 2: the operational capacity was calculated out of facilities which provided reproductive health services by offering at least one EmOC signal function (the most available was assisted vaginal delivery (figure1)). We have added some comments in the main text before Table 2 which has been also updated.
Comment 21: Table 3: In Kinshasa only 11 health facilities have CEmOC services available according to Table 1. Can you explain the 66 facilities for Kishasa in Table 3?

Answer 21

Comment 22: Table 1-3 no need for the footnotes if the detailed explanations were included in Methodology section. What do P-values in Table 2 compare?

Answer 22: P-values in Table 2 compare the different response modalities for each variable of interest. For example, compare the availability of guidelines for basic EmOC between different types of health facilities, etc ...

Comment 23: Figure 1 edit the EmOC signal functions nomenclature according to suggested corrections above.

Answer 23: We have corrected figure 1

Comment 24: Figure 3: The index is expected to result into facilities with high and low Quality. Instead, here the individual index components are displayed. Needs revision.

Answer 24: Figure 3 has been revised by integrating data indicating the result for the variable “facilities with low quality of basic EmOC”

Reviewer #2: The authors should be commended on undertaking a large amount of work on a relatively unexplored topic. The subject matter of the study, the lack of existing data on EmONC in the DRC, and the quality of the paper warrants publication. However, a number of revisions is needed before the article can be accepted for publication, as follows:

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ABSTRACT

Comment1
Background:

The aim did not match the methods.

You conducted a cross-sectional study on availability of basic and comprehensive EmONC and problems reported by the staff through interviews, document reviews, and direct observation.

Saying that you identify 'ways to improve' implied intervention, which you did not do.

Suggest revising the wording to make the objective more accurate.

Answer 1: we agreed to correct the aim of the study to meet the data collected.

Comment 2

Methods:

The information in this section is unclear. Did the authors test all assumptions? If so, between what and what?

Answer 2: Associations between the dependent and each independent variable were tested by using the mentioned tests (Odds Ratio and Pearson’s khi square)

Comment 3

Results:

- State that the survey included n=1555 facilities. This is a landmark paper!
- 'A few facilities' is unclear.
- State how many facilities yielded complete information, how many had EmONC care;
  Otherwise just state the number of facilities

with complete information and go with the 9.1% and 2.9% figures.

Answer 3: ok, corrected
Conclusion:

Re: "The lack of regulation appears to be a key contributing factor to this state of affairs."

- Is it the lack of regulation, or is it the lack of monitoring for appropriate standard procedures for providers that contribute to the state of affairs? If so, please state that in the RESULTS part

Answer4: We believe that it is the weak regulation of the functioning of health facilities (lack of effective control of the application of standards) that may explain why front-line/first-line health facilities are organizing cesarean and blood transfusion when it’s known that they do not have all the necessaries.

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Comment 5: INTRODUCTION

- Page 5, Line 8: "...Africa and Asia carry the greatest burden [of maternal mortality] [1].

- Move the objective statement from the first paragraph in the METHODS section to the beginning of the final paragraph in the INTRODUCTION section.

Answer5: Ok

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METHODS

Comment 6 - Page 8, Line 31: What are the 11 strata in sample selection?? Provinces? Districts? Please specify

Answer6: The 11 strata corresponded effectively to the 11 provinces of the DRC
Comment 7 - Page 8, Line 54: Generally, it was unclear as to how stratified sampling (of 11 strata and 4 sub-strata) was done in order to obtain the 1568 facilities that was the final sample size.

Answer7: To ensure the representativeness of different types of health facilities, we used stratified random sampling, which allowed each sub-stratum to be represented in the sample according to its weight.

Comment 8 - Page 9, Line 26: (The index of availability of EmONC, #2 Staff): Does the staff member has to be on standby in the room at all times, or can this person work in another ward and be on all for EmONC? Please specify.

Answer8: The staff had to be available to administer care where necessary, but depending on the organization of the facility, they could have other responsibilities.

