

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Assessing Australian women's knowledge and knowledge preferences about long-term health after hypertensive disorders of pregnancy: a survey study
AUTHORS	Roth, Heike; Homer, Caroline; LeMarquand, Grace; Roberts, Lynne M.; Hanley, Lisa; Brown, Mark; Henry, Amanda

VERSION 1 – REVIEW

REVIEWER	Haruna Idris Federal Medical Centre, Bida, Niger State, Nigeria.
REVIEW RETURNED	25-Aug-2020

GENERAL COMMENTS	<p>The manuscript is well written and adequately answers the research questions.</p> <p>The reviewer provided a marked copy with additional comments. Please contact the publisher for full details.</p>
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REVIEWER	Lucy Chappell and Danielle Ashworth King's College London
REVIEW RETURNED	27-Aug-2020

GENERAL COMMENTS	<p>This is a well-designed, and well written manuscript, in a novel (and often neglected) area, of clinical importance.</p> <p>* Originality Although other papers (Traylor, Hutchesson, Brown) have explored women's knowledge of long-term health risks after hypertensive disorders of pregnancy (HDP) this manuscript appears to have novelty in the context of the combination of method (survey), setting (Australia) and population (HDPs, with breakdown of type and women without HDP).</p> <p>* Importance of work The educational needs of long-term CVD health after HDP are important to women and their families and to clinicians. The authors might consider adding a newly published reference to the James Lind Alliance Priority Setting Partnership in Pregnancy Hypertension, which specifically raised the issue of information giving, an area predominantly selected by lay respondents as being in their top ten (and often not so high on the radar of researchers). It is good to see a group evaluating this information gap with the intention of addressing the deficit using their findings. Ho A, Webster L, Bowen L, Creighton F, Findlay S, Gale C, Green M, Gronlund T, Magee LA, McManus RJ, Mistry HD, Singleton G, Thornton J, Whybrow R, Chappell L. Research priorities for</p>
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	<p>pregnancy hypertension: a UK priority setting partnership with the James Lind Alliance. <i>BMJ Open</i>. 2020 Jul 14;10(7):e036347. doi: 10.1136/bmjopen-2019-036347.</p> <p>* Scientific reliability The research question is clearly defined, and the study design is appropriate, including the study population (although note caveats below).</p> <p>* Methods The methods are appropriate and well described. Minor areas of clarification could include:</p> <ul style="list-style-type: none"> - How the survey was face-validated - Making eligibility clearer (e.g. in data collection paragraph) - Providing a stronger rationale for choice of the two distractor conditions - Whether how low/ moderate/ high categories were assigned to fixed bands (e.g. see Table 2), if these were based on mean scores (which might have varied across the risk factors) - Whether an ideal sample size was established before the study started. <p>* Results The results are well presented. The authors could clarify:</p> <ul style="list-style-type: none"> - Whether all the comparisons by HDP type are necessary in Table 2 (and this entails multiple comparisons, so caution with inference)? - Provide examples of 'Key organisations' (in the main text) <p>* Interpretation and conclusions The interpretation and conclusions are broadly appropriate, with reference to existing studies and limitations of the study. The authors could expand further on future work and impact of this work and how it might inform interventions to address the knowledge gap.</p>
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REVIEWER	Dr. Peter Barrett School of Public Health, University College Cork, Ireland
REVIEW RETURNED	02-Oct-2020

