**PEER REVIEW HISTORY**

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**ARTICLE DETAILS**

<table>
<thead>
<tr>
<th>TITLE (PROVISIONAL)</th>
<th>Torn between two worlds: parental experiences of neonatal follow-up for infants with hypoxic ischemic encephalopathy in India—a qualitative study using interpretative phenomenological analysis</th>
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<tr>
<td>AUTHORS</td>
<td>Chandrasekaran, Suja Angelin; John, Hima; Ross, Benjamin; Arumugam, Asha; Balan, Indira; Samuel, Reema</td>
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**VERSION 1 – REVIEW**

<table>
<thead>
<tr>
<th>REVIEWER</th>
<th>Susan Ireland</th>
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<td>James Cook University College of Medicine and Dentistry</td>
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<tr>
<td>REVIEW RETURNED</td>
<td>30-May-2022</td>
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**GENERAL COMMENTS**

- This is an interesting, well designed and presented study. There are a few suggestions and a couple of amendments required.
- The abstract reads well and is accurate in portraying the study.
- Strengths and limitations - page 3 line 52 - I am not sure that the use of a specific software can be said to be a strength (although as a researcher it is certainly helpful).
- Pg 3 line 56 - please change the wording as I think you are trying to convey that the telephonic interviews might have reduced the ability of the parents to communicate (or be interpreted?) easily - rather than saying 'their expression'
- Another potential limitation might be the use of clinicians who care for the child in the follow up clinic also interviewing the parents about the follow up as it may inhibit the parents from being negative.
- Introduction
  - Pg 4 line 66 - I presume that the 1.2 million infants with moderate to severe disability is in India? - please specify.
  - Pg 5 line 87 - The sentence starting 'The severity increases...' would be improved by clarifying if this is the severity of the guilt or the severity of the stigma - I am not sure which is alluded to.
- Participants
  - Pg 6 line 131 - did all potential participants who were approached agree to participate? - if not, please say how many refused as a high refusal rate might suggest that there is unexplored negativity towards the study or it subject. In the COREQ it is stated as NA, if there were no refusals please state this.
- Results
  - Table 2 - please correct the statistics of percent mothers and fathers - at present mothers plus fathers only add up to 67.3%
  - I do have a bigger concern about the disability demographics. Have you presented the most significant clinical finding for each patient? -
it seems very unlikely that 3 patients only had CP but no other disability given the descriptions given by parents in the results - did some also have intellectual disability? Also 2 only had intellectual disability - without speech delay? - although it is possible given the small numbers, many children are likely to have issues across several domains, in which case the 'disability' found would not come to 10 which is the number of patients. If this is the predominant disability, it would be acceptable to state this as the 'main disability as perceived by parents' or something similar. If, indeed, the children all only have isolated single disability then no change would be required. Please clarify.

Table 3 - There are excellent quotes given in the body of the results. A few of the quotations given in the table, however, are not clearly linked to the theme - 1. pg 10 line 18 - the quote given seems to suggest it belong in the guilt/blame theme. 2. Similarly, the first quote used on page 10 line 39 - under challenging parental experiences seems to be about the social milieu or socio-cultural. The body of the results is well described.

Discussion
The discussion is balanced and places the findings well within the relevant literature. It offers an interesting insight into the challenges for parents in India who have babies with HIE. As a clinician in Australia, I found it surprising how many common themes we could have in a similar study here, whilst showing the socio-cultural differences which could improve follow up in India. As people travel and move elsewhere, the study is generalisable.

Figure 1 - the thematic map is excellent and displays the results well.

REVIEWER
Balamurugan Thyagarajan
Princess Anne Hospital, Neonatal Unit

REVIEW RETURNED
03-Aug-2022

GENERAL COMMENTS
Many thanks for asking me to review this manuscript. My aim is to provide an honest appraisal of the manuscript and I do not have any competing interests other than a genuine interest in this topic.

Torn between two worlds: Parental experiences in Neonatal follow up of infants with hypoxic ischemic encephalopathy – A qualitative study.

The authors have attempted to address an important question which will be of interest to the clinicians, patients and perhaps even the wider public. I will break down my review into short segments so that it is manageable. I present my review as comments to specific segments of the manuscript and then followup with some overall comments.

