Author's response to reviews

Title: Why do women present late for antenatal care? A qualitative interview study

Authors:

Rosalind Haddrill (r.haddrill@sheffield.ac.uk)
Georgina L Jones (g.l.jones@sheffield.ac.uk)
Caroline A Mitchell (c.mitchell@sheffield.ac.uk)
Dilly OC Anumba (d.o.c.anumba@sheffield.ac.uk)

Version: 2 Date: 17 April 2014

Author's response to reviews: see over
Dear Editor,

Re: Why do women present late for antenatal care? A qualitative interview study

We would be very grateful if you would consider our revised manuscript for publication in BMC Pregnancy and Childbirth. We have attached the revised manuscript and have detailed the reviewers’ comments and our responses, with the appropriate page numbers, below.

We hope your editorial team and reviewers will give it your full consideration.

Yours sincerely,

Ms Rosalind Haddrill
Dr Georgina Jones
Dr Caroline Mitchell
Professor Dilly Anumba

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<th>Reviewer 1:</th>
<th>Response</th>
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<td>1. While a lot is already written on determinants of late initiation of care, the authors found that their results differ from others as the social-cultural stereotyping was not found. I think this definition or concept is not made clear enough in the paper, and therefore it is difficult to understand the difference between these current and previous findings. eg. in Downe et al (that presents a review of qualitative studies) aspects of ‘not knowing’, avoidance and relation with professionals also seemed to be important elements in weighing up and balancing out the choice to attend antenatal care, and as such the difference between the findings in this paper could be made more explicit.</td>
<td>Whilst vulnerable groups are strongly represented in this cohort, women do not always fit a socio-cultural stereotype of a ‘late booker’ [3,4,13-15]. Many themes associated with late booking found in previous studies of marginalised women are evident amongst women across the social, educational and cultural spectrum in this study [19]. However our themes suggest a different emphasis to the denial, concealment and disadvantage frequently reported. Particularly there is a greater emphasis on considerations of convenience, relevance and familiarity (leading to the postponement of care), and a lack of a pregnancy ‘mindset’ relating to the expectation of becoming pregnant.</td>
<td>p22</td>
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2. **What is meant by this web of decisions bound up with preventative factors? And how could this be taken up prior to an antenatal appointment?**

We apologise this was not made clearer. By the ‘web of decisions’ we meant that there are multiple interrelated influences on women’s acceptance of their pregnancies and their decision to access early antenatal care; all occurring prior to their first antenatal appointment. For a small number of (potentially the most vulnerable) women preventative factors may also be part of this acceptance and decision-making. Lack of reproductive knowledge could be part of this. To address this requires intervention prior to conception as well as in early pregnancy.

3. **In Europe it is generally accepted that care should start in the first trimester, EU-Peristat defined this period before 12 completed weeks of gestation, the NICE guidelines (are also mentioned in the paper) confirm this optimal timing of onset. In this paper however 19 weeks were chosen as inclusion criterion. This means that other elements influencing attendance could be different in those subgroups and therefore potentially not made explicit.**

Thank you, this is an important point. NICE guidance for pregnant women with complex social factors [20] identifies the limit of early booking as 12\(^{6}/40\) (Euro-Peristat by the end of the first trimester: 14/40 [21]) but late booking as 20/40. Women booking at 13 weeks gestation are likely to demonstrate significantly different reasons and attitudes towards their care than a woman booking at a more advanced gestation such as 20 weeks and beyond. The gestation was chosen to maximise the number of women who had purposefully chosen to delay the initiation of care, rather than as a result of the late discovery of pregnancy.


4. **The link with including reproductive education in community settings is very accurate, also internationally. How could this be organized, do the authors have suggestions?**

Yes, we agree that this is significant. We consider that a more holistic view of women’s reproductive health (health through women’s ‘life course’) and reproductive health targeting need to be adopted. This would maximise opportunistic contraceptive/health reviews in primary care, and re-emphasise the value of the 6 week postnatal check for women (currently poorly attended), to highlight the value and relevance of early antenatal care. Our study suggests that the risk of repeated late booking may be associated with direct and indirect experience of late booking, and this area is worthy of further research.

There is also a role for community-based information/advice campaigns (as introduced
locally, influenced by the findings of this study) about early pregnancy symptoms and care, particularly targeting areas with higher than average late booking.

5.  **I would like some more information about the concept of the ‘joined up’ approach.**

   Improved communication between community midwives, family doctors and reproductive and sexual health services, also health and social care services that are outside of the NHS, could help to ensure the transfer of appropriate information, and the referral and follow up of women in early pregnancy.  

**Reviewer 2:**

1.  **Consistency of terminology needed:**

   ‘learning disability’ (p.8) or ‘learning difficulty’

   Thank you for identifying this inconsistency. References to learning difficulties have been removed: ‘learning disabilities’ is used throughout.

   p8, 9, 12-14, 16, 24, 34, 47, 48

2.  **Clarity needed around the issue of no funding for interpreters (p.8) e.g non-English speaking women were excluded (p.32 mentions language problems’.)**

   Yes, we acknowledge this was unclear. Clarification of the recruitment process has been given.

   ‘for whom English was not their first language’ has replaced ‘language problems’.

   p8, p34

3.  **Remove ‘focus groups’ from p.36**

   Removed.

   p38

4.  **Include recruitment strategy/ethical dilemmas if women did have learning disabilities e.g consent and how this was addressed**

   We have clarified the recruitment strategy for vulnerable women, such as the teenagers and women with learning disabilities.

   p8-9

5.  **Include search terms for literature review**

   Whilst we could include these search terms within the main text of the paper, this would necessarily have increased the word count. A systematic review using search terms such as antenatal/prenatal/maternity/care/access/initiation/delay/late/barriers identified papers relevant to this topic. For the purposes of this paper we have restricted our citations to key background, policy and qualitative literature identified by our systematic search and appraisal of the literature.

   p5

**Editorial comment:**

*Please remove ages from quotes*

Removed.

p14, 16, 18