PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Sociodemographic differences in women's experience of early labour care: a mixed methods study
AUTHORS	Henderson, Jane; Redshaw, Maggie

VERSION 1 - REVIEW

REVIEWER	Vanora Hundley Bournemouth University, UK
REVIEW RETURNED	26-Feb-2017

GENERAL COMMENTS	This is an important and well-written paper that describes the challenging issue of early labour care. The study involves a large sample of women from across England, randomly selected by the ONS. Although the response rate is low, the findings echo previous studies looking at women's experiences of early labour care and further strengthen the evidence in this area. The findings with regard to BME women are novel and add to the debate on how best to support and prepare women for early labour. The paper can be accepted as is, but I think it would strengthen it to add a couple more sentences in the methods (page 6) for international readers who may not be familiar with the national survey.

REVIEWER	Yvonne Hauck Curtin University, Perth, Western Australia, Australia
REVIEW RETURNED	28-Feb-2017

GENERAL COMMENTS	BMJ Open - women's experience of early labour care: a mixed methods study Thank you for the opportunity to review this manuscript that addresses a very important issue for all maternity health care professionals. The mixed methods approach provides greater insight into women's experience of early labour care through a large survey component and the qualitative component. I feel the presentation of the qualitative findings and the implications for the results could be strengthened and hope my comments are useful. Abstract - The response rate (47%) is noted in the article summary. It would be useful for the reader it is was included in the abstract. A research design is not articulated in the abstract or the methods, although it is mentioned in the title. I would recommend stating this

research design in the abstract and methods.

Page 6 line 5 (aim) - How is early labour defined in this study? Is ‘early’ labour relating to the time labouring women were still at home (and not the regularity of their contractions or cervical dilation)? They could have been in active labour whilst still at home (particularly multiparous women). How would women be able to gage that they were in ‘early labour’ [latent phase] rather than the active phase when they are at home?

Page 6 line 13 - Methods – the survey was sent to a random number of women which excluded those women who had a planned caesarean birth. How many surveys were sent out and when (i.e. within XX months following a recent birth)?

Page 6 line 6 – given this was a mixed methods study what was the aim/purpose of the qualitative component? The aim and hypothesis for the quantitative component (survey design) was clearly presented.

Page 7 line 23 - Qualitative analysis – who conducted the qualitative analysis? A team approach or one person? Credibility is greater if a team approach was used whereby an independent analysis occurred with different researchers who then came together to share their tentative findings and final themes were negotiated and refined. Any discrepancies in interpretation can be addressed by referring back to the raw data.

Page 8 line 10 – “Worry about knowing when labour would start was significantly greater in those aged 40 years and older…..” however the results in Table 1 suggest that those women 20 to 24 years of age (54.5% - highest percentage) were very/quite worried compared to women 40 years + (41.2% - the lowest percentage).

Page 9 line 5 – contacted a midwife or hospital …”was more likely in younger women”, however in Table 2 the percentages are very similar from <20 up to 39 years (78.2%, 77.7%, 79.5%, 77.2% and 76.4%) with a noticeable drop for those 40+ (62.9%). So what age does “younger women” refer to? What ages are being referred to within the statement ‘younger women’?

Page 10 line 46 – clarification within the general statement “maternal age, parity and ethnicity for worries about knowing when labour would start …..” would be useful as according to Table 4 only those mothers (20 to 24 years), multiparous women and women from black or minority ethnic

groups had significant results. For all other age groups (younger than 20 or older than 24) did not have significant results.

Page 11 line 41 - How many primiparous women were not able to attend antenatal classes? For how many primiparous women was this because the classes were not offered (classes not available in their NHS hospital) or were they fully booked? Were there alternatives suggested around antenatal classes in the community or at another local hospital?

Page 11 line 47 – ‘denied’ antenatal classes? Very emotive language and does this reflect the context? Do women have to be ‘offered’ the classes or is this around providing information that

classes are available so that women are able to register? If classes are fully booked are there waiting lists or alternatives available?

Qualitative component – was data saturation achieved for the main themes?

Page 13 line 36 - Themes – ‘assumptions about identifying women in active labour’ – please clarify the definition for active labour (regularity of their contractions or cervical dilation). I thought the focus was on ‘early’ labour while the woman was still at home? Is this a concern that women expressed so that they would be taken seriously and could then be advised to come into hospital?

