Author's response to reviews

Title: Self-Management Experiences among Men and Women with Type 2 Diabetes Mellitus: A Qualitative Analysis

Authors:

Rebecca T Mathew (rmathew@nosm.ca)
Enza Gucciardi (egucciari@ryerson.ca)
Margaret DeMelo (margaret.demelo@uhn.on.ca)
Paula Barata (pbarata@uoguelph.ca)

Version: 2 Date: 10 October 2012

Author's response to reviews: see over
To the Editorial Team at BMC Family Practice:

Thank you for your consideration of our article titled, “Self-Management Experiences among Men and Women with Type 2 Diabetes Mellitus: A Qualitative Analysis” (MS: 1398343811730763).

Please find below a point-by-point response to the comments made by the BMC Family Practice reviewers.

Reviewer 1

1a). Is the question posed original, important and well defined? Discussion about barriers is missing and would be a strong addition.

Please note that we have included new text in the third paragraph of the Introduction section that discusses gender-specific barriers to self-care activities among patients with T2DM (page 2, line 18-28, underlined text). We feel as though our study findings have much to contribute to this growing area of research:

“There is also literature demonstrating differences in barriers to self-management of T2DM but limited studies examining gender specific differences... A study by Whitemore et al. among women with diabetes demonstrated more positive outcome measures, including metabolic control, diet and diabetes-related distress with increased self-confidence in living with diabetes and positive social supports. This study suggests that barriers to diabetes self-care among women might include lack of self-confidence and inadequate support from their immediate friends and family. Another qualitative study by Cherrington et al. examining barriers and facilitators to diabetes self-care among Latino immigrants found that women’s barriers related to inadequate social support at home, especially related to food preparation. On the other hand, the predominant barriers to self-care faced by men were lack of flexibility and schedule intensity within the workplace.”

1b) We also included the lack of discussion of cultural differences in our paper as a future research direction in the Limitations section (page 13, line 10-15, underlined text) as the reviewer raised this as a potential concern as well:

“Furthermore, we have limited information about the characteristics and time spent in the North American healthcare system of foreign-born participants and the amount of potential assimilation to western role expectations – this might act to potentially confound our results. We did not collect specific information regarding the ethnic and cultural background of those patients who reported being foreign-born, nor did we identify which cultural background participants identified with most strongly. Given the wide variations in cultural norms regarding diet, physical activity, and gender roles and norms influencing health behaviors, the role of culture should be further investigated in future studies.”

2. Are the data sound and well controlled?

Please note that we have re-worked the Methodology section to include a full description of thematic data analysis and our rationale for selecting this methodology (page 3, section starting at line 6).

During thematic analysis, our research team often returned to the narratives in the transcripts to identify areas of focus by men and women based on our preliminary themes. However, once the overarching themes were derived from the preliminary analysis, the narratives were only further utilized to draw direct quotations that represented examples of these themes.

MD is a clinical expert in diabetes mellitus as she is a diabetes educator at a Diabetes Education Center. EG is an academic context expert in the area of diabetes self-management. PB is an expert in qualitative methodology but not in diabetes content. The lead author, RM, has a special interest in T2DM as a resident physician but is not a diabetes expert.

The 5 overarching themes have now been summarized in the last paragraph prior to the Results section as per the reviewer’s comments (page 4, line 33 – page 5, underlined text):

“The five overarching themes identified were: identity and disclosure as a person living with diabetes, self-monitoring of blood glucose levels, struggles with diet and nutrition, utilization of diabetes resources and social supports.”

Please see the answer to Reviewer 3 – question 7 for a discussion on qualitative rigor and trustworthiness.

3. Is the interpretation (discussion and conclusion) well balanced and supported by the data? More than half of the participants were foreign born and no information is provided as to time spent in the health care system and whether there is assimilation to mainstream role expectations and if role expectations were informed by cultural beliefs.
Unfortunately, we do not have further data for the foreign-born study participants. The ‘foreign-born’ status of the participants was based on the self-reported answer to the multiple-choice question, "Were you born in Canada?" with responses being yes or no. We do not have further divisions as to the ethnic background of each participant. However, the purpose of our analysis was to better understand some of the issues contributing to gender differences in diabetes self-care and not to examine impact of cultural differences on diabetes self-care.

4. A question is whether culturally based sex-role norms are a factor to consider in the analysis?

As mentioned above, we did not collect ethnicity data so this cannot be taken into consideration. Please see the Limitations section of the paper as this is discussed there (page 13, line 12-15):

"We did not collect specific information regarding the ethnic and cultural background of those patients who reported being foreign-born, nor did we identify which cultural background participants identified with most strongly. Given the wide variations in cultural norms regarding diet, physical activity, and masculine and feminine gender roles and norms influencing health behaviors, the role of culture should be further investigated in future studies."

