Author's response to reviews

Title: Delivery of maternal health care in Indigenous primary care services: baseline data for an ongoing quality improvement initiative

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Author's response to reviews:

Dear Editor,

Thank you for providing reviewers' comments, and for the opportunity to improve our manuscript. We have addressed issues raised as outlined below:

Reviewer: Glen Mola

Major Compulsory Revision

The main limitations of the work is the fact that only ~60% of the facilities participated in this review and the smallness of the numbers in each facility. I think this should be brought out more clearly. It should also be explained why so many facilities did not participate in the review and what attempts at gaining the participation of facilities which did not spontaneously respond in the first instance were made.

Response: We acknowledge that the fact that only ~60% of participating services undertook the maternal audit is a limitation. Of note, this was also raised by the other reviewer – Christine Roberts, who commented that this issue has been well covered in the discussion. It may help to clarify for the reviewer that services in this study were already participating in an on-going quality improvement study that began with a focus on chronic disease and was then expanded to support
services to improve their care in other program areas. The maternal audit described in this paper was undertaken to provide baseline data for individual services that chose to improve their maternal health care, as part of this study. As a result the services are self-selected and therefore not representative of all Indigenous primary care services in Australia. We have elaborated on this point in the seventh paragraph of the discussion.

We have also amended the title to better reflect that this paper is part of an on-going quality improvement study, to the following:

Delivery of maternal health care in Indigenous primary care services: baseline data for an ongoing quality improvement initiative

Regarding the sample size in each facility, within the ABCD project detailed protocols for the sampling process have been established, tested and refined. The sample size has been sufficient to show meaningful trends over time and differences between communities (see also the response to point 1 raised by the other reviewer).

Discretionary Revisions
The research question is well defined and acceptable, and the methodology standard for a cross sectional study.

The data is sound but it is disappointing that only 34 out of 56 primary health care facilities ‘chose’ to participate in the review. I would have thought that when setting up an “Audit for best practice” project (ABCD) that the M&E component should have stipulated that there would be a defined review and that it would be mandatory for all participating facilities to be involved in the review.

As only about 60% of facilities participated in the review, the validity of the data must be in question; this is compounded by the fact that the numbers of women who were reviewed is quite small. In many cases non-participatory facilities are likely to have worse performance and outcomes.

At least some comment about this issue should be made by the authors; ie why M&E was not part of the set up process of the project.

See response to the comments in the major compulsory revision requested by this reviewer above.

The manuscript does report the data (small and incomplete as it is) in a standard way.

The discussion of the data is generally speaking balanced; however, it would be good to include some comment about the following issues.

1. Some explanation as to why Standard Protocols were not followed by health workers of each cadre in the participating health facilities,

Response: We can only speculate as to why standard protocols were not
followed in the participating centres. It is possible that protocols were not followed because of the major challenges to providing primary care services in this environment, for example, due to poor resourcing, inadequate health literacy, high burden of acute care needs etc. It is also possible that protocols were followed but were not documented, either due to poor organisation of records or health staff not documenting care appropriately. As the reasons for the poor delivery of certain aspects of care are unclear, we would like to avoid being overly speculative in the paper, and have not amended the current wording of the Discussion.

2. Antenatal care is only part of the total maternity care package, - and ANC is divorced or at least not integrated with labor and delivery care as well as post partum care, - the package is very unlikely to be functional and deliver quality care. The paper makes virtually no mention at all of labor and delivery care, -except to report very high rates of CS, - and in one service (North Qld) high rate of unknown means of delivery. Some comments from the authors as to why there is no integration of ANC, labor and delivery care and post partum care would be useful.

Response: We acknowledge that antenatal care is only one part of maternity care. We have amended the discussion (paragraph nine) to provide more information about the context of this study and the reason why in this setting ANC is not more integrated into intrapartum care, namely, local policies which require women in remote areas to be transferred into regional centres for birthing from 36 weeks gestation.