GENERAL COMMENTS	<p>Thank you for the opportunity to review this interesting study. I suggest major</p> <p>Thank you for the opportunity to review this interesting study. Overall I think that this study adds value to this area of research. The use of PPI in survey design is a strength. The manuscript contains a number of useful and relevant findings. However, I have reservations about how the Results have been presented and I have suggested a number of major and minor amendments.</p> <p>Major amendments: Introduction: The risk of CVD is clearly set out for the uninitiated reader. However, there is no information given on the risk of CKD or ESKD in women here, nor on the risk of diabetes. These risks should be outlined for the range of HDP (including gestational HTN) from the outset given that the Results section emphasises women's lack of knowledge of these associations. There is an increasing body of recent research linking preeclampsia and gestational HTN with CKD, ESKD, and T2DM (and indeed diabetic nephropathy). Similarly, in Lines 441-444, the risk of maternal</p>
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	<p>CKD and T2DM is not mentioned – the focus is almost exclusive to CVD.</p> <p>Methods final paragraph, Lines 159-170. I suggest that this needs to be clearer or simplified. When reading this together with Table 2, some results are unclear to me. For example, do the 15 women with hx. of gestational hypertension only have moderate knowledge of their own risk of chronic HTN in the future? Or is it that all participants in the study only had moderate knowledge of the specific association between gestational HTN and chronic HTN?</p> <p>Many women who develop HDP may have CVD, CKD, diabetes or other relevant comorbidities at baseline (i.e. before becoming pregnancy). Were these women excluded? If not, were there any sensitivity analyses whereby those women were removed? I understand that they are described in Supplementary Table 1 but the impact of these pre-pregnancy comorbidities does not appear to be taken in to account in the Results, and this is a limitation.</p> <p>The survey herein is possibly most relevant to women who experience HDP without any previous comorbidities. These are the women who may be least likely to receive information about long-term cardio-renal risk by their healthcare provider and they are more likely to “slip through the net”. Arguably, their results are most important in this study. I do not think that the results of a self-selected sample of women, many of whom had pre-existing diabetes or CKD (and would thus be almost certainly engaged with a healthcare provider already), are generalizable to women who were otherwise healthy and may have had one isolated episode of preeclampsia. The latter are less likely to attend a GP regularly postpartum and may never receive information about their long-term health risks.</p> <p>Table 1 is excessively detailed and a bit to read. The absolute numbers for gestational HTN, PE and CH groups are superfluous in my opinion. I would prefer to see summary data for women with HDP vs. without HDP. If differences between groups are to be presented, I would prefer to see a summary p value for each variable here.</p> <p>I think Table 3 should be moved to the appendix, and suggest keeping the text of the key findings here. If possible, replace this with a Table showing any differences between women who had HDP + pre-pregnancy comorbidities vs. HDP without pre-pregnancy comorbidities, or an alternative analysis which gives consideration to this aspect. This is more relevant and may help external validity.</p> <p>Table 4 is also excessively detailed and a bit difficult to read, like Table 1. This needs to be simplified and I would prefer to see summary data here. The information is relevant and important, but it needs to be easier for the readers to digest. Otherwise the findings will be skipped over. Suggest dropping the columns where women are categorised by 3years vs. earlier. Although this is an interesting point, none of the findings are statistically significant so you can just state that in the text and omit some of the detail from the Table as it is currently difficult to interpret.</p> <p>Table 5 – suggest remove some/all of the absolute numbers, again it makes the table a bit busy and difficult to read. The information here is relevant and useful, but it needs to be easy for the reader to interpret. Please also make it clear that this only relates to the women who had HDP (not all survey respondents).</p> <p>Lines 315-321, interpretation of GH needs more acknowledgement of the small numbers involved in this study.</p>
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	<p>Lines 323-345 needs some elaboration on the different settings involved in these studies. This is done in relation to Hutchesson et al. but it's unclear from the text whether the other studies are based on the Australian context or from other comparable healthcare settings? This would help the flow in to the next paragraph (lines 347-354).</p> <p>There is some limited discussion of selection bias in the Discussion section, but I do not think this has been adequately addressed. I am not convinced that this sample is representative of the wider female population of Australia, let alone comparable countries internationally. This does not take away from the relevance of the results. But there needs to be further elaboration on the sources of selection bias herein, particularly given the manner in which women were recruited. At present, the authors focus on their linguistic similarities to the general population and the fact that they may have higher knowledge. I would suggest that the participants may also systematically differ in terms of their engagement with healthcare providers, their use of online resources, their level of concern about their previous HDP etc.</p> <p>Minor amendments:</p> <p>Line 77, please rephrase "is not associated with adverse pregnancy outcomes". Gestational HTN may itself be considered an adverse pregnancy outcome</p> <p>Line 176, why were the 2 individuals with CH who did not progress to superimposed PE excluded? Was this because of the small number of women in this subgroup? Need to be clearer about this.</p> <p>Table 2, minor point but I'm unsure whether the columns of p values for PE vs. GH and PE vs CH are helpful here, particularly when the numbers of women with GH or CH were small. Most important are the p values for differences between HDP vs. no HDP.</p> <p>Lines 220-224 wording could be improved here.</p> <p>Lines 229-232 wording could be improved here.</p> <p>Line 283 and throughout: "HDP and non-HDP women" wording needs to be improved. A woman who has experienced PE, GH or CH is not defined by that experience. Suggest alternative like "among both women who experienced HDP and those who did not".</p> <p>Line 307, suggest use a synonym for "concerningly" – sounds odd</p> <p>Line 311-313 – perhaps relevant to consider lack of consistency in existing guidelines here. This is likely why healthcare providers are not providing this advice in a standardised way.</p> <p>Finally, there needs to be some further discussion or consideration of the relevance of including women who did not have HDP. I am uncertain how this is truly a strength of the study. The bottom line is that we need women who experience HDP to be aware of their long-term risks of CVD, CKD and T2DM. This is especially important for women who experience HDP with no previous medical comorbidity as they are less likely to be engaged in frequent postpartum surveillance or follow-up with a healthcare provider. It's fine for women without HDP to be aware of these risks too, and that's a positive thing overall, but arguably that's less important?</p>
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VERSION 1 – AUTHOR RESPONSE

