Effect of antenatal care on low birth weight prevention in Lao PDR: A case control study [version 1; peer review: 1 approved with reservations, 1 not approved]

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Abstract

Background: Low Birth Weight (LBW) is a worldwide public health problem, which subsequently may affect the health status of the child. Lao PDR has high incidence of LBW. Antenatal care (ANC) is provided to improve maternal and child health outcomes. The aim of this study was to identify the effect ANC on LBW prevention in Lao PDR.

Methods: This case control study was conducted in tertiary hospitals of Lao PDR. The ratio of case: control was 1:3, of which there were 52 cases and 156 controls that passed the inclusion criteria included in the study. In our analysis information on pregnancy and ANC including height of mother, maternal weight gain during pregnancy, maternal gestational age at delivery, type of delivery, supplementary vitamins, and other covariates including age, marital status, educational attainment, occupation, family income, health insurance, family size and living condition were described and determine their association with LBW using multiple logistic regression analysis.

Results: There were only 32.69 % of complete ANC among cases and 57.69% in control. Incomplete ANC (<4 times) were significant increased the odds of having LBW (adj. OR=2.97; 95%CI: 1.48 to 5.93; p-value =0.002). Other covariates which also influenced LBW were having maternal weight gain during pregnancy less than 10 kg. (adj.OR=2.28; 95%CI: 1.16 to 4.49; p-value = 0.017), maternal gestation age at delivery less than 40 weeks (adj. OR=3.33; 95%CI: 1.52 to 7.32; p-value =0.003).

Conclusion: Complete ANC could help both mother and child in term of weight gain and full term delivery which may effect on LBW reduction.

Keywords

Infant, Low Birth Weight (LBW), Maternal Risk Factors, Case – Control Study.
Corresponding author: Wongsa Laohasiriwong (drwongsa@gmail.com)

Author roles: Oulay L: Conceptualization, Data Curation, Formal Analysis, Methodology; Laohasiriwong W: Conceptualization, Data Curation, Formal Analysis, Methodology; Phajan T: Conceptualization, Formal Analysis, Methodology; Assana S: Conceptualization, Formal Analysis, Methodology; Suwannaphant K: Conceptualization, Formal Analysis, Methodology

Competing interests: No competing interests were disclosed.

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The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

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Introduction

Low birth weight (LBW) refers to a baby who has a birth weight of less than 2,500 grams. LBW may cause birth asphyxia, amniotic fluid aspiration, hypoglycemia and hyponatremia. An infant weight of 1,500–2,500 grams has been shown to have 5–10 times higher mortality rate than normal infants. During 2005–2010, LBW incidences in countries of the Association of Southeast Asian nations ASEAN were 21.0% in Philippines, 11.0% in Malaysia, Cambodia and Lao PDR, 9.0% in Indonesia, 7.0% in Thailand and 5.0% in Vietnam. The incidence of LBW reflects a country’s socio-economic development. Mortality of LBW babies is as high as 1% when compared with 0.2% among normal children. At the 2005 World Summit a plan was announced to improve quality of life called Millennium Development Goals (MDGs), covered goals to be achieved worldwide by the year 2015.

Maternal and child health problems have been considered as indicators of the health service performances. In Southeast Asia, 28% of all deaths of 1 month-old infants were from infection, and 20% from preterm birth and LBW. LBW is commonly used as an indicator of health status and is important for national health policy development. Important factors associated with LBW are maternal factors, such as socioeconomic status, food consumption behaviors, calorie intake, urinary tract infection and prenatal care, smoking, genital infections, maternal health and stress.

Antenatal care (ANC) is care provided to pregnant women by health personal. Care includes risk identification, prevention and management of pregnancy-related or concurrent disease, and health education and health promotion. The World Health Organization’s ANC model, also known as focused or basic ANC is a goal-orientated approach to delivering evidence-based interventions at four critical times for ANC during pregnancy; therefore completed ANC in this study is having ANC for at least 4 times.

High incidence of LBW and high mortality of both mothers and children in Lao PDR has been hypothesized as being caused by various influencing factors, such as low socio-economic status and limited access to qualified health services related to pregnancy. However, there are limited studies identifying the role of ANC in reducing LBW incidence in Lao PDR. Therefore this study aimed to determine whether having ANC at least four times during pregnancy could help reduce LBW when controlling for other covariates related to socioeconomic and pregnancy factors. The results could be used to develop appropriate measures for prevention of LBW and obtaining better maternal and child health statuses.