3. Birth spacing and family planning are not only post natal issues, however they are only mentioned in this cross-sectional study in the post natal section. There is no mention at all of the fact that un-planned pregnancy and closely spaced pregnancy is associated with higher rates of perinatal mortality and infant morbidity.

Response: We acknowledge that birth spacing and family planning and not only post natal issues, and ideally, should be discussed pre-conception, however we believe this is beyond the scope of the current paper.

4. Again there is no real discussion about why there is such a low rate of post-natal follow-up (53%): and in this context the rate of post partum contraception advice (50% of 53%) is abysmal.

Response: We are not aware of other published studies in the primary health or hospital sector that have reported rates of postnatal follow up, so there is no appropriate benchmark with which to compare our results to. Therefore we can only speculate that these rates are low. See also response to comment 1 above.

5. It is mentioned in the discussion that ‘quality of care indicators’ in this primary care setting should be contextualized, - however, there is no discussion about or recommendations as to how this could be done. I would have thought that glucose tolerance testing and ultrasound examinations for morphology testing
might be amenable to this sort of thing. There is also no mention of cervical cancer screening as part of ANC.

Response: The quality of care indicators in this study focus on processes of antenatal and postnatal care, which reflect delivery of routine screening investigations and treatment of abnormal findings that are consistent with local guidelines. We have amended paragraph nine of the discussion to include further information about this. More widespread adoption of the quality of care indicators in this study is currently not possible as there is no national agreement on the standard components of antenatal care in Australia, as previously discussed in paragraph nine of the discussion.

We acknowledge that cervical screening is a component of Antenatal care. However, it was not collected as part of this audit because it is covered by a general preventive services audit tool that was completed by all participating health centres.

6. The issue of Data Feedback to Local Services is mentioned, but no discussion of what form, or what feedback would be appropriate as a result of this review is made.

Response: As stated earlier, this paper describes baseline data to inform an on-going quality improvement study. Annual cycles of feedback to and interpretation of results with participating health centre staff is a key component of this on-going study. We have amended paragraph seven in the discussion to include further information about this.

Reviewer: Christine L Roberts

This paper presents an audit of maternity care services in remote indigenous communities in Australia. Baseline data are reported from a review of maternal health records from 34 of 56 primary health care centres. The aim is clear and the methods appropriate and well described. Descriptive analyses are presented in 6 large tables. The paper is clearly written and will presumably form the basis of ongoing work in improving maternal health care for indigenous women. The main limitation of the study is that 22 centres chose not to participate in the audit, raising questions about the generalizability but this is covered well in the discussion. The authors report that some of the data have been previously published (page7, para 5, reference 25) but I cannot access this paper.

Discretionary revisions
The paper uses local geographical terminology that may not be accessible to an international audience. The authors could consider including a map.

Response: We have added a sentence in the first paragraph of the methods to describe the wide distribution and very remote locations of many of the participating services. We attach a map for your reference which shows the participating services, however we feel that this map is not very informative and that the point is better addressed in the text.
1. Cover why 30 records were chosen as the sample size for each centre.

Response: We have added the following sentence into the second paragraph of the methods:

In the ACBD project these sampling methods have been demonstrated to be sufficient to show meaningful differences between communities and trends over time.

2. There is variation in the use of terminology around screening. Screening descriptions could be included in the methods (fetal anomaly screening, nuchal translucency, screening for NTDs, first trimester combined, 14-20 serum screening, morphology ultrasound (text), ultrasound 16-20 weeks (table)), especially as some do not appear to be standard eg 14-20 serum screening

Response: We have clarified the terminology around fetal anomaly screening and ultrasound in the text so that it is consistent with the text in the table.

3. The last line on page 14 appears to be a reference that should be in the reference list.

Response: This reference has been added to the reference list and the numbering in the text has been corrected.

We hope this revision meets with your satisfaction.