Reviewer 1

1	The manuscript is well written and adequately answers the research questions.	Thank you for taking time to review the manuscript and for your kind comment.
2	The title could be better put "Knowledge and knowledge preferences of Australian women on long-term effect of hypertensive disorders of pregnancy: a survey study"	Thank you for the suggested title change. We have considered this and would prefer to retain the original title commencing with a verb describing the processes of our study.
3	Abstract: give summary of the 'Background' of your study	<p>We have used abstract sub-titles as specified by BMJ Open, which do not indicate background information to be summarised in the abstract. The background is provided in the Introduction of the main document.</p> <p><i>Could the Editor please confirm whether the first section of the abstract should contain Objectives only, not background information?</i></p>
4	'do proper punctuation to L141'	We have altered the sentence to address this. Line 157-159
5	'...by recent pregnancy' (line 234)	'Recency' in the context of the original manuscript is used as a noun rather than an adjective. However, we have changed the wording to "time since pregnancy" to clarify. Line 258

Reviewer 2

1	This is a well-designed, and well written manuscript, in a novel (and often neglected) area, of clinical importance.	Thank you for your time taken to review the manuscript and for your kind comment. We hope to significantly and positively contribute towards the body of knowledge addressing this topic.
2	Originality: Although other papers (Traylor, Hutchesson, Brown) have explored women's knowledge of long-term health risks after hypertensive disorders of pregnancy (HDP) this manuscript appears to have novelty in the context of the combination of method (survey), setting (Australia) and population (HDPs, with breakdown of type and women without HDP).	Thank you.

3	<p>Importance of work: The educational needs of long-term CVD health after HDP are important to women and their families and to clinicians. The authors might consider adding a newly published reference to the James Lind Alliance Priority Setting Partnership in Pregnancy Hypertension, which specifically raised the issue of information giving, an area predominantly selected by lay respondents as being in their top ten (and often not so high on the radar of researchers). It is good to see a group evaluating this information gap with the intention of addressing the deficit using their findings.</p> <p>Ho A, Webster L, Bowen L, Creighton F, Findlay S, Gale C, Green M, Gronlund T, Magee LA, McManus RJ, Mistry HD, Singleton G, Thornton J, Whybrow R, Chappell L. Research priorities for pregnancy hypertension: a UK priority setting partnership with the James Lind Alliance. <i>BMJ Open</i>. 2020 Jul 14;10(7):e036347. doi: 10.1136/bmjopen-2019-036347.</p>	<p>Thank you for the suggested inclusion of this reference, which was published after the initial preparation of this manuscript. We agree that it is extremely relevant and have incorporated it into the updated discussion section. Line 402-413</p>
4	<p>Scientific reliability: The research question is clearly defined, and the study design is appropriate, including the study population (although note caveats below).</p>	<p>Thank you. We will address the items in their respective sections below.</p>
5	<p>Methods: The methods are appropriate and well described. Minor areas of clarification could include:</p> <ul style="list-style-type: none"> - How the survey was face-validated - Making eligibility clearer (e.g. in data collection paragraph) - Providing a stronger rationale for choice of the two distractor conditions - Whether how low/ moderate/ high categories were assigned to fixed bands (e.g. see Table 2), if these were based on mean scores (which might have varied across the risk factors) - Whether an ideal sample size was established before the study started. 	<p>Face-validation: This process is addressed under the <i>Patient and Public Involvement</i> section and has been extended to include further details.</p> <p>Line 123-129</p> <p>Eligibility: Clarification has been added Lines 134-138</p> <p>Distractors: We have provided further rationale for including distractors Lines 458-467</p> <p>Knowledge score classification: We have clarified the classification of the score categories in the revised manuscript Line 184-185</p>