Page 15 line 34 - You must be careful with suggesting a theme like ‘staff attitudes’ because they may not actually reflect staff attitudes but appear to be women’s perceptions of staff behaviours rather than attitudes.

Pages 16 to 20 - Rather than providing a series of long quotes, qualitative findings usually present the findings in text and then weave relevant quotes in text that support the findings. The examples from Table 7 should be mentioned in text with quotes inserted within the paragraph to support the interpretation of these examples. The term ‘examples’ is confusing – do you mean subthemes under the main theme or are these statements actually the explanation/description of the theme? Usually short quotes (<40 words) are included in text and longer quotes (>40 words) are set aside in separate paragraphs. To reduce the list of long quotes the authors could retain a select number of short quotes in text and then include a column in Table 7 to include extra quotes. The table could then have 3 columns (theme name, description/explanation, and supportive quote).

Page 15 line 55 – “another common theme was women feeling vindicated……” however this is under the theme of ‘staff attitudes’? Is this a subtheme or is this still capturing the description/explanation of what this theme refers to?

Page 17 line 8 – ‘not being checked’ is noted as a subtheme but in Table 7 it is grouped with an example of ‘be examined/checked – having to beg for a VE’.

Page 17 line 32 – “some midwives were reportedly unwilling to take account of parity in assessing….” You must be careful with this assertion as the findings state women’s perceptions of staff behaviours and not what midwives may have been actually thinking/considering in their assessment.

Page 16 line 23 – the theme ‘consequences for women’. Although women wrote comments around not being able to come into hospital and stay when they wanted, you cannot suggest that this

resulted in consequence’s such as requiring a C-section, fetal distress or a precipitous birth. Although women may not have been satisfied, the authors must clarify that it was the women’s perceptions that these consequences occurred due to not being admitted when they wanted. There is no ‘cause and effect’ for the outcomes the women were describing. Their comments appear to reflect their frustration and/or dissatisfaction.

	Discussion – any suggestions as to why women 20 to 24 years were more worried about not knowing when labour would start compared to those women <20 years or >24 years? Implications for women not being able to access antenatal classes due to being fully booked – NHS need to consider whether their services are meeting the needs of women and/or whether the services should be expanded. Page 21 line 14 – refers to theme of ‘staff assumptions and attitudes’ but this isn’t a theme in Table 7. See my earlier comment about considering women’s perceptions of staff behaviours as women don’t know what midwives were thinking. They were interpreting their behaviours. Page 21 line 47 – “women reported negative consequences resulting in inaccurate diagnosis of labour”. The findings do not support this and you must remember that this is women’s perceptions and not confirmed misdiagnosis. It appears to be more around women’s dissatisfaction with aspects of their labour and birth and retrospectively attributing this to their early labour care and/or not being admitted to hospital when they possibly felt they should have been. Attributing delayed attachment to care in early labour is a subjective personal interpretation and oversimplifies a complex issue. Implications – the reality of women being admitted when they want to in contrast to following an assessment to guide care should be discussed. Issues around maternal anxiety may be considered especially for women in false labour or very early labour who want to stay but their clinical assessment suggests this isn’t warranted. Is it appropriate for the NHS to suggest that women come into the hospital and then decide for themselves whether they stay or go home? Can a NHS hospital realistically admit all women in very early labour who want to stay when considering staffing and workload? The access to antenatal education is concerning if demand is greater than services offered. A final consideration is around exploring the process to ensure women are informed about antenatal classes at their NHS hospital early enough to make a booking. Is information about antenatal classes being shared during their regular antenatal clinical visits with midwives and/or medical staff?

REVIEWER	Mechthild M. Gross Hannover Medical School, Germany
REVIEW RETURNED	14-Mar-2017