6. Can the writing, organization, tables and figures be improved?

Please see Appendix 1 (title) as we have added to the caption to indicate that the guide was based upon the Brewer-Lowry Self-Management Framework.

The addition of a box figure with display of differences and what is similar may be helpful in presentation of results.

Please see the addition of Table 2 in the attached files as this has been added.

In the discussion section, it may be helpful to include subheadings of differences and alike in some ways.

We opted to write the discussion focusing on the similarities and differences within each theme and then include relevant literature as each topic is elaborated upon in the Discussion. We believe that further dividing theses sections would reduce the flow of the discussion and increase its length. As noted above, we have now included a table that makes these similarities and differences explicit, which should help readers follow this section without the need for further sub-headings. We have tried to be clear in describing the differences and similarities between men and women in the Discussion section. Perhaps the editor could let us know if further sub-headings are required.

Reviewer 2

1. The abstract is lacking in details about the study population. For example, age, and number of participants.

Please see the Methods section of the Abstract for the total number of participants interviewed (page 1, line 4, underlined text). Also, please see first sentence in Results section of Abstract for the average age and gender distribution of the participants (page 1, line 6, underlined text).

2. In the first sentence of the Methods section, authors mention 'culturally diverse'. What exactly is culturally diverse in this population and how could this affect self-management, if at all?

We no longer refer to our sample as 'culturally diverse' in the manuscript. The labeling of participants as 'foreign-born' was made based on the self-reported answer to the question, "Were you born in Canada?" It was a yes or no response on the survey. Of all of our participants, 71% were foreign-born. The study took place in a large, metropolitan city in Canada, which is culturally diverse meaning


However, no specific information on cultural background was collected in this study so we are unable to further expand on this comment. Please see response to Reviewer 1, question 1b.

3. What were participants’ medical regimen, and adequacy of DM control? How has this affected diabetes self-management?

Information on medical management and DM control was not collected. The primary objective of our research was to have participants describe their accounts of self-managing diabetes and comparing themes that arose among men and women, regardless of medical management. Thus, collecting this information was beyond the scope of research aim. Based on our initial study findings, it is clear that self-management of blood glucose is a difficult skill and associated with a substantial degree of anxiety for the participants.

4. Why 3-8 participants in each focus group? How did authors conclude that 3-8 participants was sufficient for this type of analysis?

In determining the size of our focus groups we were guided by the rule of thumb that focus groups should range from 6-10
participants. However, small groups may be appropriate when the topic is expected to be of personal interest to the participants. As our topic was expected to be of personal interest to the participants we recruited 8 for each group with an expected drop out of 2-3 per group. However, we had difficulty with scheduling in one group and more drop-out than expected, which lead to one group of 3. Our remaining groups were either 5 or 8 people. Our initial focus group was a mixed sex, but for the remaining focus groups, we organized 4 single sex focus groups in order to allow for sex-specific discussions that might have otherwise not occurred in the mixed-sex group in addition to the individual interviews.

Perhaps the editors can provide guidance as to if they would like this statement to be included in the body of the manuscript.

5. Where were transcripts kept? Confidentiality and anonymity?

Please see page 3, line 29-32:

"All focus groups and interviews were audio-recorded and subsequently transcribed into Nvivo 2.0. The interview transcripts were kept in password protected and secure hard drives at our research lab throughout all stages of data analysis to ensure confidentiality and data security. Following initial data collection, all identifying information of the participants was removed and objective identifiers were used on the transcripts to ensure anonymity."

6. Since themes were identified, it would help to add number of participants to each theme in order to support why authors chose the quotes related to the theme?

We used a thematic analysis, and created our overarching themes based on the synthesis of preliminary themes and codes from the data. The specific quotes that were chosen were selected because they represent general experiences, expressions or ideas that were pulled from the data during the analysis stage. Quantifying participants who support each theme is neither common practice when using thematic analysis nor in qualitative research.

Reviewer 3

1. Is the question posed by the authors well defined?

"Why isn't there literature describing previous studies on e.g. beliefs about health and illness in men and women or gender issues related to beliefs and illness that might underlie and direct self-management? There are studies concerning this by Hjelm et al. that can be used..."

Please note the second paragraph in the Introduction (page 2, line 9-17) as we have cited several studies demonstrating differences in attitudes, beliefs and fears between men and women with diabetes.

Please note that we have cited the Hjelm et al. article in our Introduction (page 2, line 15-16, underlined text). Please let us know if there is another article that would be more relevant to include by Hjelm et al.

2. The aim stated is different in the paper, the Abstract, and in the Discussion! There should be one and the same in the whole paper.