		Sample size: An ideal sample size was not established prior to commencement of the study. We opted for a targeted convenience sample. We have added this information into the reviewed manuscript Lines 143-147
6	Results: The results are well presented. The authors could clarify: - Whether all the comparisons by HDP type are necessary in Table 2 (and this entails multiple comparisons, so caution with inference)?	Table 2: This table has been adjusted to include less detail. It has also been remodeled so it is easier to read Line 229
7	Results: - Provide examples of 'Key organisations' (in the main text)	A 'key organisation' example has now been provided in the results Line 295
8.	Interpretation and conclusions: The interpretation and conclusions are broadly appropriate, with reference to existing studies and limitations of the study. The authors could expand further on future work and impact of this work and how it might inform interventions to address the knowledge gap.	The survey was followed up with further inquiry and clarification (interviews with women who participated in the survey) about content format and distribution of preferred educational material. Concurrently, a similar process was conducted with healthcare providers. These findings will inform a future pilot study, evaluating education on health after HDP initiatives suggested by the participants. Line 513-519

Reviewer 3

Major amendments

1	Thank you for the opportunity to review this interesting study. Overall I think that this study adds value to this area of research. The use of PPI in survey design is a strength. The manuscript contains a number of useful and relevant findings. However, I have reservations about how the Results have been presented and I have suggested a number of major and minor amendments.	Thank you for taking the time to review our manuscript and provide suggested amendments. We have addressed your comments in the respective sections below.
2	Introduction: The risk of CVD is clearly set out for the uninitiated reader. However, there is no information given on the risk of CKD or ESKD in women here, nor on the risk of diabetes. These risks should be	We have now addressed CKD, ESKD and T2DM in the introduction and have supported these with relevant references. Lines 88-91.

	<p>outlined for the range of HDP (including gestational HTN) from the outset given that the Results section emphasises women's lack of knowledge of these associations. There is an increasing body of recent research linking preeclampsia and gestational HTN with CKD, ESKD, and T2DM (and indeed diabetic nephropathy). Similarly, in Lines 441-444, the risk of maternal CKD and T2DM is not mentioned – the focus is almost exclusive to CVD.</p>	<p>The discussion highlights that knowledge about T2DM was low amongst participants and that this gap needs to be addressed. Lines 313-316</p>
3	<p>Methods final paragraph, Lines 159-170. I suggest that this needs to be clearer or simplified. When reading this together with Table 2, some results are unclear to me. For example, do the 15 women with hx. of gestational hypertension only have moderate knowledge of their own risk of chronic HTN in the future? Or is it that all participants in the study only had moderate knowledge of the specific association between gestational HTN and chronic HTN?</p>	<p>Data in Table 2 are presented according to (a) the knowledge of each subgroup of HDP re their <i>own</i> risk of the various conditions (b) the knowledge of HDP women overall of their own risk, versus the knowledge of non-HDP women overall regarding the risk of a woman who has had HDP. So for example regarding chronic hypertension:</p> <p>The 15 women with GH had, as a group, moderate knowledge of their increased risk of CH</p> <p>The 143 women after PE and 16 women after CH had high knowledge of their increased CH risk.</p> <p>The 174 HDP women (all subtypes) collectively had high knowledge as a group of their increased CH risk, while the 92 non-HDP women had moderate knowledge that after HDP women have an increased risk of CH.</p> <p>Table 2 has been simplified which we hope makes it easier to read, and clarification has also been added to both the “data collection instrument” and the final paragraph sections of the Methods.</p> <p>Lines 157-161</p>
4	<p>Many women who develop HDP may have CVD, CKD, diabetes or other relevant comorbidities at baseline (i.e. before becoming pregnancy). Were these women excluded? If not, were there any sensitivity analyses whereby those women were removed? I understand that they are described in Supplementary Table 1 but the impact of these pre-pregnancy</p>	<p>Your point is valid, unfortunately our survey did not ask women to provide pre-pregnancy health details. The question collected details on whether participants had any of the listed conditions before, during or after pregnancy (Appendix 1, p6, q11).</p>