GENERAL COMMENTS	Thank you for giving me the opportunity to review this paper. General comments: This is a well written paper in an area which received more and

	more attention during the last years. Increased knowledge is available on early labour issues in general and also women's experiences of early labour (Eri, Bondas, Gross et al. 2015). Due to the existing body of knowledge in this field, it is interesting that the authors focus on differences between sociodemographic groups. This is – in a general sense – pointing into an interesting academic direction as it will allow – if appropriately done - specific recommendations for subcohorts of women. Specific comments: Title: "Women's experience of early labour care" sounds very general. Due to the specific sociodemographic interest pointed out in the objectives, I would recommend to name this aspect already in the title. Abstract: Could the authors try to connect the effects of antenatal education on differences between sociodemographic groups? This would allow a more comprehensive picture of the scene. At the moment, it appears that two different topics are presented in one paper. Outcome measures: Free text comments are not an outcome. This term belongs to the methods section. Methods: Are authors not required to provide anything regarding methods? I would expect at least some information regarding the origin of the data set and also statistical methods for analysis. Results: A couple of words on descriptive results are desired (e.g. on sociodemographic data). Due to the missing methods, it remains unclear whether and how generalizable these results are. Article summary: It is appreciated to report the limitation regarding the response rate of 47% in the article summary. Usually, sociodemographic factors show more missings compared to more central topics of interest. Are there any data on missings available? Introduction: Women should stay at home as long as possible. This is recommended as evidence based, but the clinical trials which allow these kind of conclusion are often mixed up with observational data.

	To meet the requirements of a high impact journal, it is advisable to see the reported literature separating these two aspects. I completely agree with the authors that no studies specifically examined early labour experiences from different sociodemographic groups. Three of the four references referring to poorer experience of maternity care belong to the authors of the current study. It would be nice to put the own publication references into a wider picture. Methods: Please could you provide a DOI number to your reference 25? Thanks. It is really great that an 18 non-English languages survey was created. How did you do that? Any survey validation? Maybe you could refer to a section addressing this issue in your report. How was the validated worries checklist (ref. 26) operationalized in the 18 non-English surveys? Any validations procedures (e.g. forward-backward translations)? Is there any information available on how many of those women were induced? Analysis needs to adjust for induction. In many studies on early labour women with induction are excluded. Page 7, line 2ff. This short paragraph informs on woman's age group, country of birth, marital status, parity, and IMD. From reading the methods section, it is not clear to me which items are considered as the sociodemographic ones. Please include a section in your methods about how you operationalize sociodemographic factors. Page 7, line 10. A paragraph on data analysis should contain all the relevant information. Information on women with planned C-section can be moved up and does not belong to data analysis. Please extend your information on what kind of descriptive analysis is going to be provided in the results. Table 1 provides significant results, but the reader does not receive any information which tests were applied. Results: Please start with describing your sample. I understand that this information is already provided somewhere else, but it is really missing at the start of the results section. The authors compare respondents with non-respondents. I wonder regarding the varying ns. In Table 1, the authors provide numbers with subsamples with n=2075, n=2011, n=2075, n=2022 or n=2288, n=2240, n=2289, n=2231 or n=1562, n=1509, n=1562, n=1525 and

	n=2798, n=2735, n=2799, n=2730. So it is quite obvious that some items didn't receive an answer. The reader needs to get more information regarding the missings of sociodemographic results and missings regarding worries about early labour. Page 10, line 39: The reasoning why the authors did a binary logistic regression does not belong into the result section. Please add to methods under the data analysis section. Please describe your adjustment for several factors in the data analysis section. Page 11, Table 4: What do you mean with combined effects? This needs further exploration in the methods section. Any adjustments? Page 11, Antenatal education As already stated earlier, this section appears like a second research aim. Page 12, Qualitative results Page 13, Table 6: The authors refer to "all women who completed the questionnaire". For me, it would have been easier to understand if a TOTAL would have been under all the factors. It remains unclear what they mean with "all" (age n= 4576, education n=4484). Women with free text comments count up regarding age (n=59), parity (n=57), ethnicity (n=58), IMD (n=59), education (n=59). The abstract refers to 4571 women. Did you count those women who provided free text comments into the sample of "all women who completed the questionnaire"? Page 13 refers to the various categories. In the way how the categories are presented, they appear to be of some kind of explorative nature. It would have been interesting to quantify the categories and include them into further analysis. But this would require to present them first and not as an appendix of the study. The categories appear to have some kind of plausibility and probably relate to existing categories from other studies. Discussion:

