Author's response to reviews

Title: Women's and care providers' perspectives of quality prenatal care: A qualitative descriptive study

Authors:

Wendy Sword (sword@mcmaster.ca)
Maureen I Heaman (maureen_heaman@umanitoba.ca)
Sandy Brooks (sbrooks@mcmaster.ca)
Suzanne Tough (suzanne.tough@albertahealthservices.ca)
Patricia A Janssen (patti.janssen@ubc.ca)
David Young (david.young@iwk.nshealth.ca)
Dawn Kingston (dawn.kingston@ualberta.ca)
Michael E Helewa (helewam@cc.umanitoba.ca)
Noori Akhtar-Danesh (daneshn@mcmaster.ca)
Eileen Hutton (huttone@mcmaster.ca)

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Author's response to reviews: see over

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Arnold Bongcayao
Journal Editorial Office
BioMed Central

Dear Mr. Bongcavao:

> Re: 1189731910632401 - Women's and care providers' perspectives of quality prenatal care: A qualitative descriptive study

Thank you for the opportunity to revise and resubmit this manuscript. We also thank Drs. Thomson and Beeckman for their careful review of our manuscript and suggestions for revisions. We have addressed each of their comments as follows:

Reviewer: Gill Thomson

Major compulsory revisions:

1. A pseudonym or interview/participant number should be included after each of the quotes so it is clear to the reader that these views were elicited across a number of different participants.

> **We have identified the source of each quote. While the views of all participants are reflected in the findings, the voices of approximately 28 women and 20 care providers are captured in the quotes used in the manuscript.**

2. The balance between the interpretations and quote material does need to be addressed for a number of the sub-themes reported – on occasion, this reads more as a list of quotes, particularly when quotes are reiterating the same points. I would suggest that the sub-themes are reviewed and the data is re-synthesised and/or further consideration of what the additional quotes offer to the interpretations is considered.

> **We further synthesized some of the data under "clinical care processes" by combining "attention to risk factors" and "health promotion advice" under a new theme "health promotion and illness prevention". We also deleted some quotes throughout the manuscript where they were reiterating the same points.**

3. Whilst the 'meaningful relationship' is a key and important concept highlighted within this study, why were 'staff characteristics' (part of the structures of care theme) not considered to be of significance in this relationship – particularly when similar issues of trust are discussed in this section, and many would argue, that the staff characteristics are the basis upon which meaningful relationships are/can be forged?

> **Thank you for noting this discrepancy. In reviewing the theme "staff characteristics", we realized that characteristics of prenatal care providers are**

relevant to the establishment of a relationship. We now note in the manuscript that the theme "meaningful relationship" was woven throughout the interviews and was a theme that cut across the data.

4. Further details of what actual questions were posed (from Donebedian's model) during the interviews need to be included in the paper.

We have provided a description of the types of questions included in the interview guide.

5. Needs to be explicit within the methodology section how many participants/who were nvolved in the study.

In the "Methods" section we describe the sampling strategy and eligibility criteria. As is typically done for a research manuscript, the sample size and sample characteristics are presented at the start of the "Findings" section.

6. Check and remove references to wider literature when you are reporting on your findings (e.g. under emotional support sub-theme)

We included some references in the "Findings" section to provide validation for inclusion of data under a specific theme. For example, the literature review by Krishnasamy (1996) identifies the behaviours listed as exemplars of emotional support. Another example of the importance of using the literature to validate the data for a theme is when we identify the key principles of women-centred care as defined by the Vancouver/Richmond Health Board.

7. There is some slight repetition of points – e.g. on page 27, under emotional support, it refers to how reassurance concerning babies development leads to women feeling 'cared for' – this point is also made within the screening and assessment sub-theme.

We addressed this repetition by deleting the reference to feeling "cared for" under screening and assessment. The concept is more congruent with the emotional support theme.

Discretionary revisions:

1. As the study states that a key aim of the research was to develop and test an instrument to measure quality of prenatal care –a few sentences to inform the reader about the next steps to be taken in this work would be useful within the discussion section.

We have added a statement about next steps just prior to the discussion of future research.

2. Include full participant details within the table, e.g. where were the remaining 8 participants born?

We have revised the table (specifically country of birth and language spoken at home) so that the percentages for each characteristic now total 100%. We did not identify specific countries for women born outside of Canada as they were quite varied.

3. A further limitation may be that health professionals requested/identified women to take part, which may have led to a sampling bias – this needs to be considered within the discussion section, together with suggestions for further research.

We believe it is very unlikely that health professionals requested or identified women to take part as, for the most part, women were recruited from different health care organizations than the prenatal care providers. Moreover, the staff involved in identifying women often were not prenatal care providers (e.g., receptionists, public health nurses).

Reviewer: Katrien Beeckman

Major Compulsory Revisions

1. The authors state that the aim of their research is to develop and test an instrument to measure quality of prenatal care (p7), also they state that there is no agreement on what constitutes quality prenatal care of (p6, background section), I agree with this statement and argumentation, however I believe that the paper insufficiently provides in an answer to this. Suggestions about the items that such an instrument, to measure quality of prenatal care, should include are missing.