Line 68: Studies in India have shown that the compliance to neonatal follow-up is moderate (59.2 %) resulting in low participation and reduced effectiveness.4 Comment: perhaps readers of this journal would be more interested in a range rather than a single figure of 59.2%. There is clearly an opportunity to look for any other follow-up figures published since 2006.
Line 74: At adolescence, the reported rates of disability following moderate encephalopathy are higher, with 30% having CP, and 70% of those without CP having a cognitive disability that interferes with their daily life.6

Comment: The authors quote a much higher rate of CP than widely accepted as the norm. Perhaps they can kindly clarify whether the rates refer to any particular high-risk population of interest and whether these rates were observed in the pre- or post-therapeutic hypothermia era.

337 DISCUSSION
338 Parents of children with HIE are torn between two worlds - an atmosphere of support and one of criticism. They face reassuring and distressful experiences during the NICU stay, post-discharge and early parenting years.

Comment: the authors discuss parents facing reassuring and distressful experiences during the NICU stay. However, it is not clear how many of the interviewed parents are currently staying in NICU and what was the duration of stay or how long after the stay were the parents interviewed.

345 The first finding of this study is that during NICU stay, mothers faced disproportionate attribution of blame by family, society, and even spouses.

Comment: not clear when the interviews were done.

355 prominence to family values over individuals; elders over younger persons. In this context, it is hard for new parents to transgress existing support systems.

Comment: these statements are

364 NICU due to the constant fear of their child becoming ill again. Parents in this study reported that information on what to expect and regular follow-up visits in the first year helped them with this transition. This is similar to the findings of other studies.

Comment: It is not described what information was given to parents at the time of discharge if any.

382 In this study, parents perceived socio-cultural factors to help or hinder follow-up irrespective of the extent of the child's disability. Beliefs and rituals acted as opportunities and barriers to neonatal follow-up.

Comment: not clear regarding the supporting evidence for this statement.

384 The cultural barriers that include mothers not being allowed to make independent decisions in extended families add challenge to existing difficulties of caring for an infant with HIE.

Comment: Not clear from the manuscript how many of the interviewed parents come from ‘extended’ families.
Overall comments:

This study was approved by the Institutional Review and Ethics Board of Christian Medical College, 124 Vellore (IRB no:12382).

This study was conducted in Tamil: the interviews and FGD were audio-recorded, translated, and transcribed verbatim for content analysis.

Comment: It is safe to assume that the interviews were translated from Tamil to English: how the translation from Tamil to English was handled has not been described.

Has the research addressed a question that had to be answered?

The authors state that to their knowledge, there are few studies done in Low and Middle-Income Countries (LMIC) that explore the barriers and ways to overcome them from the parent's perspective. This study aims to understand the barriers and facilitators for neonatal follow-up as perceived by parents of infants with HIE.

This study makes an original contribution to the scant literature on socio-cultural influence on parenting and follow-up experience of parents of children with HIE. The effect of socio-cultural factors on parenting and neonatal follow-up in a traditional country such as India is new to the field. Parents expressed that socio-cultural factors predominantly influenced the compliance to follow-up and therapy than institutional and financial factors. This is something that clinicians, policy makers, patients or the public need to know but the authors need to describe the social and policy implications of their research.

Research question: Although the introduction provided a clear research question (to understand the barriers and facilitators for neonatal follow-up as perceived by parents of infants with HIE), how this is answered from the questions asked during the interview was not clear. The authors used 4 semi-structured questions: it is not clear how the questions were developed and delivered in Tamil language.

Originality of the research: Literature review was done but omitted some publications on parental perceptions in HIE.


Has this never been done before?

Such studies have been done before in other populations which the authors have not adequately referenced. The impact of therapeutic hypothermia itself has not been explored in the parental perceptions.
Is the design right for answering the research question? yes

Methods:
Data has been collected through interviews in the Tamil language. Subsequently, it is implied that the data has been translated into English. – however, the translation process has not been described and how the translation was agreed was not described.
The sampling of participants has not been described.
The researchers could have had a much bigger or better-recruited study as this is an important topic with a large social burden.

Analyses: Quantitative analysis was presented. The comments were organised in themes. However, it is not clear how the themes were agreed upon by the individual reviewers and how conflicts were handled.

Conclusions: This is a qualitative study of parents experiences. Most of the conclusions had supporting data. But the authors go beyond the presented evidence in their conclusions.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

Strengths and limitations:

1) Strengths and limitations - page 3 line 52 - I am not sure that the use of a specific software can be said to be a strength (although as a researcher it is certainly helpful).