	The authors state that variation of women's experience of early labour is depending on sociodemographic characteristics. The methods refer to associations, but not to depending factors which point more in the direction of causalities. And this is certainly not what the authors want to say. Figure 1 Refers to 3867 women, but the abstract refers to 4571 complete questionnaires. Further down in Figure 1, 3760 are considered as 100%. So even if the authors declare that 107 women are missing, it does not really make sense that they consider the 3760 as 100%. In conclusion: This study is interesting, but lacks of appropriate synthesis of the various sections of the paper. The authors have published several papers in this area. Why did the authors not consider a multivariate logistic regression? It would also be nice to build up numerical categories from the qualitative answers which in itself would be a major research process. But as I can see from the available data, the numbers are obviously too few.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	
This is an important and well-written paper that describes the challenging issue of early labour care. The study involves a large sample of women from across England, randomly selected by the ONS. Although the response rate is low, the findings echo previous studies looking at women's experiences of early labour care and further strengthen the evidence in this area. The findings with regard to BME women are novel and add to the debate on how best to support and prepare women for early labour. The paper can be accepted as is, but I think it would strengthen it to add a couple more sentences in the methods (page 6) for international readers who may not be familiar with the national survey.	Thank you.

	Additional information describing the survey has been added (Methods, 1st para).
Reviewer 2	
This is a well written paper in an area which received more and more attention during the last years. Increased knowledge is available on early labour issues in general and also women's experiences of early labour (Eri, Bondas, Gross et al. 2015). Due to the existing body of knowledge in this field, it is interesting that the authors focus on differences between sociodemographic groups. This is – in a general sense – pointing into an interesting academic direction as it will allow – if appropriately done - specific recommendations for subcohorts of women.	Thank you.
Specific comments: Title: "Women's experience of early labour care" sounds very general. Due to the specific sociodemographic interest pointed out in the objectives, I would recommend to name this aspect already in the title.	The title has been amended as suggested.
Abstract: Could the authors try to connect the effects of antenatal education on differences between sociodemographic groups? This would allow a more comprehensive picture of the scene. At the moment, it appears that two different topics are presented in one paper. Outcome measures: Free text comments are not an outcome. This term belongs to the methods section. Methods: Are authors not required to provide anything regarding methods? I would expect at least some information regarding the origin of the data set and also statistical methods for analysis.	More data relating sociodemographic differences in offer and update of antenatal education have been included as supplementary data. There is not space in the abstract to include this. The second aim around antenatal education arose from the first. This has been moved. In the Instruction to Authors, no Methods section is specified. However, we agree that one is needed and have added this.

Results: A couple of words on descriptive results are desired (e.g. on sociodemographic data). Due to the missing methods, it remains unclear whether and how generalizable these results are.	Some descriptive results are already included. Generalisability is addressed in the Discussion (p22 lines 16-19).
Article summary: It is appreciated to report the limitation regarding the response rate of 47% in the article summary. Usually, sociodemographic factors show more missings compared to more central topics of interest. Are there any data on missings available?	Number of missing values for each variable has been added to the tables. The sociodemographic data from ONS were essentially complete.
Introduction: Women should stay at home as long as possible. This is recommended as evidence based, but the clinical trials which allow these kind of conclusion are often mixed up with observational data. To meet the requirements of a high impact journal, it is advisable to see the reported literature separating these two aspects. I completely agree with the authors that no studies specifically examined early labour experiences from different sociodemographic groups. Three of the four references referring to poorer experience of maternity care belong to the authors of the current study. It would be nice to put the own publication references into a wider picture.	These were all observational studies, this has been clarified (p4 line 8). Two new references have been added (refs 25 and 26) describing experiences of women in the Australian context.
Methods: Please could you provide a DOI number to your reference 25? Thanks. It is really great that an 18 non-English languages survey was created. How did you do that?	Ref 25 (now ref 27) does not have a doi number but we have added the URL to enable access to the report. Apologies, we were not clear here. It was only one sentence giving a Freephone number to an interpreter on 18 non-English languages. This has been clarified (p6 lines 9-10).

