Author’s response to reviews

Title: Reasons for late presentation for antenatal care, healthcare providers’ perspective

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Reviewer reports:
Ramprakash Kaswa (Reviewer 1)

General comments: Health care provider and health provider are used inconsistently throughout the article.

• Thank you for pointing out this, we have corrected to healthcare provider on the title and throughout the document.

Abstract: There is three objective of the study but most of study findings surrounding to insights of health care workers but concluded the other two objectives.

• We thank the review for this comment, we have corrected accordingly line 34-38

Background: ANC is much more than preventive care for pregnant women. It is integrated services with many components. The BANC policy is essential part of primary health care services.

• We thank the review for this comment and we have made corrections accordingly - lines 45-49

• We also corrected the abstract - lines 13-15

Methods:

Inclusion criteria?

• We have added the inclusion criteria – lines 120-123.
Is there any interview guide was used
A summary of the interview guide has been included - table 1

Describe the role of researcher and how to overcome the bias

• We have corrected accordingly - lines 142-147
Needs the description of framework used= to analysis of data.

• We have corrected accordingly – lines 140-142
Consent obtained from all health care worker or study participants?

• Thank you for noticing this oversight, we have corrected – lines 122-123

Results: Many sub-themes are overlap and needs reorganization under appropriate themes. Needs detail description of structural framework to make trustworthiness of findings. There is lack of analytic scrutiny.

• We thank the review for this comment. What figure 1 shows in column 1 titled “Healthcare providers’ perceived patient reasons for late ANC presentation” is what healthcare providers say were the reasons they think women present late for ANC, the second column titled “Healthcare providers’ experience with late presentation for ANC” shows the challenges that healthcare providers have to overcome as a result of presenting late for ANC by women and the third column shows how healthcare providers respond when they are faced with the challenges of late presentation of ANC.

• We have also added an interview guide (table 1) to make trustworthiness of findings.

All subheading under section 3.4 are not in align with heading.

3.4.3: This headline and contents under this headline are mismatched. The contents are talking about lack of knowledge and language barriers.

• We thank the review for this comment. However, we were trying to point out that even though the healthcare providers acknowledged that women lack knowledge and language and lack of privacy are barriers to effective ANC activities they did not stop there but went further to explain how they empathise with patients by educating them and by devising ways to overcome the language and space barriers.

Conclusion: The conclusion is not answering the study objectives. The recommendation also needs to re-look.

• We have revised this section (line 427-440) and it now reads; “The timing of ANC is influenced by a lot of decision making that is involved during pregnancy, starting from accepting the pregnancy itself to acknowledging the need for antenatal care. To positively effect this decision making for the benefit of early ANC barriers such as lack of knowledge should be addressed prior pregnancy through campaigns and awareness programmes. Moreover, a more determinant specific information campaign about the significance of early attendance of ANC is needed at individual and community level, with a strong focus on the importance for early HIV treatment for PMTCT. In addition to factors such as personal barriers, system and service failures, negative attitudes and behaviours are major deterrents to care seeking behaviour of pregnant women. Healthcare providers need to be encouraged and empowered to make necessary changes in patient flow challenges. The relationship between healthcare providers and
women should be emphasized when training healthcare providers. More investigation is needed to better understand the patient-providers’ relationship in ANC services and ways of promoting positive interactions between these two parties to improve early and frequent attendance of ANC services in pregnancy.”

Limitations of the study: Sample size not a limiting factor for qualitative study.

• Thank you for pointing this out, we have corrected accordingly – lines 422-425. This section now reads, “Reasons for late presentation from the women’s perspective were not included. Including these women may have enhanced our understanding of the reasons for women presenting late. A dialogue between patients and healthcare providers is needed to assess if healthcare providers and women point out the same reasons.”

Triangulation is lacking

• While we acknowledge this limitation, we wanted to focus on the healthcare providers’ perspective into late presentation of care and compare it to what women give as reasons for late ANC presentation in literature.

Conclusion: The conclusion is not based on study findings. The recommendation also needs to re-look.
• We thank the reviewers for this comment. We have made changes to this section, lines 427-440

Rosalind Haddrill, PhD (Reviewer 2):

Thank you for asking me to review this paper. I have a number of concerns relating to the paper, particularly in relation to the discussion and conclusions formed but also some relating to the general writing, the methods and the results presented.

Background
- Be careful about the use of emotive phrasing such as 'rampant' (p2, line 23), and 'even…' (line 28, 33)
  • Thank you for pointing out this, we have corrected accordingly – lines 53, 55 and 57.