<p>comorbidities does not appear to be taken into account in the Results, and this is a limitation. The survey herein is possibly most relevant to women who experience HDP without any previous comorbidities. These are the women who may be least likely to receive information about long-term cardio-renal risk by their healthcare provider and they are more likely to “slip through the net”. Arguably, their results are most important in this study. I do not think that the results of a self-selected sample of women, many of whom had preexisting diabetes or CKD (and would thus be almost certainly engaged with a healthcare provider already), are generalizable to women who were otherwise healthy and may have had one isolated episode of preeclampsia. The latter are less likely to attend a GP regularly postpartum and may never receive information about their long-term health risks.</p>	<p>All HDP women who participated in this survey however will have had GH, PE and/or CH at least in one of their pregnancies by the time they were asked these questions. They were not all primiparous women.</p> <p>We agree that women with a known, pre-existing condition may already have been attending a GP regularly and have had higher knowledge regarding long-term health risk. We considered those women who had CH coming into pregnancy such an example. Despite potential pre-existing comorbidities or one or more pregnancy with HDP, knowledge gaps were still identified. Amongst a cohort of women who are educated, have access to healthcare, speak English, have access to the internet and have been involved with a specialist doctor at some stage of their HDP experience, there are still gaps evident in the CH group, so we would suggest it is wise to not assume that the CH group are already being appropriately informed, managed and followed-up. (This has also been our experience in our currently underway RCT of structured follow-up and lifestyle intervention after all forms of HDP).</p> <p>It should also be noted that although women with pre-morbid conditions may be more likely to have pre-existing engagement and follow-up with healthcare providers, there is strong evidence to suggest women (versus men) with cardiovascular risk factors generally receive lower levels of general practitioner assessment of their CV risks, and, for reproductive age women, they are less likely to receive appropriate management (1).</p> <p>We did explore whether women with a family history or women who experienced HDP with severe features (assumed with herself or her baby in high acuity care around birth) had higher knowledge compared to those who had HDP with non-severe features. These were findings illustrated in similar studies and we were interested in verifying whether this was similar with the participants in our study. No</p>
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		significant differences in knowledge were noted, hence these were not discussed in our findings.
5	Table 1 is excessively detailed and a bit to read. The absolute numbers for gestational HTN, PE and CH groups are superfluous in my opinion. I would prefer to see summary data for women with HDP vs. without HDP. If differences between groups are to be presented, I would prefer to see a summary p value for each variable here.	We have re-modelled Table 1 so that it is clearer. Given the quantitative nature of this study, we feel the demographics included in the table along with absolute numbers (and proportions) are important detail. It provides insight into the demographic of participants. We have maintained N(%) in the total columns only. Sub-types of HDP have been represented in % only.
6	I think Table 3 should be moved to the appendix, and suggest keeping the text of the key findings here. If possible, replace this with a Table showing any differences between women who had HDP + pre-pregnancy comorbidities vs. HDP without pre-pregnancy comorbidities, or an alternative analysis which gives consideration to this aspect. This is more relevant and may help external validity.	We agree and have moved Table 3 to the supplementary files and have re-named it Supplementary Table 13. We have kept the text relating to these findings Line 258 As explained above, we did not collect information on pre-pregnancy comorbidities and can therefore not make further comment on this.
7	Table 4 is also excessively detailed and a bit difficult to read, like Table 1. This needs to be simplified and I would prefer to see summary data here. The information is relevant and important, but it needs to be easier for the readers to digest. Otherwise the findings will be skipped over. Suggest dropping the columns where women are categorised by 3years vs. earlier. Although this is an interesting point, none of the findings are statistically significant so you can just state that in the text and omit some of the detail from the Table as it is currently difficult to interpret.	Table 3 (previous Table 4) has been re-modelled to read more easily. It now presents summary data only. Line 279 The full table with data by HDP sub-type has been added as Supplementary Table 15. We have kept summary findings here, despite none of the findings being significant. The aim was to highlight that in fact there is no statistically significant difference between the under and over 3-years since pregnancy groups including the 'no discussion' choice that women were able to select. This contributes to the gaps found regarding women's knowledge about long-term risk factors.
8	Table 5 – suggest remove some/all of the absolute numbers, again it makes the table a bit busy and difficult to read. The information here is relevant and useful, but it needs to be easy for the reader to interpret. Please also make it clear that this only relates to the women who had HDP (not all survey respondents).	Table 4 (previous Table 5) has been re-modelled to read more easily. We have left the 'Total' column as N(%), and have left only the % values for the 'GH', 'PE', 'CH' columns. Line 298