Thank you. This point is removed from the strengths and limitations section. We also added other valid details about the methodology. (See page 3, lines 11 – 35)

“Strengths and Limitations:

- This is the first qualitative study from India to explore the follow up experiences of parents from varied socio-cultural backgrounds.

- The interviewers being the therapists who cared for the child in the follow up clinic might have inhibited the participants from expressing negative experiences.

- The multmethod qualitative approach using interviews as well as focus groups supported data triangulation.

- The interviews were conducted a few years after the NICU stay, which could have led to recall bias in participants.

- Telephonic interviews could have limited the interviewer’s ability to interpret emotional expressions while recounting experiences.
2) Another potential limitation might be the use of clinicians who care for the child in the follow up clinic also interviewing the parents about the follow up as it may inhibit the parents from being negative.

We agree and this suggestion has been included in the strengths and limitations section. (See page 3, lines 23 to 25)

“The interviewers being the therapists who cared for the child in the follow up clinic might have inhibited the participants from expressing negative experiences”.

Introduction:

1) Pg 4 line 66 - I presume that the 1.2 million infants with moderate to severe disability is in India? - please specify.

Yes, it is in India and we have mentioned it. (See page 4, line 9)

“Of 1.2 million infants with moderate to severe disabilities in India, 40% of children have a history of HIE”

2) Pg 5 line 87 - The sentence starting ‘The severity increases...’ would be improved by clarifying if this is the severity of the guilt or the severity of the stigma - I am not sure which is alluded to.

Thank you for pointing this out. The sentence is made clear including the word stigma. (See page 5, line 4)

“The severity of stigma increases when the infant is known to have a medical condition at birth like HIE and is at risk of disability”.

Participants:

Pg 6 line 131 - did all potential participants who were approached agree to participate? - if not, please say how many refused as a high refusal rate might suggest that there is unexplored negativity towards the study or it subject. In the COREQ it is stated as NA, if there were no refusals please state this.

Thank you for pointing this out. We have included the information under participants section. (See page 7, lines 5 and 6)

“We contacted 20 families and 13 of them consented to participate”.

Results:

1) Table 2 - please correct the statistics of percent mothers and fathers - at present mothers plus fathers only add up to 67.3%

We corrected the percentages. Thank you. (Please see Table 2, page 9, lines 11 to 13)
2) I do have a bigger concern about the disability demographics. Have you presented the most significant clinical finding for each patient? - it seems very unlikely that 3 patients only had CP but no other disability given the descriptions given by parents in the results - did some also have intellectual disability? Also 2 only had intellectual disability - without speech delay? - although it is possible given the small numbers, many children are likely to have issues across several domains, in which case the 'disability' found would not come to 10 which is the number of patients. If this is the predominant disability, it would be acceptable to state this as the 'main disability as perceived by parents' or something similar. If, indeed, the children all only have isolated single disability then no change would be required. Please clarify.

Yes, we had categorized them according to the parents’ complaints. The children with Cerebral Palsy and Intellectual disability also had speech delay. Now we have named the title as ‘Main disability perceived by the parent’. We hope that this makes it clearer. (Please see Table 2, page 10, line 6)

3) Table 3 - There are excellent quotes given in the body of the results. A few of the quotations given in the table, however, are not clearly linked to the theme - 1. pg 10 line 18 - the quote given seems to suggest it belong in the guilt/blame theme. 2. Similarly, the first quote used on page 10 line 39 - under challenging parental experiences seems to be about the social milieu or socio-cultural.

Yes, the sentences at the end of the second quote (pg 10 line 18) sounds more like guilt/blame. We have added the part where the mother emphasized the restriction and have removed the part about the blame. (See page 10, lines 52 to page 11, line 3)

“During the last months of pregnancy we usually go the mother’s place. For that also they said there is some “ketta nachathram” (bad star) towards my mother’s city side and I should not go there. They did not allow me to go to my mother’s house till the end which put a lot of stress on me…” (M3).

The first quote on page 10 line 39 – under challenging parenting experiences have been changed to a different quote that better represents the challenges. (See page 11, line 18)

“My son did not sit in the balvadi (government pre-school) for almost one year as he had problems speaking and understanding. I used to sit along with him even when I was pregnant with my second one. I had him on my lap for 2 hours continously. Then slowly after a year he got adjusted to his teachers. That was very difficult for me as I had to come home and do all the house work alone”. (FGDM1)

Reviewer 2:

Introduction

1) Line 68: Studies in India have shown that the compliance to neonatal follow-up is moderate (59.2%) resulting in low participation and reduced effectiveness.