Any survey validation? Maybe you could refer to a section addressing this issue in your report. How was the validated worries checklist (ref. 26) operationalized in the 18 non-English surveys? Any validations procedures (e.g. forward-backward translations)? Is there any information available on how many of those women were induced? Analysis needs to adjust for induction. In many studies on early labour women with induction are excluded.	Sections of the survey were validated including the Oxford Worries about Labour Scale (now ref 28). The analyses have been re-run to exclude inductions.
Page 7, line 2ff. This short paragraph informs on woman's age group, country of birth, marital status, parity, and IMD. From reading the methods section, it is not clear to me which items are considered as the sociodemographic ones. Please include a section in your methods about how you operationalize sociodemographic factors.	This has been added (p7 lines 6-8).
Page 7, line 10. A paragraph on data analysis should contain all the relevant information. Information on women with planned C-section can be moved up and does not belong to data analysis. Please extend your information on what kind of descriptive analysis is going to be provided in the results. Table 1 provides significant results, but the reader does not receive any information which tests were applied.	The information about exclusion of women with induction and planned caesareans has been moved up (p7 lines 8-9). More details regarding the analysis have been provided (p7 lines 8-13).
Results: Please start with describing your sample. I understand that this information is already provided somewhere else, but it is really missing at the start of the results section. The authors compare respondents with non-respondents. I wonder regarding the varying ns. In Table 1, the authors provide numbers with subsamples with n=2075, n=2011, n=2075, n=2022 or n=2288, n=2240, n=2289, n=2231 or	Details of the sample are now provided (Results 1st para)

n=1562, n=1509, n=1562, n=1525 and n=2798, n=2735, n=2799, n=2730. So it is quite obvious that some items didn't receive an answer. The reader needs to get more information regarding the missings of sociodemographic results and missings regarding worries about early labour.	Numbers of missing values are now given in Table 1.
Page 10, line 39: The reasoning why the authors did a binary logistic regression does not belong into the result section. Please add to methods under the data analysis section. Please describe your adjustment for several factors in the data analysis section.	This reasoning is now given in the Methods (p7 lines 13-15). Details of adjustment are also now in the Methods section (p7 lines 15-16).
Page 11, Table 4: What do you mean with combined effects? This needs further exploration in the methods section. Any adjustments?	The title of Table 4 has been clarified and 'combined' deleted. Each variable is adjusted for all the others, now clarified in the title.
Page 11, Antenatal education As already stated earlier, this section appears like a second research aim.	It is a second research aim as clarified at the end of the Introduction (p6 lines 3-4).
Page 12, Qualitative results Page 13, Table 6: The authors refer to "all women who completed the questionnaire". For me, it would have been easier to understand if a TOTAL would have been under all the factors. It remains unclear what they mean with "all" (age n= 4576, education n=4484). Women with free text comments count up regarding age (n=59), parity (n=57), ethnicity (n=58), IMD (n=59), education (n=59). The abstract refers to 4571 women. Did you count those women who provided free text comments into the sample of "all women who completed the questionnaire"?	Total rows have been added to this table. 'All women' is indeed all women who completed the questionnaire as indicated in the column header. Apologies, the abstract was incorrect: 4578 women completed questionnaires. This has been corrected. It does include those women who wrote free-text comments.
Page 13 refers to the various categories. In the way how the categories are presented,	Qualitative research does not normally use

they appear to be of some kind of explorative nature. It would have been interesting to quantify the categories and include them into further analysis. But this would require to present them first and not as an appendix of the study. The categories appear to have some kind of plausibility and probably relate to existing categories from other studies.	quantitative methods.
Discussion: The authors state that variation of women's experience of early labour is depending on sociodemographic characteristics. The methods refer to associations, but not to depending factors which point more in the direction of causalities. And this is certainly not what the authors want to say.	The wording has been amended accordingly (p20 line 19).
Figure 1 Refers to 3867 women, but the abstract refers to 4571 complete questionnaires. Further down in Figure 1, 3760 are considered as 100%. So even if the authors declare that 107 women are missing, it does not really make sense that they consider the 3760 as 100%.	The numbers in the Figure (and tables) have been changed as a result of excluding women with induction of labour. We hope it now makes more sense.
In conclusion: This study is interesting, but lacks of appropriate synthesis of the various sections of the paper. The authors have published several papers in this area. Why did the authors not consider a multivariate logistic regression? It would also be nice to build up numerical categories from the qualitative answers which in itself would be a major research process. But as I can see from the available data, the numbers are obviously too few.	The manuscript does include binary logistic regression. As indicated above, it is not usual to quantify qualitative data.
Reviewer 3	
Thank you for the opportunity to review this manuscript that addresses a very important	Thank you.

