Author's response to reviews

Title: Do health systems delay the treatment of poor children? A qualitative study of child deaths in rural Tanzania.

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Author's response to reviews: see over
Coverletter


Dear editors,

Please find attached the revised manuscript. We would like to thank the two reviewers for their careful reading of the revised manuscript. We appreciate the comments and proposed changes. Please find below our point by point response to each of the two reviews.

Reviewer 1 (Claudia Hanson).

1. We have read the manuscript carefully and corrected the faults mentioned by the reviewer. In addition, the manuscript has been proof read by a professional proof reader. The number of mothers included in the study has been corrected (to 16 – not 1616).
2. The section on “Study Limitations” has been modified and moved to the discussion section.
3. The first subheading in the result section now includes the paragraph above as suggested.

Reviewer 2 (Helen J Smith)

1. We have changed the subheading to Background (instead of ‘Introduction’ in order follow the conventions of this journal.

We have deleted the references to our results in the introduction/background section. The following section has been deleted:

Our intention is not to place blame on health professionals but to challenge the assumption often put forward both by health professionals and in research-based literature that parents carry the main responsibility for delay in timely access to adequate health care. We point out some of the structural factors embedded in everyday routine practices at health facilities, which work as silent injunctions of the patients.
We use the notion *biomedical technologies* in our analysis of the systematic delays taking place in relation to the treatment of poor children when they attend a health facility.

We use the notion *biomedical technologies* in our analysis of delays health facilities.

In addition, we discuss what changes could be adopted to reduce these delays.

In addition, we discuss what changes could be considered in order to make timely access to treatment achievable for the poorer segments of the population.

In this discussion, we apply the “power, trust, risk nexus” as described by Grimen [1] as an underlying conceptual framework for the study. This conceptual framework takes the notion of power into consideration in the sense that the health professional–patient relationship is characterised by a hierarchy in which the former is superior and the latter by definition inferior.

We see this statement as an expression of Grimen’s ‘power, trust risk nexus’. Esther acknowledges the asymmetric relation between herself and the health professionals. She takes on the blame for
the death of her child while she from her structurally inferior position, trusts that the health professionals potentially had the skills and knowledge to save her child.

In the discussion, we again use Grimen’s analytical concept to explain the particular vulnerability of the patients.

The structural inferiority on the part of the patient is as suggested by Grimen partly determined by the knowledge gap between the health professional and the patient [ref]. In addition, patients are by definition in a vulnerable position due either to their own physical or mental illness or to the stress and worries of having a sick child.

4. The method section has been revised considerably.
   a. We have added the following three sub-headings: Study setting, Data collection, Ethics
   b. We have revised the description of our field study (see response no. 5 below)
   c. We have moved the last paragraph of the Method section (on Ethical Clearance) to the beginning of the sub-section entitled Ethics
   d. The following part of this section has been shortened and the informal wording deleted. The section now reads as follows:
      The interviewees all gave informed consent and were asked to sign a consent form. Interviewees were informed about the study and the meaning of confidentiality and anonymity. During the informed consent process, it was made clear what we aimed to talk about and why, and we specifically asked each woman if she would be comfortable discussing this highly sensitive topic. The in-depth interviews were conducted by the authors with translators and focused on the mother’s recall of illness and health seeking events that occurred prior to their child’s death.
   e. The following section has been deleted:
      During the informed consent process, it was made clear what we aimed to talk about and why, and we specifically asked each women if she would be comfortable discussing the topic. We also made the women aware that they could withdraw from the interview at any point in time. During interviews, we observed the women carefully to see if they appeared distressed or withdrawn and we frequently enquired if they were still comfortable with continuing the discussion.
   f. The language is tightened up, eg. “We went along with them...” has been replaced with “We followed them.” “As it turned out” has been replaced with “However...”.

5. The section describing data collection has been changed. It is now explained how the two study periods are related and we make it clear that the data used in this article were collected during the 2007 fieldwork. A section called “Data Collection” explains the fieldwork as follows:

Fieldwork for this article was carried out in 2007. We had been involved in a multidisciplinary study conducted on behalf of the Ministry of Health and Danida the year before, focusing on differences in child mortality in four districts of Tanzania. In that study, the district of Mpwapwa was defined as ‘underperformer’ (with a lower decrease in child mortality than expected) based on a comparison.
of census data from 1988 and 2002 adjusted for non-health system related factors [ref]. In 2007 we had an opportunity to conduct a follow up study where we were interested in focusing in more detail on concrete experiences with child death and access for the treatment of sick children. The fieldwork in 2007 included a total of sixteen mothers who had lost a child two months to one year earlier (see Table 1 for an overview of mothers’ accounts)...

6. The section on “Study Limitations” has been modified and moved to the discussion as suggest by both reviewers.

7. The first section of the result section has been corrected. It should now be clear that we have conducted in-depth interviews with sixteen women who had lost a child within the previous two years. As mentioned above, we have now in a section called ‘Data Collection’ clarified the relationship between the 2006 and the 2007 studies. We deleted the information about the number of interviews during the 2006 study as our manuscript only draws on interviews conducted during the 2007 fieldwork.

We have also re-visited the reviewers’ previous comments to our section on analysis and findings. As a further response to this, we have added the following sentence in order to specify the importance of detailed note taking as part of the data handling:

**Detailed notes were taken during observations of consultations and when following cases of illness through the system.**

Furthermore, to the question as to whether we use the case study method, we would like to clarify that the sixteen cases of child deaths are seen as cases – but we have not used the extended case study method. When following patients through the health care system, we use the term ‘case’, but in this context, it is not understood as a specific methodological approach.

As to the question about similarities and differences between the 16 cases, we hope that it is now clear that the four obstacles described and analysed in this article are the result of a careful analysis of similarities between the cases. We have also described differences between the cases. In the section on communicative practices we write that “In some cases, the patients take on the guilt and feel that the scolding by the health staff is justified...”. We also describe differences between the cases in the section on “Inadequate referral systems”, where we describe the difference between Agnes and Happiness (Agnes was never referred to the higher level of the health care system, whereas Happiness was eventually referred from the dispensary to the health centre).

8. We have as mentioned above moved the section on study limitations to the beginning of the discussion section.

The sentence:

We have here focused on the delays in receiving care (the third delay) and scried four factors...

Has been rephrased:
This study focused on the delays in receiving adequate care at the health facilities (the third delay) and described four factors.

The language of the manuscript has been strengthened and we have been particularly observant in keeping an academic style. The paper has been proof read by a native English speaking social scientist.

9. We have responded to all the comments point by point.

Again we would like to express our appreciation of the careful reading of our manuscript and all the useful comments and suggestions. We think the paper has been strengthened considerably by this reviewing process.