Comment: perhaps readers of this journal would be more interested in a range rather than a single
figure of 59.2%. There is clearly an opportunity to look for any other follow-up figures published since 2006.

We have included 2 new studies in the reference. By comparing these 3 studies done in India, the range of follow up rate is approximately 50-60%. This is mentioned in the first paragraph of the introduction. (Page 4, lines 14 to 16)

“Studies in India have shown that the compliance to neonatal follow-up is moderate (50-60 %) resulting in low participation and reduced effectiveness.”

2) Line 74: At adolescence, the reported rates of disability following moderate encephalopathy are higher, with 30% having CP, and 70% of those without CP having a cognitive disability that interferes with their daily life.

Comment: The authors quote a much higher rate of CP than widely accepted as the norm. Perhaps they can kindly clarify whether the rates refer to any particular high-risk population of interest and whether these rates were observed in the pre- or post-therapeutic hypothermia era.

We have included a different study done in India that gives the percentage of adverse outcomes after HIE. We hope that this reference would be more relevant as it is done in the same population. (See page 4, lines 25 to 35)


“Following HIE, at 2 years of age, 36% of children have adverse outcomes like Cerebral Palsy, hearing loss and Intellectual disability. Symptoms of hyperactivity and Autism Spectrum Disorder have also been reported by 5 years of age. The adverse neurodevelopmental outcomes are seen even at adolescence that interferes with their daily life, thus needing long-term follow up.”

Discussion

1) Parents of children with HIE are torn between two worlds- an atmosphere of support and one of criticism. They face reassuring and distressful experiences during the NICU stay, post-discharge and early parenting years.

Comment: the authors discuss parents facing reassuring and distressful experiences during the NICU stay. However, it is not clear how many of the interviewed parents are currently staying in NICU and what was the duration of stay or how long after the stay were the parents interviewed.

We have mentioned the duration of stay and the number of years after which the parents were interviewed in the participants section. (See page 6, lines 45 to 49)
“The inclusion criteria was infants with HIE who were admitted in NICU for a minimum of 5 days. We decided to include children presently aged 4 to 7 years, whose parents would have a few years of parenting experience”.

2) The first finding of this study is that during NICU stay, mothers faced disproportionate attribution of blame by family, society, and even spouses.
Comment: not clear when the interviews were done.

We have mentioned the duration of stay and the number of years after which the parents were interviewed in the participants section. (See page 6, lines 45 to 49)

“The inclusion criteria was infants with HIE who were admitted in NICU for a minimum of 5 days. We decided to include children presently aged 4 to 7 years, whose parents would have a few years of parenting experience”.

3) 364 NICU due to the constant fear of their child becoming ill again. Parents in this study reported that information on what to expect and regular follow-up visits in the first year helped them with this transition. This is similar to the findings of other studies.
Comment: It is not described what information was given to parents at the time of discharge if any.

Thank you for mentioning this. We have included the information given to the parents during discharge under the section settings. (Page no 6, line 12 to 20)

“After discharge from the NICU, the parents are instructed and given a booklet about breastfeeding, developmental milestones, early stimulation, physical growth charts, and the schedule for the follow up visits”.

5) In this study, parents perceived socio-cultural factors to help or hinder follow-up irrespective of the extent of the child's disability. Beliefs and rituals acted as opportunities and barriers to neonatal follow-up.
Comment: not clear regarding the supporting evidence for this statement.

Yes noted. We have edited the second part of the sentence to relate more to the supporting evidence. (Page 20, lines 46 to 48)

“Beliefs and rituals around child-birth act as opportunities and barriers to the health care providers”.

6) 384 The cultural barriers that include mothers not being allowed to make independent decisions in extended families add challenge to existing difficulties of caring for an infant with HIE.
Comment: Not clear from the manuscript how many of the interviewed parents come from ‘extended’ families.
Thank you. We have added this information in Table 2. There were 7 extended families and 3 nuclear families. (Page 9, lines 15 to 20)

Overall comments:
1) This study was approved by the Institutional Review and Ethics Board of Christian Medical College, 124 Vellore (IRB no:12382).

This study was conducted in Tamil: the interviews and FGD were audio-recorded, translated, and transcribed verbatim for content analysis.
Comment: It is safe to assume that the interviews were translated from Tamil to English: how the translation from Tamil to English was handled has not been described.