issue for all maternity health care professionals. The mixed methods approach provides greater insight into women's experience of early labour care through a large survey component and the qualitative component. I feel the presentation of the qualitative findings and the implications for the results could be strengthened and hope my comments are useful.	
Abstract - The response rate (47%) is noted in the article summary. It would be useful for the reader it is was included in the abstract.	This has been added.
A research design is not articulated in the abstract or the methods, although it is mentioned in the title. I would recommend stating this research design in the abstract and methods.	This has been added.
Page 6 line 5 (aim) - How is early labour defined in this study? Is 'early' labour relating to the time labouring women were still at home (and not the regularity of their contractions or cervical dilation)? They could have been in active labour whilst still at home (particularly multiparous women). How would women be able to gage that they were in 'early labour' [latent phase] rather than the active phase when they are at home?	As all the data came from self-completion postal questionnaires, we can only go by what women reported. This has been clarified in the Methods (p6 lines 23-25) and the limitations this imposes in the Discussion (p22-3 lines 24-2).
Page 6 line 13 - Methods – the survey was sent to a random number of women which excluded those women who had a planned caesarean birth. How many surveys were sent out and when (i.e. within XX months following a recent birth)?	Women were only excluded if aged <16 yrs or if their baby died. Planned caesareans were excluded from this study only. This has been clarified in the Methods and more information added about the survey (Methods 1st para).
Page 6 line 6 – given this was a mixed methods study what was the aim/purpose of the qualitative component? The aim and hypothesis for the quantitative component (survey design) was clearly presented.	The primary aim of both parts of the study was 'to explore the experiences of early labour care, both quantitatively and qualitatively, among women with different sociodemographic characteristics'. (p6 lines 1-4)
Page 7 line 23 - Qualitative analysis – who conducted the qualitative analysis? A team approach or one person? Credibility is greater if a team approach was used whereby an independent analysis occurred with different researchers who then came together to share their tentative findings and final themes were negotiated and refined. Any discrepancies in interpretation can be addressed by referring	This was carried out by both authors and this has been clarified (p7 lines 22-23).

back to the raw data.	
Page 8 line 10 – “Worry about knowing when labour would start was significantly greater in those aged 40 years and older…..” however the results in Table 1 suggest that those women 20 to 24 years of age (54.5% - highest percentage) were very/quite worried compared to women 40 years + (41.2% - the lowest percentage).	The numbers in the tables are slightly different now having excluded women who had an induction. The text now more accurately reflects the tables.
Page 9 line 5 – contacted a midwife or hospital …”was more likely in younger women”, however in Table 2 the percentages are very similar from <20 up to 39 years (78.2%, 77.7%, 79.5%, 77.2% and 76.4%) with a noticeable drop for those 40+ (62.9%). So what age does “younger women” refer to? What ages are being referred to within the statement ‘younger women’?	This has been clarified.
Page 10 line 46 – clarification within the general statement “maternal age, parity and ethnicity for worries about knowing when labour would start …..” would be useful as according to Table 4 only those mothers (20 to 24 years), multiparous women and women from black or minority ethnic groups had significant results. For all other age groups (younger than 20 or older than 24) did not have significant results.	This has been clarified.
Page 11 line 41 - How many primiparous women were not able to attend antenatal classes? For how many primiparous women was this because the classes were not offered (classes not available in their NHS hospital) or were they fully booked? Were there alternatives suggested around antenatal classes in the community or at another local hospital?	We have included some further data in a Supplementary file about antenatal education. This shows that only 3% of primiparous women could not attend antenatal classes due to them being booked up, and 11% were not offered them. We don’t know whether alternatives were suggested.
Page 11 line 47 – ‘denied’ antenatal classes? Very emotive language and does this reflect the context? Do women have to be ‘offered’ the classes or is this around providing information that classes are available so that women are able to register? If classes are fully booked are there waiting lists or alternatives available?	More information is provided about provision of AN classes in the UK (p12 lines 9-11). The expression ‘denied antenatal classes’ has been moderated to ‘did not have access to’ (p13 lines 2-3). Fully booked classes would normally have a waiting list but this is not something we collected data on.
Qualitative component – was data saturation	All qualitative data came from free-text comments in the questionnaires and all relevant