Methods

Participants

Postpartum mothers who had delivered babies and came for regular checkup after delivery in four tertiary hospitals in Vientiane, Lao PDR between July and December 2016 were included in this study. The four hospitals were Mahosot Hospital, Sethathirat Hospital, Mothers and Child Center Hospital, and Mitraphaph Hospital.

The sample size was calculated using the formula for the analysis of a relationship in a case-control study. The formula indicated that the sample size of the study group (cases) should be 52 participants. The control group was 3 times the size of the study group (case:control ratio of 1:3). Therefore, the control group included 156 participants, which made a final total of 208 participants. Cases and controls were not matched for demographics.

Inclusion criteria were mothers who had delivered babies in the four hospitals during the study period, who were 18 – 49 years of age. This age range was chosen as the reproductive age of women is 15–49 years old. However, those aged below 18 are considered as a vulnerable group, therefore we selected 18–49 year-olds. The exclusion criteria were mothers who delivered twins, did not live in the study area and who were not willing to participate. The samples in this study were divided into two groups:

1) Case group: mothers of babies whose birth weight was <2,500 grams (LBW);
2) Control group: mothers of babies whose births weight was ≥2,500 grams who were born during the same period as the cases.

Data collection

The tool for data collection was a structured questionnaire interview that consisted of seven parts (Supplementary File 1): Part I, general information; Part II, sociodemographic characteristics; Part III, knowledge of health care during pregnancy; Part IV, maternal factors and pregnancy status; Part V, environmental factors and support for ANC; Part VI, prenatal distress (as assessed using the Edinburgh Prenatal Depression Scale); Part VII, obstetric information at delivery (gathered from the mother’s medical records).

The questionnaire was content validity tested by five experts in terms of theory and understanding. Unclear questions were edited and some information that was missing was added. Reliability was tested among 30 mothers (from Xaythany and Sisattanak Hospitals), indicating the high reliability with the Cronbach’s alpha coefficient of 0.84.

Data was collected by four physicians who were trained in using the questionnaire. These interviewers were blinded for the infant status of normal or LBW. The interview of the participants took place in a postpartum patient room or nursing room within 5 days of agreement to participate.

Statistical analysis

STATA version 10.0 was used to analyze data. Descriptive statistics frequency, percentage, means, standard deviation, minimum, maximum were used to present data on the following characteristics: characteristics of mothers, knowledge on health care during pregnancy of the mother, pregnancy status, environment factors and support for ANC, prenatal distress and obstetric information at delivery.
Simple logistic regression was used to determine factors associated with LBW. The factors which had association with LBW (p-value <0.25) were analyzed using multiple logistic regression. Multiple logistic regression was applied to identify the association of ANC and LBW when controlling for other covariates, presenting adjusted OR, 95% confidence interval (95% CI) with the levels of significance at 0.05.11

Ethical statement
We submitted the proposal and questionnaire to the Ethical Committee of Khon Kaen University, Thailand (reference No. HE 592087) and the Ethical Committee of University of Health Sciences, Lao PDR (reference No.13/16) for approval. Both committees granted approval of this study, including the reliability test of the questionnaire. Written informed consent was obtained from all participants.

Results
The study involved a total of 208 mothers, of which 52 were cases and 156 were controls. There were a higher proportion of younger mothers (<20 years) among cases than controls (17.31% and 11.54%, respectively). Controls had higher educational attainment of upper secondary (43.59%) compared to cases (28.85%). More controls lived in urban areas than cases (60.26% and 51.92%, respectively), and 21.15% of cases had average monthly family income ≤1,000,000 (Kips) which was 9.62% among controls (see Table 1).

Only 32.69% of cases completed ANC (≥4 times) check-ups while 57.69% controls completed these. The bivariable analysis of ANC, socioeconomic and maternal factors with LBW showed that going to ANC check-ups <4 times had higher odds of having LBW than those who went to at least 4 times (OR=2.80; 95% CI: 1.44 to 5.43; p-value = 0.002).