Please note that we have changed the aim statements throughout the paper so that they are consistent. The objective of this study was to explore diabetes self-management experiences, specifically needs, challenges and barriers identified by men and women using qualitative methods. Please refer to page 1 (lines 2-3), page 3 (lines 1-2), page 10 (lines 26-27).

3. Are the methods appropriate and well described? The study design and motive for the choice of it. An answer on what year the study was undertaken.

A clear description of how participants were recruited and by whom, as well as the data collection procedure. And how the interview guide was developed and what differed between focus groups interviews and individual interviews.

Please note that we have made major changes to the Methods section of the paper. These changes include addition of the year in which the study was undertaken (2006-2007) (page 3, line 9). We have also included more details regarding the study design (page 3, lines 11-29), recruitment of participants (page 4, lines 1-8) and data collection (page 4, lines 13-17).

In terms of rationale for selection of methodology, our research aims were initially broad because we planned to use thematic analysis that was 'data-driven' and we did not want to force the data to fit into pre-determined research questions. We chose to do a qualitative study using thematic approach because while the relevant body of literature does demonstrate use of some qualitative studies, the analyses have often been done deductively with specific research questions in mind. We chose our study methodology to address the limitations of previous studies by using a thematic, inductive analysis.

Focus groups were used in order to provide an interactive atmosphere where individuals could create meaning through debate and discussion. Our interview guide used open-ended questions in order to allow individuals to identify and explore their personal experiences as well as the issues and feelings that were most important to them. The discussion within focus groups also stimulated areas of discussion that participants rarely talk about in their daily lives and also gave participants an opportunity to give and receive the support of other individuals also managing their diabetes.

The same interview guide was used in the focus group interviews and the telephone interviews in order to maintain consistency in the interview processes, guide the discussion and keep the data focused on our research objectives. The
practice of combining focus groups and interviews has been used in previous research studies, and this might have even been beneficial because it allowed for participants to discuss their concerns in different ways. In addition, we made the decision to include interviews because it was clear that some participants would not be able to attend a focus group and we did not want to exclude their experiences from our analysis. As a research group, we felt that it was more important to interview more participants than to include only those who were able to attend a focus group, a bias in itself.

4. I do lack methodological literature on focus groups and motives to the group sizes and a description of how the groups were composed. Further, something about the group dynamics under the interviews. How long did the interviews last. Where were they held? Audio-taped or not? Transcribed and then by whom?

Please see the numerous changes made to the Methods section, more specifically:

Page 4, lines 13-17, underlined text:

"We conducted five focus groups: one mixed sex group, two with only men and two with only women to allow for sex specific discussions. The focus groups were distributed in this manner to allow for sex-specific discussions of personal issues among participants that may not have surfaced if all groups were mixed-sex. Interviews lasted 1-2 hours and were held in one of the Diabetes Education Centers from which the participants had been initially recruited."

Page 3, lines 29-30, underlined text:

"All focus groups and interviews were audio-recorded and subsequently transcribed into Nvivo 2.0."

Please note that all focus groups occurred at the original Diabetes Education Center from which participants were recruited.

Please see answer to Reviewer 2, question 4 with regards to size and description of focus groups organization.

We are unsure what is meant by the reviewer’s comment, "...something about the group dynamics” – please elaborate.

4. It is not clear either in the methods section or in the discussion how the self-management framework by Brewer-Lowry et al. was used, please explain. And connect to the data analysis.

The Brewer-Lowry framework was used to develop our interview guide, a comprehensive framework to better understand the lived experience of diabetes self-management. It was used more as a general guide to support the multi-factorial nature of diabetes management and understand the cross-connections between self-care in multiple domains and outcomes in various areas on a patient’s life. This framework examines diabetes self-care as a series of intersecting tasks (diet, physical activity, glucose monitoring, foot care, medications) and services/resources (self-care, informal and formal medical care). We also made sure to ask about impact of self-care across various domains in participants’ lives as the Brewer-Lowry framework would suggest that struggles in a single domain might have substantial consequences in both the short and long term in other domains of a person’s life.

However, our analysis was completed using our thematic approach and focused on emergent themes as outlined in the Methods section of the paper.

5. Was the data analysis made inductively or deductively or abductively?

Please see page 3, line 11, underlined text:

“This original research question is broad, so as to accommodate for inductive, data-driven thematic analysis.”

6. Please add an example of a coding scheme as an appendix.

Please note that we did not begin with a coding scheme. Three of the authors read and re-read individual transcripts and conducted an initial microanalysis of the data. The team then came together to talk about codes and built a coding scheme as the discussion progressed. As the analysis continued, the codes were groups and collapsed, in line with our inductive approach.

Please see a list of our original codes and how they were collapsed below, however this is for the purpose of answering the reviewer’s question and not for publication in the manuscript unless the editor feels as though it is necessary to include.