Thank you for pointing this out. We have added this information under data collection. (Page 8, lines 14 to 18)

“The interviews and FGD were audio-recorded, translated from English to Tamil by a translator fluent in both the languages. All the authors involved in the analysis were fluent in Tamil”.

2) This study makes an original contribution to the scant literature on socio-cultural influence on parenting and follow-up experience of parents of children with HIE. The effect of socio-cultural factors on parenting and neonatal follow-up in a traditional country such as India is new to the field. Parents expressed that socio-cultural factors predominantly influenced the compliance to follow-up and therapy than institutional and financial factors.

This is something that clinicians, policy makers, patients or the public need to know but the authors need to describe the social and policy implications of their research.

Thank you for the suggestion. We have included the implications at the end of the discussion. We also added a new reference about how support groups are important for maternal mental health. (Page 22, lines 30 to 48)


“Population-based strategies include improving awareness of the risk of disability when follow up is compromised, reducing stigma related to disability and expanding the support system for parents of children with disabilities. This could be done through creating easier access to the Government provided disability benefits, developing support groups for parents in their respective villages and regular home visits from the HCPs to assess community barriers. Support groups are a crucial part of NICU in other countries52. Social cultural influences need to be evaluated and considered as an additional risk factor while making policies regarding educational interventions post discharge and follow up care for HRIs. Also, including the extended family members in the sessions wherever possible will improve the support for parents”.

3) Research question: Although the introduction provided a clear research question (to understand the barriers and facilitators for neonatal follow-up as perceived by parents of infants with HIE.), how this is answered from the questions asked during the interview was not clear. The authors used 4
semi-structured questions: it is not clear how the questions were developed and delivered in Tamil language.

The questions were framed to understand the barriers and facilitators starting from the NICU admissions. (Page 7, lines 42 to 52)

“The interview and FGD guide were reviewed by all members of the study team and consisted of 4 semi-structured questions. The interview questions were broad, so as to accommodate inductive, data-driven thematic analysis. These questions were translated from English to Tamil to be used in the interviews and FGD (Table 1). To deepen the narrations, follow-up questions were asked, “Can you tell me more? Can you give any further explanation? Can you give me an example?”

4) Originality of the research: Literature review was done but omitted some publications on parental perceptions in HIE.

The first reference is added at the beginning of the discussion where we explain about the challenges faced by the parents in the NICU stay. (Page 19, lines 14 to 16)

“Experiences of self-blame, anxiety and depression by parents while in NICU have been described in developed countries.”29–32

The second reference is added when we explain individual-based strategies in the discussion. (Page 22, lines 25 to 30)

“Psychosocial support for parents should be provided from the NICU stay and continued as children grow as parenting challenges and expectations from therapy change over time.”50

Has this never been done before?
Such studies have been done before in other populations which the authors have not adequately referenced. The impact of therapeutic hypothermia itself has not been explored in the parental perceptions.

We have added these references as mentioned in the above comment.

Methods:

1) Data has been collected through interviews in the Tamil language. Subsequently, it is implied that the data has been translated into English. – however, the translation process has not been described and how the translation was agreed was not described.
This information is added in the data collection section. (Page 8, lines 14 to 19; Page 7, lines 42 to 51 respectively)

“The interviews and FGD were audio-recorded, translated from English to Tamil by a translator fluent in both the languages. All the authors involved in the analysis were fluent in Tamil, and used both the transcripts as well as audio recordings during analysis”.

“The interview and FGD guide were reviewed by all members of the study team and consisted of 4 semi-structured questions. The interview questions were broad, so as to accommodate inductive, data-driven thematic analysis. These questions were translated form English to Tamil to be used in the interviews and FGD (Table 1). To deepen the narrations, follow-up questions were asked, “Can you tell me more? Can you give any further explanation? Can you give me an example?”

2) The sampling of participants has not been described.

Thank you for mentioning this. We followed purposive sampling and we have added this information in the methods section. The participants were recruited until data saturation occurred. This is mentioned in the data collection section. (Page 6, line 51; page 8, lines 12 -14 respectively)

“Using purposive sampling, the research team accessed hospital medical records to identify parents eligible for the study and contacted them by telephone for participation”.

“Sample size was finalized when saturation occurred with no new data emerging from participants’ accounts.”

3) The researchers could have had a much bigger or better-recruited study as this is an important topic with a large social burden.

We agree with this comment. Initially, we had planned to recruit a larger sample. This study happened during the COVID pandemic when there was complete lockdown with no transport facilities for participants to travel to the hospital. Also, the investigators agreed that data saturation seemed to have been achieved and we decided to stop recruitment. We are currently planning how to use the insights from this study to improve the follow-up program for infants with HIE.