In the bivariate analysis, which considers the association of one independent variable with the outcome (LBW), we selected factors with a p-value <0.25 to proceed to the multivariable analysis. These factors were height of mother (cm), taking any supplementary vitamins, prenatal depression, maternal weight gain during pregnancy (kg), maternal gestational age during delivery (weeks), and type of delivery (see Table 2).

The multivariate analysis of maternal risk factors of LBW show that after adjusting for the effect of covariates there was significant association between ANC check-ups <4 times and LBW (adjusted OR = 2.97; 95% CI: 1.48 to 5.93; p-value = 0.002). Other covariates that were also significantly associated with LBW were maternal weight gain during pregnancy <10 kg (adjusted OR =2.28; 95% CI: 1.16 to 4.49; p-value = 0.017), maternal gestation at delivery <40 weeks (adjusted OR= 3.33; 95% CI: 1.52 to 7.32; p-value =0.003) (see Table 3).

Discussion
Our study demonstrated that inadequate ANC, poor maternal weight gain during pregnancy and maternal gestational age at delivery were significant independent determinants of LBW in Lao PDR. Only about one third of the mothers with LBW babies (cases) had completed ANC (≥4 times), whereas about half of the mothers with normal weight babies (control) had completed ANC. This finding supports the results of other studies16–17, which indicated that ANC (times) were found to be significant maternal risk factors for LBW babies. In this study, the mothers who attended ANC fewer than 4 times had almost 3 times higher odds of having LBW. Previous studies in general hospitals have indicated that ANC visits <4 times were LBW risk factors18–21. Antenatal visits of the pregnant mothers are very important as they provide chances for monitoring the fetal wellbeing and allow timely intervention for fetal-maternal protection. Little ANC could increase prenatal fetor-maternal complications22. In the present study, among mothers who did not receive ANC, there was 1.122 times higher changes than those who received ANC and ANC < 4 visits OR was 1.41 (95% CI: 1.02 to 1.94). These are similar findings to results found in Thailand24–26.

Maternal age in some studies has no significant association with LBW27; however other studies had different results28–30. For example, Fariha et al. found that maternal age was found significantly associated with LBW infants31, and some studies reported that the older the mother, the higher the risk of having LBW infants32. LBW babies among older mothers, whose age is 35 years and above, was 23.89%. It was significantly higher than the percentage of LBW babies for mothers in other age categories (p = 0.004)33–35. For maternal weight gain during pregnancy it was found that weight gain <10 kg were risk factors for LBW in the present study, which is similar to the result of a study in Indonesia among others36–38. Low maternal weight gain reflects poor child growth, which puts both mother and child at risk for morbidity and mortality39,40.

Maternal gestational age at delivery of <40 weeks was another associated factor for LBW in the present study, which is similar to a result found in Malaysia41. Some studies showed that the risk factor of LBW infants was a gestational ages of <37 weeks42–44. When the mother delivers a baby before the baby is at full term, the baby is not fully grown. Therefore the babies are more likely to be small (LBW) and have higher risk for mortality since some organs such as lung is not fully functioning.

One limitation in this case-control study could be data collection bias due to interviewer prejudices. However, we minimized this by blinding the interviewers; therefore the manner in which they asked the questions were the same in both case and control groups.

Conclusion
This hospital-based case-control study was conducted in Vientiane, Lao PDR and indicated that ANC checkups at least 4 times could help reduce LBW of babies. Consequently, policy should improve coverage and quality of ANC of at least 4 times for all pregnant women in this population.