achieved for the main themes?	data were included. This has been clarified (top of p7 line 3). It is not possible to know if data saturation was achieved.
Page 13 line 36 - Themes – 'assumptions about identifying women in active labour' – please clarify the definition for active labour (regularity of their contractions or cervical dilation). I thought the focus was on 'early' labour while the woman was still at home? Is this a concern that women expressed so that they would be taken seriously and could then be advised to come into hospital?	As indicated above, we were reliant women's understanding of their labour. Although the focus of the study is early labour, for the women, one of the main issues was differentiating between early and active labour. This has been clarified (p6 lines 23-25).
Page 15 line 34 - You must be careful with suggesting a theme like 'staff attitudes' because they may not actually reflect staff attitudes but appear to be women's perceptions of staff behaviours rather than attitudes.	Agreed. We have added 'perceptions' at various points through the manuscript to stress this (p6 line 25, p21 line 17).
Pages 16 to 20 - Rather than providing a series of long quotes, qualitative findings usually present the findings in text and then weave relevant quotes in text that support the findings. The examples from Table 7 should be mentioned in text with quotes inserted within the paragraph to support the interpretation of these examples. The term 'examples' is confusing – do you mean subthemes under the main theme or are these statements actually the explanation/description of the theme? Usually short quotes (<40 words) are included in text and longer quotes (>40 words) are set aside in separate paragraphs. To reduce the list of long quotes the authors could retain a select number of short quotes in text and then include a column in Table 7 to include extra quotes. The table could then have 3 columns (theme name, description/explanation, and supportive quote).	'Examples' has been replaced with 'Sub-themes' and a third column 'Examples' added. The number of quotes has been reduced to make this section more concise.
Page 15 line 55 – "another common theme was women feeling vindicated……" however this is under the theme of 'staff attitudes'? Is this a subtheme or is this still capturing the description/explanation of what this theme refers to?	Vindication was viewed as a sub-theme. This has been clarified (Table 7).
Page 17 line 8 – 'not being checked' is noted as a subtheme but in Table 7 it is grouped with an example of 'be examined/checked – having to beg for a VE'.	This has been clarified (Table 7).
Page 17 line 32 – "some midwives were	This is preceded by the word 'reportedly' – i.e. it

reportedly unwilling to take account of parity in assessing….” You must be careful with this assertion as the findings state women's perceptions of staff behaviours and not what midwives may have been actually thinking/considering in their assessment.	is what the women perceived to be the case (p18 line 15).
Page 16 line 23 – the theme 'consequences for women'. Although women wrote comments around not being able to come into hospital and stay when they wanted, you cannot suggest that this resulted in consequence's such as requiring a C-section, fetal distress or a precipitous birth. Although women may not have been satisfied, the authors must clarify that it was the women's perceptions that these consequences occurred due to not being admitted when they wanted. There is no 'cause and effect' for the outcomes the women were describing. Their comments appear to reflect their frustration and/or dissatisfaction.	Agreed. This has been changed to 'Perceived consequences for women' (p 19 line 12).
Discussion – any suggestions as to why women 20 to 24 years were more worried about not knowing when labour would start compared to those women <20 years or >24 years?	There is some research evidence on this subject which has been alluded to (p21 line 1-3).
Implications for women not being able to access antenatal classes due to being fully booked – NHS need to consider whether their services are meeting the needs of women and/or whether the services should be expanded.	Thank you, this has been added (p23 line 19-20).
Page 21 line 14 – refers to theme of 'staff assumptions and attitudes' but this isn't a theme in Table 7. See my earlier comment about considering women's perceptions of staff behaviours as women don't know what midwives were thinking. They were interpreting their behaviours.	This has been amended (p 21 line 17).
Page 21 line 47 – “women reported negative consequences resulting in inaccurate diagnosis of labour”. The findings do not support this and you must remember that this is women's perceptions and not confirmed misdiagnosis. It appears to be more around women's dissatisfaction with aspects of their labour and birth and retrospectively attributing this to their early labour care and/or not being admitted to hospital when they possibly felt they should have been. Attributing delayed	That these findings relate to women's perceptions has been stressed.

attachment to care in early labour is a subjective personal interpretation and oversimplifies a complex issue.	
Implications – the reality of women being admitted when they want to in contrast to following an assessment to guide care should be discussed. Issues around maternal anxiety may be considered especially for women in false labour or very early labour who want to stay but their clinical assessment suggests this isn't warranted. Is it appropriate for the NHS to suggest that women come into the hospital and then decide for themselves whether they stay or go home? Can a NHS hospital realistically admit all women in very early labour who want to stay when considering staffing and workload?	This section has been amended (p23 lines 12-14).
The access to antenatal education is concerning if demand is greater than services offered. A final consideration is around exploring the process to ensure women are informed about antenatal classes at their NHS hospital early enough to make a booking. Is information about antenatal classes being shared during their regular antenatal clinical visits with midwives and/or medical staff?	As indicated above, a short extra section has been added describing AN education in the UK (p12 lines 9-11).