- There are some inconsistencies with referencing, for example use of 'etal' in places, not in others.
  • We have corrected this.

Also starting a sentence with a reference in parentheses is poor writing - e.g. line 59 should read "Ebonwu et al (2018) found that…”
• We thank the reviewers for this comment, we have corrected accordingly – line 73.

- Line 36: I assume this should say 'reduce' the risk of adverse obstetric outcomes rather than 'prevent', as even regular ANC attendance cannot prevent poor outcomes?
  • We thank the reviewers for the comment, we have corrected accordingly – line 58.

- Line 43: what is MOU? You explain later but not here, the first time you use the abbreviation. Be careful about this. There are other examples of this throughout the work, e.g. PHC (line 56), ART (p3, line 57), PCR (page10).
  • We acknowledge this mistake, we have corrected accordingly – lines 63-64, line 83, line 112, line 334.
- You present some slightly conflicting evidence without any discussion, for example around low parity being associated with early attendance but first pregnancy with late attendance. Also mention about jealousy and bewitchment without any explanation at all, which was odd.
  * We thank the reviewers for pointing this out, we have corrected this – lines 75-82

- You talk about 'the recommended 20 weeks gestation" (p3 line 41) – whose recommendation is this? You don't say.
  * We have corrected this mistake – line 102-103.

- I think the aim of your study could have been more explicit at the end of this section, rather than the content of the paper.
  * We have added the aim of the study at the end of this section – lines 101-104

Methods:
- You mention about the participants were all nurses, but from a Midwife Obstetric Unit - later you tell us some of the participants were midwives, which is confusing.
  * We thank the reviewers for this comment, we corrected accordingly – line 108.

- Data collection: where is your topic guide/list of questions and how did you decide what to ask the participants?
  * We thank the reviewers for this comment, we included a summary of the interview guide – Table 1

- Data analysis: I think you need more information about your pre-assigned codes and pre-conceptual framework - why did you use this method and how did you derive the codes?
  * We have corrected this – lines 139-147. The section now reads like, “Data were analysed using a thematic approach of pinpointing, examining, and recording patterns within the data. Initially deductive, pre-assigned codes were used based on a conceptual framework built around providers’ perspectives on reasons for ANC late presentation. This was followed by inductive code development to deepen the data analysis. Two transcripts were completely coded by three researchers and compared for inter-coder reliability and the codebook for analysing the remaining transcripts was thereafter revised and finalized. To overcome bias transcripts were coded by 3 researchers, two of the researchers CM and NJ had conducted the interviews and one researcher AM had not conducted the interviews and DO was also involved in checking and verifying the interpretations of the data.”

- Why does 'patient-reasons' have a hyphen?
  * Thank you for pointing this out, we have corrected it accordingly – lines 160, 162, 164, 165

Results:
- You seem to write in different tenses in this section, some in the present, some in the past, sometimes in the same sentence (e.g. page 11, lines 12-15).
  * We corrected – lines 233-235

- Page 6, line 54 - why 'indisputably’?
  * Thank you for pointing this out, we have removed the sentence, we realised that this point does not belong on this section.

- 3.2.2 You mention that staff recognised the patient provider relationship was important and that women believe that 'the nurses have got attitude' but 'were unable to determine how they could go
about doing this' - did you ask them? This seems a huge point but is hardly mentioned at all. Should this be a theme in itself?

• Thank you for pointing this out. We acknowledge that this point does not belong on this section and we have removed the sentence; “Healthcare providers acknowledged the importance of patient-provider relationship in creating demand for ANC services in subsequent pregnancies but were unable to determine how they could go about doing this”

Also 3.2.5 "Healthcare workers seem unable to address factors that increase long queues at PHCs and despair that the practice of turning patients away is likely to continue" - where are the quotations to support this statement? You don't present them.

• We have added the quote to support this statement, lines 243-251. It now reads like; “Healthcare workers seem unable to address factors that increase long queues at PHCs and despair that the practice of turning patients away is likely to continue. A midwife at an MOU when asked about the challenges that healthcare providers face due to late presentation of ANC and how the government can support, had this to say

“Increase staffing. Also counsellors should be there to assist the sisters (nurses and midwives). It is like the sisters are being traumatized somehow. Because you need to see twenty patients on the line, five of them are new and among them maybe four are positive. You need to stay plus or minus an hour with one patient. And then there are complaints that you are delaying yet there is a lot to do” (Midwife, MOU)

- 3.2.3 you say that women had a poor understanding of ANC but "Women seem to also ignore the optimal time to start ANC" which suggests a deliberate rejection rather than a not knowing - be careful with your use of language.