Dataset 1. Raw data supporting the results presented. Since this study did not analyse knowledge of health care of the mothers or environmental factors and support of ANC, answers to Parts III and V of the questionnaire have not been included in the dataset
http://dx.doi.org/10.5256/f1000research.15295.d210148
Table 1. Demographic and socioeconomic status of mothers (n = 208).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Cases (n=52)</th>
<th>Controls (n=156)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Maternal age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>9</td>
<td>17.31</td>
</tr>
<tr>
<td>20–34</td>
<td>38</td>
<td>73.08</td>
</tr>
<tr>
<td>≥35</td>
<td>5</td>
<td>9.61</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>26.55 (5.97)</td>
<td>26.79 (5.68)</td>
</tr>
<tr>
<td>Median (Min: Max)</td>
<td>26.5 (16:37)</td>
<td>27 (17:40)</td>
</tr>
<tr>
<td>Living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>27</td>
<td>51.92</td>
</tr>
<tr>
<td>Suburban</td>
<td>25</td>
<td>48.08</td>
</tr>
<tr>
<td>Marital status</td>
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<td></td>
</tr>
<tr>
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<td>52</td>
<td>100.0</td>
</tr>
<tr>
<td>Not married</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education</td>
<td></td>
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</tr>
<tr>
<td>Primary</td>
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</tr>
<tr>
<td>Lower secondary</td>
<td>15</td>
<td>28.85</td>
</tr>
<tr>
<td>Upper secondary</td>
<td>15</td>
<td>28.85</td>
</tr>
<tr>
<td>Middle diploma or greater</td>
<td>14</td>
<td>26.92</td>
</tr>
<tr>
<td>Occupation (mother)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government officer</td>
<td>10</td>
<td>19.23</td>
</tr>
<tr>
<td>Private/enterprise</td>
<td>6</td>
<td>11.54</td>
</tr>
<tr>
<td>Business</td>
<td>9</td>
<td>17.31</td>
</tr>
<tr>
<td>Farmer</td>
<td>1</td>
<td>1.92</td>
</tr>
<tr>
<td>House wife</td>
<td>26</td>
<td>50.00</td>
</tr>
<tr>
<td>Family income (Kips)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤1,000,000</td>
<td>11</td>
<td>21.15</td>
</tr>
<tr>
<td>1,000,001–1,500,000</td>
<td>11</td>
<td>21.15</td>
</tr>
<tr>
<td>1,500,001–2,000,000</td>
<td>10</td>
<td>19.23</td>
</tr>
<tr>
<td>≥2,000,001</td>
<td>20</td>
<td>38.46</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>2,207,692 (1,140,943)</td>
<td>2,616,667 (1,856,978)</td>
</tr>
<tr>
<td>Median (Min: Max)</td>
<td>2,000,000 (500,000:5,900,000)</td>
<td>2,000,000 (550,000:6,000,000)</td>
</tr>
<tr>
<td>Health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>11</td>
<td>21.15</td>
</tr>
<tr>
<td>Out of pocket payment</td>
<td>41</td>
<td>78.85</td>
</tr>
<tr>
<td>Family size (persons)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 – 3</td>
<td>8</td>
<td>15.38</td>
</tr>
<tr>
<td>4 – 5</td>
<td>31</td>
<td>59.62</td>
</tr>
<tr>
<td>6 – 7</td>
<td>7</td>
<td>13.46</td>
</tr>
<tr>
<td>≥8</td>
<td>6</td>
<td>11.54</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>5.13 (1.88)</td>
<td>4.89 (1.65)</td>
</tr>
<tr>
<td>Median (Min: Max)</td>
<td>5 (2: 10)</td>
<td>5 (2: 13)</td>
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</table>
Table 2. Bivariable analysis of factors associated with low birth weight (LBW) in Lao PDR (n = 208).

<table>
<thead>
<tr>
<th>Variables</th>
<th>LBW</th>
<th>Crude OR (95%CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Case (n=52)</td>
<td>Control (n=156)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Antenatal care check-ups (number of times)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (≥ 4)</td>
<td>17</td>
<td>32.69</td>
<td>90</td>
</tr>
<tr>
<td>No (&lt;4)</td>
<td>35</td>
<td>67.31</td>
<td>66</td>
</tr>
<tr>
<td>Taking any supplementary vitamins</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>46</td>
<td>88.46</td>
<td>143</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>11.54</td>
<td>13</td>
</tr>
<tr>
<td>Height of mother (cm)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>≥ 161</td>
<td>3</td>
<td>5.77</td>
<td>21</td>
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<tr>
<td>156-160</td>
<td>19</td>
<td>36.54</td>
<td>49</td>
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<tr>
<td>≤ 155</td>
<td>30</td>
<td>57.69</td>
<td>86</td>
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<tr>
<td>Prenatal depression</td>
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<tr>
<td>No depression</td>
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<td>82.69</td>
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<tr>
<td>Depression</td>
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<td>17.31</td>
<td>44</td>
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<tr>
<td>Maternal weight gain during pregnancy (kg)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥10</td>
<td>25</td>
<td>48.08</td>
<td>109</td>
</tr>
<tr>
<td>&lt;10</td>
<td>27</td>
<td>51.92</td>
<td>47</td>
</tr>
<tr>
<td>Maternal gestational age during delivery (weeks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥40</td>
<td>10</td>
<td>19.23</td>
<td>68</td>
</tr>
<tr>
<td>&lt;40</td>
<td>42</td>
<td>80.77</td>
<td>88</td>
</tr>
<tr>
<td>Type of delivery</td>
<td></td>
<td></td>
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<tr>
<td>Vaginal</td>
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<tr>
<td>Caesarean</td>
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<td>90.38</td>
<td>124</td>
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Table 3. Multivariable analysis factors associated with low birth weight (LBW) in Lao PDR (n = 208).