Analyses:

Quantitative analysis was presented. The comments were organised in themes. However, it is not clear how the themes were agreed upon by the individual reviewers and how conflicts were handled.

We have now explained about the analysis better and added some references. We hope this is clearer. (Page 8, lines 33 to 52)

“HJ, RS and SA familiarized themselves with the transcripts and listened to audio-recordings multiple times. They noted down early observations and met weekly to discuss these. Each investigator prepared first, second and third level codes using the Quirkos software, where they had access to
each other’s data. Codes were then examined for patterns across the dataset, and overlapping codes were collapsed. Codes thus agreed upon were promoted to provisional themes. Each investigator proceeded to form their thematic maps. Distinct themes were reviewed for alignment to research question. These themes were integrated into a final thematic map. Rigor was thus addressed by repeated coding of transcripts by different team members, by constant comparison between current literature and new data and discussion of final themes with all authors”.

Conclusions:

This is a qualitative study of parents experiences. Most of the conclusions had supporting data. But the authors go beyond the presented evidence in their conclusions.

The conclusion is modified to better relate to our findings. (Page 23, lines 20 to 36)

“This study makes an original contribution to the scant literature on socio-cultural influence on parenting and follow-up experience of parents of children with HIE. The study throws light on the various challenges faced by parents in dealing with children with disabilities in India. Parents struggle between the conflicting advices given from HCPs versus their communities. Mothers in our study considered fathers’ support crucial as it was easier for parents to cope with stigma and superstitions together. Including fathers and extended family members in every aspect of follow-up would result in family-centered approach to children with disabilities. Parents of children born with HIE need long-term ongoing psychosocial support from the HCPs. This study helps the HCPs to understand better the contextual factors that modify the adherence to therapy goals or follow up. This might result in better neonatal follow-up compliance in the long-term”.

VERSION 2 – REVIEW

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<th>Susan Ireland</th>
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| REVIEW RETURNED   | 19-Sep-2022 |

| GENERAL COMMENTS  | Note that the manuscript appears in duplicate, and I assume that the manuscript from pages 31-54 is the most recent version. This is unusual as the earlier version is usually deleted. I assume this will be corrected at editing. |
|-------------------| I have only a few suggested corrections. |
| Pg 37 line 18     | the numbers of participants do not add up - there should be 5 fathers but you only assign 4 to different groups - this needs to be corrected |
| Pg 39 line 34     | In the demographics table, ‘Paternal working status’ is a separate section to maternal education where it seems to appear |
| Pg 42 line 10     | The facilitators are clearly separated later in both the results section and the thematic map. They need to be separated out into the same 3 subthemes shown in the map - ie the strong family support. |
I commend this interesting manuscript which should be of interest for its similarities and differences to high income contexts.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 1
Dr. Susan Ireland, James Cook University College of Medicine and Dentistry, Townsville Hospital and Health Service

Comments to the Author:

Note that the manuscript appears in duplicate, and I assume that the manuscript from pages 31-54 is the most recent version. This is unusual as the earlier version is usually deleted. I assume this will be corrected at editing.

I have only a few suggested corrections.

1) Pg 37 line 18 - the numbers of participants do not add up - there should be 5 fathers but you only assign 4 to different groups - this needs to be corrected

Thank you for pointing this out. We have done the correction.

"We conducted one FGD (3 mothers and 1 father), 5 face-to-face interviews (2 mothers and 2 fathers), and 4 telephonic interviews (3 mothers and 2 fathers)".

See page 39, line 16.

2) Pg 39 line 34
In the demographics table, 'Paternal working status' is a separate section to maternal education where it seems to appear

Thank you. It has been modified in the Table. See page 41, line 43

3) Pg 42 line 10
The facilitators are clearly separated later in both the results section and the thematic map. They need to be separated out into the same 3 subthemes shown in the map - ie the strong family support, positive health care feedback and supportive workplace

We have altered the subthemes related to facilitators like in the map as follows:

"Emotional reappraisal of the situation (See page 47, line 46) and Support from family and HCPs" (See page 48, line 16) – these 2 subthemes for facilitators for the second theme. See page

“Supportive family and work environment” – this subtheme for the third theme. See page 50, line 25
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<td>Manuscript reads well, corrections clarify data collection and thematic analysis of results</td>
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