• We thank the review for this comment, we have corrected this – lines 205-207

- 3.2.6: you talk about professionals' 'dismay' and 'disbelief' but again these are not reflected in the quotations.

• Again like in section 3.2.2, we acknowledge that this point does not belong in this section and we have removed the sentence “The expressions of disbelief and in some case dismay, suggests that healthcare providers don’t feel equipped to address these misconceptions.”

- 3.4.2: it wasn't clear what the PCR was and why this related to women attending or not attending for ANC.

• We thank the reviewers for this comment. PCR has been explained – lines 334-335. Here we were trying to show how healthcare workers respond to the consequences of late presentation for ANC by women, therefore this quote describes how healthcare workers are frustrated by high workload which resulted from late ANC presentation by women and lack of resources.

Discussion:
- This section seems quite limited and you seem to provide very little explanation for why the staff feel the way they do and what specifically should be done about this to improve early attendance for ANC. This needs to be stronger to demonstrate your study has value.
- Page 12, line 19 and 31: I would be very careful about the use of such negative and disparaging words 'ignorance' and 'ignore',
  • Thank you for pointing out this, we have corrected accordingly – line 391.

- 3.3.2 Also lines 26-27: 'presumed knowledge and experience about pregnancy' seems to suggest that staff don't believe women do have this knowledge and experience, even if they have had several healthy babies before. This language seems to epitomise the negative views of women reflected, as you say, in forceful behaviour, shouting, etc. by healthcare professionals. - Why professionals feel like this isn't really explored at all in your paper
  • Thank you for pointing this out, but in the paper (section 3.3.2), we talked about healthcare providers admitting that they have attitude and this quote demonstrates that the healthcare providers sometimes become forceful; “There is attitude, from both of us. Sometime the client will come in having this negative attitude or having heard from other people that there is this and she just came in, even if she was not mistreated, she comes in prepared, fighting. By the time you ask her questions she is not nice. Because of some of the things that are being done by her, then the staff will start to be negative towards her.”

- Was there a difference between nurses, midwives and doctors in these views? You don't say.
  • There was no difference between the nurses and midwives, we did not enrol any doctors.

- Again, you talk about how staff "are aware of these factors, they seem unable to effectively respond to them" and see them as inevitable, but you've not really presented any evidence about this - I think this needs to be clearer.
  • We were referring to the negative attitude and forceful behaviour that is demonstrated in this quote, “There is attitude, from both of us. Sometime the client will come in having this negative attitude or having heard from other people that there is this and she just came in, even if she was not mistreated, she comes in prepared, fighting. By the time you ask her questions she is not nice. Because of some of the things that are being done by her, then the staff will start to be negative towards her.”

- What did you actually ask them about this?
  • We asked them the following; “What are the challenges you or your colleagues face in implementing ANC and PMTCT in relation with your capacity?”

- What did they say?
  • They talked about women’s attitude toward staff, shortage of staff, and counselling space

- You talk about a need for sensitivity, empathy and positive attitudes towards women but this isn't really evident in your results, and you haven't really explored why this is the case. –We hope the reviewer will find the explanation given in section
  • We thank the reviewers for this comment. We talked about some healthcare workers being sensitive and showing empathy to women who lack knowledge on the importance of ANC in section 3.4.3, healthcare providers’ negative attitude towards women in section 3.3.2.

- What are the 'quality improvement processes' you mention? You could have really developed the final
sentence "There is a need for structured approaches…" too, as this is a very broad statement which requires more detailed exploration and some much clearer ideas about how things can improve.

• We thank the reviewers for this comment, we have corrected this section (lines 411-420) and it now reads “South Africa has embarked on the Ideal Clinic program to guide healthcare providers in quality improvement processes by ensuring that an ideal clinic has good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and harnesses partner and stakeholder support. The impact of this intervention on healthcare providers’ awareness of elements of quality care and their capacity to address clinic process challenges is yet to be adequately evaluated. There is a need to implement the Ideal clinic programme described above to address challenges experienced and expressed by PHC and MOU-based healthcare providers and leverage on their awareness, sensitivity and empathic attitude towards patient experiences in PHCs levers in efforts to motivating healthcare providers to provide quality care.”