<table>
<thead>
<tr>
<th>Variables</th>
<th>LBW</th>
<th>Crude OR (95%CI)</th>
<th>Adjusted OR (95%CI)</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Case (n=52)</td>
<td>Control (n=156)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Antenatal care check-ups (number of times)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (≥ 4)</td>
<td>17</td>
<td>32.69</td>
<td>90</td>
<td>57.69</td>
</tr>
<tr>
<td>No (&lt;4)</td>
<td>35</td>
<td>67.31</td>
<td>66</td>
<td>42.31</td>
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<tr>
<td>Maternal weight gain during pregnancy (kg)</td>
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<tr>
<td>≥10</td>
<td>25</td>
<td>48.08</td>
<td>109</td>
<td>69.87</td>
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<td>&lt;10</td>
<td>27</td>
<td>51.92</td>
<td>47</td>
<td>30.13</td>
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<tr>
<td>Maternal gestational age during delivery (weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥40</td>
<td>10</td>
<td>19.23</td>
<td>68</td>
<td>43.59</td>
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<td>80.77</td>
<td>88</td>
<td>56.41</td>
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</table>
Data availability
Dataset 1: Raw data supporting the results presented. Since this study did not analyse knowledge of health care of the mothers or environmental factors and support of ANC, answers to Parts III and V of the questionnaire have not been included in the dataset. DOI, 10.5256/f1000research.15295.d210148

Competing interests
No competing interests were disclosed.

Supplementary material
Supplementary File 1: Questionnaire used in the study in English. Click here to access the data.

Grant information
This research was supported by the China Medical Board Project and the University of Health Sciences, Vientiane, Lao PDR; and the Faculty of Public Health, Khon Kaen University.

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Acknowledgements
The authors are thankful to all participants, directors and heads of the Department of Obstetrics and Gynecology in participating hospitals.

References

   Reference Source
   Published Abstract
   Reference Source
   Reference Source
   Reference Source
   Published Full Text
   Publisher Full Text
   Reference Source
   Published Abstract | Publisher Full Text | Free Full Text
    Reference Source
    Reference Source
    Reference Source
    Reference Source
    Reference Source
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   Publisher Full Text
   PubMed Abstract | Publisher Full Text
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   Published Abstract | Publisher Full Text
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Open Peer Review

Current Peer Review Status: ? ×

Version 1

Reviewer Report 09 January 2019

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Zohra Lassi
The Robinson Research Institute, The University of Adelaide, Adelaide, SA, Australia

Major:
- Poorly written paper and needs English editing throughout. Many of the sentences are not clear and I could not follow many things because of grammatical errors.
- Abstract results need to be rewritten correctly.
- For the calculation of sample size, what indicators were used? Also provide the formula.
- Was the questionnaire by those physicians completed in the hospital premises? Although you did say those physicians were blinded but if they filled the questionnaire in health facilities then those physicians could have accessed the medical record data? This may add bias to the study.
- Facts such as women in cases who were young, lived in non urban areas, and had lower monthly family income were not discussed in the discussion section.
- Reference 2 is from 1998 and from Tanzania. Should use an updated citation and global figure.
- Reference 3 is very old (from 2004).
- Reference 5 indicates it is on maternal mortality. However, authors have used it for LBW burden. Please check if this is correctly cited?