Comment 9 - Page 10, Line 10: (Index quality of EMONC, #3): Does the EMONC delivery guideline have to be in the form of a book or document? Please specify.

Answer9: The delivery guidelines in the DRC are in the form of documents.

Comment 10 - Page 10, Line 29: The index quality of comprehensive EMONC was confusing. I suggest that you turn all of the information here into a table or a box with lists.

Answer 10: Given the time available to provide the answers to the different comments of the reviewers, it was not physically possible to focus on transforming these data into a table.

Comment 11- Page 12, Lines 13 thru 18: (Data Analyses) Why did you mention Odds Ratios if they were never shown in the results section?

Answer 11: The odds ratio was actually calculated through this study but we preferred to keep the p value only in place of the odds ratios with their confidence intervals.
Comment 12: RESULTS

I wonder if the data in Figures 1 thru 4 can be presented as tables? Right now the information seems to be somewhat redundant, or the amount of used space seems copious.

In Table 2, it was unclear what the P-values were for? Was it simply to look at the heterogeneity of distribution of hospitals meeting guidelines on basic EmONC, HW trained in Basic EmOND, Ambulance, and Operational Capacity Score disaggregated by province, type of facility, administrative identity and location? If so, and if this is not the main research question, I wonder how much information the P-values actually yield? Also, given the large sample size, any noticeable difference would be statistically significant, but this significance only indicates that the difference was not due to chance? A much better use of Table 2 would be in the interpretation: what does it mean for only 3 of 91 hospitals in Equateur to have basic EmONC as opposed to 35 of 91 in Kinshasa? What contributes to the heterogeneity and what can be done to overtime these gaps? These issues would be insightful to talk about in the DISCUSSION section

Answer12: Table 2 contains a lot of information. Here, the results obtained in relation to each variable are analyzed according to the main independent variables (location of the health facility, the types of health facilities, the administrative identity of the facility and the types of provinces). We sought to find out if there were any differences between the different response modalities of the dependent variables------------------------

Comment 13: DISCUSSION

"The health system in the DRC is facing the challenge of poor regulation"

- As I mentioned in the comments in the Abstract section, is it the lack of regulation or is it the lack of standards / enforcement of standards? Please be careful of the wording to avoid ambiguity

- Also, which part of your study data points to this lack? Please specify

Answer13: Would you like to refer to the section 'Organization of the health system in the DRC: we have specified that normative documents exist for obstetrical care. These documents clearly indicate that health centers and health posts should be limited to providing basic care, otherwise
known as a "minimum package of activities" that excludes the provision of caesarean section and blood transfusion. However, the results we found indicate that some hospitals do not offer these two services while the health centers and health posts, without adequate infrastructure claim to offer these interventions. Health officials are supposed to regulate the organization of services but it seems like they don’t.

Comment 14: Strengths and Limitations

- Strengths: Please mention your high response rate and its implication on selection bias, or lack thereof

- Limitations: What was the results of data validation process, when supervisors sampled and visited 10% of the facilities? Any cause for concern with regard to the limitation? If no, then it's one of your strengths; if yes, then it's a limitation.

Answer14: Strengths and Limitations section has been updated

Reviewer #3: I thank the editor for being given the opportunity to review this manuscript. Overall I think an important study, and in particularly relevant because of the lack of research coming from the DRC, for obvious reasons. Perhaps the authors could emphasise this as well. I believe the focus of the study was on availability of EmOC rather than quality, which requires major revision in the text. I acknowledge that the structural aspects and some process aspects of the Donabedian framework are indeed addressed, however the authors have not actually assessed processes of care provision, which in my opinion is a true reflection on quality. The figures and tables are very clear and helpful. I feel the results should be related to the political situation and health system structure in DRC and I would ask the authors to make recommendation how the availability, and through this indirectly the quality of care could potentially be improved.

Please find my comments and suggestions per section below.