		<p>The title of the table is “<i>HDP women’s preferences for content and distribution of information/education on future risk after HDP (multiple answers collected) in order of preference</i>” to highlight that the data relates to HDP women’s answers only. We have however made it clearer in the text accompanying the table in order to re-enforce this detail.</p> <p>Line 290 & 293</p>
9	Lines 315-321, interpretation of GH needs more acknowledgement of the small numbers involved in this study.	Amendments have been made to reflect this. Line 356-358
10	Lines 323-345 needs some elaboration on the different settings involved in these studies. This is done in relation to Hutchesson et al. but it’s unclear from the text whether the other studies are based on the Australian context or from other comparable healthcare settings? This would help the flow in to the next paragraph (lines 347-354).	We have identified the countries in which the studies we refer to were conducted. Lines 366-374
11	<p>There is some limited discussion of selection bias in the Discussion section, but I do not think this has been adequately addressed. I am not convinced that this sample is representative of the wider female population of Australia, let alone comparable countries internationally. This does not take away from the relevance of the results. But there needs to be further elaboration on the sources of selection bias herein, particularly given the manner in which women were recruited. At present, the authors focus on their linguistic similarities to the general population and the fact that they may have higher knowledge. I would suggest that the participants may also systematically differ in terms</p> <p>of their engagement with healthcare providers, their use of online resources, their level of concern about their previous HDP etc.</p>	<p>As with all surveys, it is uncertain how representative it is of the population under study i.e. it is unknown whether knowledge of non-respondents is comparable to that of respondents.</p> <p>Limitations of this study are discussed, including the possible non-generalisability of the findings. Findings of the survey and post-survey interviews along with findings from the women’s knowledge and information preferences will inform a future education implementation study.</p> <p>We have addressed selection bias and non-generalisability in more detail. Lines 494-501</p>

Minor amendments

1	Line 77, please rephrase “is not associated with adverse pregnancy outcomes”.	Thank you for this important reminder, it has been amended in the text. Line 77-78
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	Gestational HTN may itself be considered an adverse pregnancy outcome	
2	Line 176, why were the 2 individuals with CH who did not progress to superimposed PE excluded? Was this because of the small number of women in this subgroup? Need to be clearer about this.	We have clarified this in the text. Yes, it was due to small numbers. Line 202
3	Table 2, minor point but I'm unsure whether the columns of p values for PE vs. GH and PE vs CH are helpful here, particularly when the numbers of women with GH or CH were small. Most important are the p values for differences between HDP vs. no HDP.	Table 2 has been re-modelled to be more readable and some columns have been removed as suggested. Line 229
4	Lines 220-224 wording could be improved here.	We have reworded this sentence Lines 243-247
5	Lines 229-232 wording could be improved here.	We have reworded this sentence Lines 253-256
6	Line 283 and throughout: "HDP and non-HDP women" wording needs to be improved. A woman who has experienced PE, GH or CH is not defined by that experience. Suggest alternative like "among both women who experienced HDP and those who did not".	We absolutely agree that the women are not defined by their HDP experience and we do not aim to portray them as such. We have explained the use of abbreviated group names at the beginning of the results section. The abbreviated use of these group names is meant to facilitate the reporting of results whilst also being word count aware. Lines 204-205
7	Line 307, suggest use a synonym for "concerningly" – sounds odd	We have adjusted this sentence. Line 340-342
8	Line 311-313 – perhaps relevant to consider lack of consistency in existing guidelines here. This is likely why healthcare providers are not providing this advice in a standardised way.	Referring to lines 346-349 in new manuscript: ISSHP (2), SOMANZ (3) as well as further international guidelines (4) provide general recommendations on follow-up beyond the immediate post-partum period. Guidelines may not offer an in-depth and evidence-based plan of ongoing care as this is an area that remains under investigation with further studies currently exploring optimal medium to long-term care after HDP(5). Other possibilities contributing to the lack of a post-HDP risk discussion may be the lack of awareness of the HDP guidelines or the part addressing long-term risk. A German study (6)