As stated on p. 7, "The purpose of this paper is to describe women's and prenatal care providers' perceptions of quality prenatal care." We have provided a description of the major themes, which reflect women's and care providers' perceptions of what constitutes quality prenatal care. A second manuscript is in progress that focuses on the development and testing of the Quality of Prenatal Care Questionnaire (QPCQ). It is in this second manuscript where we will discuss how items were generated from the interview findings and provide details of the QPCQ items.

Several dimensions of quality of care, resulting from the interviews were described; however it is unclear how the future process to select which dimensions will be included in the questionnaire and how these dimensions will be translated into questions, are missing. Eg. Will the dimension of the care setting or the staff characteristics be equally important as the clinical care processes and interpersonal care processes?

As noted above, a second manuscript is in progress. It will include a discussion of the steps used to select and reduce items.

Women will not always know if their care provider gained 'personal experiences with pregnancy and childbirth', and I cannot believe this is a major topic to judge on the quality of prenatal care.

It is true that women will not necessarily have knowledge of a care provider's personal experience with pregnancy and childbirth; however, it is included in the manuscript as it was an idea expressed by a number of study participants.

The suggestions for further studies (p37) jump to far, in order to examine the impact of quality of care on maternal and infant outcome, we need to know how quality of care will (need to) be defined/measured. I would prefer that the authors describe future research steps in this area instead of general recommendations.

We have explained in the discussion section that the QPCQ can be used to measure quality of prenatal care in future studies. As we noted in the background section, currently there is no theoretically-grounded, psychometrically-tested instrument to measure quality of care and that our research will fill this gap through development and testing of the Quality of Prenatal Care Questionnaire.

2. In the abstract as well as in the background a clear link is made between (1) the exploration of the women's and care providers' perspectives of quality of prenatal care to (2) inform the development of items for a new instrument. The paper however only provides an answer to the first objective (1) but not on the second (2).

As stated in our response to the first major compulsory revision suggested by Dr. Beeckman, the aim of the paper is to describe women's and prenatal care providers' perceptions of quality prenatal care. Instrument development and testing merits a separate article and, as such, will be described in detail in another manuscript.

3. The authors state that the purpose of the study is to describe '… dimensions of prenatal care that ultimately might contribute to healthy outcomes for women and their infant' (p7). This is a very strong statement, however in the discussion no relation between the dimensions defined and pregnancy outcome is made.

This is a tentative hypothesis based on available literature and in the discussion section we noted the need for research that examines relationships between quality of prenatal care and a variety of outcomes.

Minor Essential Revisions:

4. The authors describe that women with variations in medical risk status were included. I agree that this is important when describing perceptions of quality of antenatal care. However this variable was not described in the table 1 and we do not know if women with medical risks have a different perception about the quality of antenatal care.

The intent of our study was not to determine differences in perceptions of quality prenatal care between any subgroups of women or prenatal care providers. We have added to the description of women study participants by providing information on the numbers who reported a pregnancy complication or a chronic health problem.

5. In the background the authors describe that 'there is emerging evidence that the quality of prenatal care, i.e., what is actually done during the giving and receiving of care, may be more important than the quantity of care.' I agree with this statement and also believe that measuring the quality of care is most important when evaluating prenatal care. After this argumentation, three studies are discussed to demonstrate this. The first with a focus on lifestyle and psychosocial support in high risk women, a second focusing on the content of health promotion (the receiving of 22 health behavior advices) and a third on centering pregnancy. A whole range of variables, that are 'actually done' and contribute to the quality of care are described in these three studies. Although the general topics: health promotion, clinical care process and interpersonal care processes described in the three studies are subject of the current study, no suggestions are made about what elements of 'what is actually done' are most important and need to be included when measuring quality of care in the Quality of Prenatal Care Questionnaire.

> **As we have explained, the manuscript describes what women and care providers perceive as important elements of quality prenatal care. It was not the intent of this qualitative work to determine which elements are *most* important. The manuscript on development and testing of the QPCQ will explain how we determined the relative importance of a preliminary list of items and how the items were reduced.**

6. We do not have any idea who will (need to) fill out this questionnaire, the women or the care providers? Women that didn't receive care in pregnancy will be excluded I guess, and can you measure quality of care in women that enter the care system very late, in the third pregnancy trimester for example? This is important especially when one aims to examine the relation between quality of prenatal care and pregnancy outcome, which was one of the objectives described.

> **These issues will be addressed in the manuscript that focuses on the development and testing of the QPCQ, which will be described as a self-report instrument designed for women. We also plan a third manuscript that describes testing of stability of the QPCQ across three time points: third trimester, immediate postpartum period, and 6 weeks postpartum.**

Discretionary Revisions

7. On p 6:' …the need for the usual 14 to 16 visits has been questioned….'. Current guidelines advice far less consultations about 10 for primiparae (eg NICE guidelines for antenatal care, ACOG guidelines), therefore I wonder why the authors choose this article to underpin their argumentation.

> **We simply wanted to make the point that that while fewer visits have been recommended, this recommendation is based on the assumption (as noted by Walker and Rising) that high quality care is offered.**

8. ‘The clinical care processes and interpersonal care processes emerged as being most essential to quality of care’ (p33), for me it is not clear how the authors came to this conclusion. I could not derive from the result’s section why one dimension was more important than another.

> **By way of explanation we have added to the statement: "Clinical care processes and interpersonal care processes emerged as being most essential to quality care as discussions of these elements of care were far more prominent than discussions of structure of care in the interviews with both women and prenatal care providers."**