VERSION 2 – REVIEW

REVIEWER	Yvonne Hauck Curtin University Perth, Australia
REVIEW RETURNED	31-Mar-2017

GENERAL COMMENTS	The authors have satisfactorily addressed all review comments and are to be commended on the strength of the manuscript which is adding important knowledge to the field. I would recommend acceptance of the manuscript pending a final check of the following points: 1. statement in Results ….“suggested that women aged 20-24 years experienced greater worry about not knowing when labour would start” – in Table 1, 46.2% of women 20-24 years were very/quite worried about knowing when labour would start which was the lowest percentage and 53.8% were not very/at all worried which was the group with the highest percentage for this category. If this is changed then the Discussion must also reflect the results 2. Statement in Results … “women aged 20-24 were significantly less likely to feel that had received appropriate advice” – in Table 1, 23.8% of women 20-24 years did not feel they received appropriate advice which was even higher for women < 20 years (25.0%). Perhaps you could just reword the statement to include women < 24 years which would capture both groups.

	3. Please update the theme names in Table 7. 'The consequences for women' should be' perceived consequences for women' and 'assumptions about identifying active labour' should be 'differentiating between early and active labour'. 4. Please consider whether the sub-themes in Table 7 are actually subthemes or more an explanation/description of the theme? The heading can be changed from 'sub-theme' to 'description'? In text where 'sub-theme' is noted, the term can be changed to 'scenario', 'example'….. "the above quote also illustrates a sub-theme of 'not being checked" could be reworded as "the above quote also illustrates a scenario of 'not being checked'…..

VERSION 2 – AUTHOR RESPONSE

Our thanks to Yvonne Hauck for carrying out such a thorough review.
1. Statement in Results …."suggested that women aged 20-24 years experienced greater worry about not knowing when labour would start" – in Table 1, 46.2% of women 20-24 years were very/quite worried about knowing when labour would start which was the lowest percentage and 53.8% were not very/at all worried which was the group with the highest percentage for this category. If this is changed then the Discussion must also reflect the results

This statement refers to the results of the logistic regressions (not Table 1) as highlighted at the beginning of the paragraph. An additional clause has been added to clarify this (p11 line 8). In the Discussion this is already explicit (see highlighted sentence p20 lined 23-24).
2. Statement in Results … "women aged 20-24 were significantly less likely to feel that had received appropriate advice" – in Table 1, 23.8% of women 20-24 years did not feel they received appropriate advice which was even higher for women < 20 years (25.0%). Perhaps you could just reword the statement to include women < 24 years which would capture both groups.

As above, this statement refers to the results of the logistic regressions. This has been clarified (p12 line 1).
3. Please update the theme names in Table 7. 'The consequences for women' should be' perceived consequences for women' and 'assumptions about identifying active labour' should be 'differentiating between early and active labour'.
Many thanks, this has been corrected.
4. Please consider whether the sub-themes in Table 7 are actually subthemes or more an explanation/description of the theme? The heading can be changed from 'sub-theme' to 'description'? In text where 'sub-theme' is noted, the term can be changed to 'scenario', 'example'….. "the above quote also illustrates a sub-theme of 'not being checked" could be reworded as "the above quote also illustrates a scenario of 'not being checked'…..

We have considered this suggestion but feel that 'sub-themes' better represents what they are. As indicated by Braun and Clarke (2006) "Sub-themes are essentially themes-within-a-theme. They can be useful for giving structure to a particularly large and complex theme, and also for demonstrating the hierarchy of meaning within the data."
Reference: Virginia Braun & Victoria Clarke (2006) Using thematic analysis in psychology, Qualitative Research in Psychology, 3:2, 77-101

VERSION 3 – REVIEW

REVIEWER	Yvonne Hauck Curtin University, Perth, Australia
REVIEW RETURNED	07-Apr-2017

GENERAL COMMENTS	The authors have satisfactorily addressed all minor comments.