Introduction:

Comment 1: Page 5, Line 31-34: Please review the sentence 'Maternal deaths accounted for 35% of all females aged between 15-49 years [6].’ - I think you mean 35% of all female deaths not all females in general.
Answer1: the correct version is “Maternal deaths accounted for 35% of all deaths of women aged 15-49”

Comment2: page 5, line 23-24: please remove capital letter C of cesarean, and perhaps rephrase. Induction of labour is not operative delivery. Perhaps you can say ... assisted delivery (e.g. cesarean section, vacuum extraction). If that is correct.

Answer2: corrected

Comment3: Page 7, line 8-9: please remove 'the strategy of'

Answer3: ok done

Comment4: Page 7, line 8-15. The introduction of AMTSL and Partograph seems a but out of the blue, these are not part of EmOC, so perhaps introduce this a bit more clearly, its relevance for your study? Or leave it out.

Answer4: we (authors) decided to maintain the idea about the partograph and AMTSL because they are part of quality of care

Comment5: page 7: The section on DRC health system should be placed under method section which possibly a subheading study setting. . Perhaps also useful to give some demographics and basic health indicators. Population, fertility rate, MMR, SBA, ANC attendance etc. Also some minor spelling and language errors. For example please revise 'at each level are attached' and 'consist of minima'. And perhaps explain what you mean when stating reproductive health services. Do you mean ANC, Birth, PNC or also Family planning, post abortion care etc? I dont think that is necessarily important to mention but therefore perhaps simply state these facilities all need to deliver ANC, Intrapartum and PNC? Or specify primary health facilities should provide Basic and district Comprehensive EmOC. Health posts and referral health centres, should they provided Basic EmOC? Also with regards to setting, would it be useful to explain a bit more about the context, political context (e.g how is the MoH functioning, is there an ongoing conflict or not etc)

Answer5: interesting comment. We effectively moved the DRC health system section to the method section and updated this section to make it clear

Comment6: Methods
Page 7, line 55-58. Objective should be at the end of the introduction. Perhaps specify the study objective rather than paper objectives. Also include information on if this is a nationwide, or region wide or district wide Emergency Obstetric and Newborn Care assessment as first objective, followed by: 'to identify ways to improve distribution and quality'

Answer6: ok, corrected

Comment 7: page 8, line 10-11: I don't think you need a reference to this as you are simply stating which type of facilities were included. Which you have introduced earlier.

Comment 8: page 8, line 46: Would it be useful to say something about the total number of HF, to position your sample within the total?

Answer 8: the 1,568 health facilities were selected out of 15,988 functioning facilities.

Comment9: page 9, line 33: remove 'at childbirth', specify what was considered assisted delivery, How was offering defined? Offered within the last three months? What is the difference between service use and offering? I believe in the Manual for Assessment of EmOC (https://www.unfpa.org/sites/default/files/pub-pdf/obstetric_monitoring.pdf ) recommends to assess based on if it has been performed in the past three months.

Answer9: this comment was also made by another reviewer and we have already considered it in the main text of the manuscript. Thank you

Comment10: page 9, line 51: I think there needs to be more information about the importance of assessing quality in relation to EmOC. This deserves more introduction, for example referring to the recent WHO recommendations focusing on quality (WHO 2016). Introduce Donabedian already in the background section, so that this does not need to be explained while also explaining the data collection process.

Answer10: corrected

Comment11: page 10, line 5: training on Basic or Comprehensive?

Answer11: Depending on the type of health facility, provider training focused on basic or comprehensive EmOC
Comment12: page 10, line 10: Isn't equipment a prerequisite for availability of care as well? If the equipment is not available you can't offer it.

Answer12: It still needed to check these elements because sometimes it happens that certain actions are asked in the absence of appropriate materials.

Comment13: page 10, line 39: What about Helping Babies Breath training? Is this being done?

Answer13:

Comment14: page 10, line 5-6: How does the availability of guidelines inform if they were used according to standards? Then the focus remains focussed on structure aspect of Donabedian framework. Also there is no reference to the third component or the donobedian approach. So perhaps the authors can consider only focussing on the structure aspect of the framework? Process of care would be properly reviewed if researchers had done direct observations of actual situations where EmOC needs to be used. Which based on the current paper has not been done. So I am in doubt if it is appropriate to present your study has reviewed the quality of care. page 12, line 20: Please present ethics clearance number and state this was the national ethics committee in DRC.