		<p>suggested that healthcare provider’s knowledge was higher and risk counselling behaviours regarding long-term risk after HDP reflected best practice when healthcare providers were aware of an HDP guideline.</p> <p>Furthermore, the issue may lie in the professional silo mentality and fragmented care and professional division potentially compromising communication channels. Ultimately, this may affect the information the women receive.</p>
9	<p>Finally, there needs to be some further discussion or consideration of the relevance of including women who did not have HDP. I am uncertain how this is truly a strength of the study. The bottom line is that we need women who experience HDP to be aware of their long-term risks of CVD, CKD and T2DM. This is especially important for women who experience HDP with no previous medical comorbidity as they are less likely to be engaged in frequent postpartum surveillance or follow-up with a healthcare provider. It’s fine for women without HDP to be aware of these risks too, and that’s a positive thing overall, but arguably that’s less important?</p>	<p>We have added clarification of the rationale of including non-HDP women.</p> <p>Line 328-335</p>

1. Hyun KK, Redfern J, Patel A, Peiris D, Brieger D, Sullivan D, et al. Gender inequalities in cardiovascular risk factor assessment and management in primary healthcare. *Heart*. 2017;103(7):492-8.
2. Brown M, Magee L, Kenny L, Karumanchi S, McCarthy F, Saito S, et al. Hypertensive disorders of pregnancy: ISSHP classification, diagnosis, and management recommendations for international practice. *Hypertension*. 2018;Jul 72(1):24-43.
3. Lowe SA, Bowyer L, Lust K, McMahon LP, Morton M, North RA, et al. SOMANZ guidelines for the management of hypertensive disorders of pregnancy 2014. *Australian and New Zealand Journal of Obstetrics and Gynaecology*. 2015;55(5):e1-e29.
4. Gamble DT, Brikinns B, Myint PK, Bhattacharya S. Hypertensive Disorders of Pregnancy and Subsequent Cardiovascular Disease: Current National and International Guidelines and the Need for Future Research. *Frontiers in Cardiovascular Medicine*. 2019;6(55).
5. Henry A, Arnott C, Makris A, Davis G, Hennessy A, Beech A, et al. Blood pressure postpartum (BP2) RCT protocol: Follow-up and lifestyle behaviour change strategies in the first 12 months after hypertensive pregnancy. *Pregnancy Hypertens*. 2020;22:1-6.
6. Heidrich M, Wenzel D, von Kaisenberg C, Schippert C, von Versen-Höynck F. Preeclampsia and long-term risk of cardiovascular disease: what do obstetrician-gynecologists know? *BMC Pregnancy and Childbirth*. 2013;13:61.

VERSION 2 – REVIEW

REVIEWER	Lucy Chappell King's College London
REVIEW RETURNED	21-Nov-2020

GENERAL COMMENTS	The authors have done a very good job in revising the manuscript to address the reviewers' comments and there are no further issues to address.
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REVIEWER	Peter Barrett University College Cork, Ireland
REVIEW RETURNED	23-Nov-2020

GENERAL COMMENTS	<p>Well done to the authors for their work on this important and valuable study. I am satisfied that my previous suggestions have been adequately addressed in this revised version. In particular, the results presented in the Tables are now much more intuitive and the added value of this study is clear.</p> <p>There are two very minor final amendments which they might consider incorporating prior to publication. Lines 75-76, the wording could be improved as it is not entirely clear. And Line 232 I would suggest replacing the word "chance" with "risk".</p> <p>Otherwise well done on an important contribution on this under-studied topic.</p>
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