Minor:
Several minor points has been raised in the attached.
- I would suggest changing the title to “Does antenatal care has any impact on reducing low birth weight. – a case-control study.”
- Several grammatical errors, would suggest getting a good proof for language and grammar.
- Abstract: suggest changing the word “problem” to concern.
  “Background: Low Birth Weight (LBW) is a worldwide public health problem..”
- Abstract: suggest changing this sentence from: Antenatal care (ANC) is provided to improve maternal and child health outcomes.” to “Women are offered antenatal care (ANC) to improve maternal, pregnancy and newborn outcomes”.
- Introduction: second line “le” should be “less than”
- Rewrite this sentence: “During 2005–2010, LBW incidences in countries of the Association of Southeast Asian nations ASEAN were 21.0% in Philippines, 11.0% in Malaysia, Cambodia and Lao PDR, 9.0% in Indonesia, 7.0% in Thailand and 5.0% in Vietnam 3.”
- Whenever you are saying compared with normal children, it should be normal weight babies.
Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
No

If applicable, is the statistical analysis and its interpretation appropriate?
Partly

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Public Health, Perinatal Epidemiology, Adolescent Health, Global Health

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Reviewer Report 03 August 2018

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This article is a case control study, aims to study the association between the complete antenatal care (ANC ≥ 4 times) and the low birth weight (LBW) in Lao PDR. It demonstrated the significance of ANC on the prevention of neonatal complication however there are a number of issues with the methods and analysis section that need to be clarified with some of the conclusion are not correspond with the results. The detail of comments by section is below:

Abstract:
The conclusion that complete ANC help mother and child in term of weight gain and full term delivery is
not from the analysis of the results. The multiple logistic regression from this study only showed that antenatal care and maternal weight gain and GA at delivery had effect to the LBW.

Introduction:
- Page 3, Paragraph 1– second sentence birthweight of le< 2500 grams, the reference about LBW incidence in ASEAN was in 2004 that should be update. The last sentence about MDGs in 2015 is out of date and irrelevant which should be removed.
- Paragraph 2- some sentences are repeat of first paragraph
- Paragraph 3- four critical times of ANC was recommended from WHO in 2002, the update of recommendation from WHO is in 2016 which can be found in http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/ , the new guideline recommend minimal 8 times of antenatal care to reduce perinatal mortality (page xvi)
- Paragraph 4- the authors mentioned there are limited studies identifying the role of ANC in reducing LBW incidence in Lao PDR, please give the detail, reference and gap of knowledge.

Methods:
The method was well described, however some points should be clarify
- The study period was 6 months in four tertiary hospitals in capital city which mean a lot of patients, with the only 52 cases of LBW and 156 control cases, the authors should mentioned about the selection method especially the control cases to avoid the selection bias.
- Some pregnancy factors that affect the LBW such as associated maternal diseases, complication during pregnancy, gravida and preterm birth should be added.

Results:
- The subjects were caesarean delivery in 90.38% of cases and 79.49% of control, 19.23% of cases and 13.46% of controls were government officer with only 1.92% of cases and 3.21% of controls were farmer. This might not be the good representative of Lao PDR pregnant women and the inferential of this study to general population might be limited.
- Paragraph 1-The control showed higher education, urban and higher income. This might cause from the convenience selection of control group and cause the better health status, more times ANC attend and higher birthweight of control group. Please clarify the method of control selection.
- Us dollar might be better than Kips for the understanding of the reader.
- Total birth, total LBW, total preterm birth and total cesarean deliveries in the study period should be added.
- Table 1- Maternal age should be 18-20 instead of <20 (<18 was excluded from this study), Famer should be changed to farmer. Only mean or median should be selected depend on the distribution of data. If median was selected, the min-max should be changed to interquartile range. Maternal medical and obstetrics complications should be added because it was an important factor for LBW.
- Table 2-The gestational age normally divided to <37, 37-<42, ≥42 instead of 40. The BMI should be used instead of maternal height and why 10 kg was used instead of the recommended weight gain during pregnancy which depends on maternal BMI. Very high cesarean section in both groups was shown, please add the reasons or indications.
- The continuous data such as age, income should be analyzed in continuous form, especially income which was statistical difference between two groups if analyzed in continuous form and should be analyzed in multiple logistic regression analysis. The downgrade of continuous data to ordinal data should be avoided.
- Normally, the premature birth is the birth before 37 weeks GA and is the most important cause of LBW. This should be used instead of 40 weeks.
Conclusion: As mentioned above, the new WHO recommendation in 2016 recommend at least 8 times of antenatal care to reduce perinatal mortality.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Partly

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Ob-Gyn

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.

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