Answer14: The used questionnaire helped to verify if the guidelines concerning the EmOC were available in the FOSA at the time of our visit. Then checks were made to know if these documents were effectively used during the case management.

Comment15: Results:

P12, line 59 and Figure 1: I miss a definition of what you defined as 'reproductive health services' and 'skilled childbirth care' they are not mentioned as variables in the methods section.

Answer15: Reproductive health service has been defined as a package of intervention comprising family planning, ANC, PNC, assisted vaginal delivery, etc...

The term ‘Skilled childbirth care’ is no longer mentioned in this figure.

Comment16: P16: Referring to earlier comment on the QoC, if you describe availability of drugs and equipment, it does not give us information if these were actually used, or used in accordance
to guidelines. So again I am in doubt if it is accurate to refer to this as high or low quality of care. It does give information about the potential ability to provide quality care, which is the structure aspect of the framework which you referred to earlier.

Answer16: cfr answer 14

Comment17: General: Can you say something about the geographical distribution of the facilities? Was this adequate? This goes to true availability of facilities to meet the needs of the population. Standards are i think one CEmOC for every 500.000 population.

Answer17: This study did not have the ambition to determine the coverage of the population in EmOC services (BEmOC and CEmOC), this would require to change the sampling procedure by integrating all health facilities in each surveyed geographical area. However, a study conducted in 2011 in three provinces of the DRC had indicated that the coverage in basic and / or complete emergency obstetric and neonatal care was very low, far below the thresholds set by the WHO.

Comment18 Discussion:

P21, Line 3-13: Again similar to previous comment you haven't explained earlier what RHS is

Answer 18: this comment has been integrated in the main text of the manuscript.

Comment19:P25, Line 19-29: Referring to previous comments, these facilities are providing services without the necessary equipment etc available, which indeed likely means it is of poor quality, but based on the study findings these challenges were similar in the other health facilities. I can imagine these facilities offer such services precisely because the coverage in their facilities of higher level facilities is poor. Perhaps this needs to be mentioned, if this is the case?

Answer 19: In the discussion part, we added a sentence along the lines of your comment

Comment20: P26, L19-29: I think such information could be provided earlier in the background. Also, this only is informative if the reader knows that what is recommended is one CEmOC in 500.000. I think this can be better structured throughout the paper.

Answer 20: We have considered this comment in the corrected part of the manuscript

Comment21:P26, L32-35: Here you refer to guidelines mother and child health, while the study focusses on EmOC, it is important to keep coherence throughout the manuscript.
Answer 21: The guidelines that currently exist in the DRC are generic, dealing with the general organization of maternal and child health services. They do not give enough indication that can provide clear information on the number of health facilities “EmOC” that the country should have for a slice x of the population.

Comment 22 P26, L35-43: This was not described in the results. How did you assess if it was operationalised?

Answer 22: by discussing with health workers and by the review of some documents.

Comment 23: P25, L45-46: Perhaps this tool should have been introduced earlier? L56: I think it requires a bit more explanation why simple presence of a physician would mean a facility would be upgraded. This raises more questions and I think this should be rephrased or left out. Is beyond what this study looks like. Or at least it would be helpful to be more clear in the beginning who is considered skilled to provided EmOC, basic and comprehensive.

Answer 23: We wanted to say that the health facilities where the doctors work are falsely considered as hospitals by some health workers and even by the population. The text of the manuscript has been modified for a good understanding.

General: I believe it would be important to reflect both in the background and discussion more on how the health system is functioning, budget allocation for Maternal and or Reproductive health, how the supply chain system works etc. Somehow the discussion is focussed on the health workers in the facilities, while they operate in larger institutions and systems which in my opinion are insufficiently addressed.