Cognitive Issues
- Insight
- Knowledge
- Distraught on Diagnosis
- Perceived value of medications
- Perception of diabetes severity
- Disconnect
- Acceptance of their diabetes
- Depression
- Conversion experience
Contemplating cause of disease
Body cues

Management Struggles
Conversion experience
Cheat
Diabetes burden
Diet barriers
Diet struggles
Exercise barriers
Finances
Multiple complications
Mourning certain foods
Pill burden

Fear
Concern for insulin
Distraught over diagnosis
Fear
Perceived value of medication
Scare tactics

Mastery
Mastery
Self-determination
Self-efficacy
Self-reliant

Self-care Activities
Exercise
Diet change
Adopt and adapt
Cheating
Blood glucose testing
Cooks their own food
Foot care
Body cues
Weight management

Social Issues
Family support
Family issues
Family history (of diabetes)
Information sharing
Spiritual support
Social support

Health Care Services
Awareness of other resources
Coordination of services
Consistent care
Delay in referral
Physician satisfaction
Resource conflict
Satisfaction with DEC services
Suggestion for DEC services
Use of other resources
Waiting time

Experiences Managing Diabetes
Blood glucose testing
Body cues
Conversion experiences
Cooking their own food
Diet change
Empowerment
Exercise
Experimentation
Family issues
Fear of diabetes complications
Footcare
Insight
Learning
Luck
Mastery
Perceived value of diet change
Perceived value of exercise
Perceived value of medications
Perceived value of glucose monitoring
Perceived value of weight loss
Perception of disease severity
Self-discrimination and weight loss

Challenges Managing Diabetes
Acknowledgement
Cheat
Diabetes burden
Diet barriers
Disconnect
Exercise issues
Fear of medications
Finances
Management fatigue
Mourning of certain foods
Multiple complications
Pill burden

Support and Resources for Diabetes Management
Conflict of information across resources
Family support
Social support
Main resource
Using other resources

Issues Regarding DEC Services
Awareness of DEC services
Satisfaction with DEC services
Shortage of staff
Suggestions for DEC improvements

Experiences Accessing Healthcare System for Diabetes
Consistent care
Coordination of services
Physician awareness
Physician communication
Physician satisfaction
Physician trust
Quality of appointments
Validation
Waiting time

Healthcare Services
Satisfaction with DEC services
Physician satisfaction
Delay in referral
Resource conflict
Use of other resources
Coordination of services
Consistent care
Waiting times
Suggestion for DEC services
Awareness of other resources

7. When reading the Methods section, I do lack information about matters of trustworthiness and rigor were handled.

Please see the Data Analysis sub-heading under the Methods section (page 4, lines 19-33) for our approach to trustworthiness and rigor. Our research team was composed of a practice expert, academic content expert and qualitative study methodology expert. While the research team did conduct the focus group and telephone interviews, the transcripts had all identifying data removed and the team attempted to maintain confidentiality and anonymity during the analysis. The study population was from a large metropolitan Canadian city and analysis was completed by gender. Our research team was composed of North American women so there may have been aspects in the analyses, especially the daily self-care of
diabetes among women, which resonated with our own experiences.

Please see page 4, lines 19-33:

"The research team addressed issues of rigor and trustworthiness based on a quality framework outlined by Meyrick. Our research team was composed of one academic expert in diabetes (EG), one practice expert (MD), one expert in qualitative research (PB) and a resident physician with a special interest in diabetes (RM). Three of the investigators (PB, MD, EG) performed the focus group and individual interviews but the transcripts had all identifying information removed so we were able to maintain confidentiality and anonymity during analysis. Our data analysis was made inductively as we created our initial themes without having a coding scheme in place.

We used thematic analysis to explore salient topics that emerged from the focus groups and interviews. Our thematic analysis involved initial independent coding by three authors (EG, MD, PB). Seventy-eight codes were identified in the preliminary analysis of the transcripts. Codes were then clustered and used to form 13 preliminary sub-themes that integrated several of the originally identified codes and encompassed more general topics that were the focus of the transcripts. The preliminary sub-themes were then analyzed by sex where similarities and differences among men and women were examined and examples of these themes (i.e. direct quotations) were identified within the transcripts. Subsequently, word documents were created around each sub-theme with relevant quotations selected from the transcripts that highlighted the sub-theme. Further analyses led to the emergence of five overarching themes that illustrated the most significant and broad similarities or differences of diabetes self-management experiences between men and women."

We chose our sampling technique to offer participation in the study to every patient at the DEC who met inclusion criteria. The rationale for using the DEC as a recruitment site was that it would provide a large database of patients from various backgrounds so as to give our study more applicability of the findings. With regards to data collection, we have provided details in the Methods section about the interview guide (please see Appendix 1), and focus groups as well as how individual interviews were conducted. We also explained that individual interviews were only offered to accommodate participants who were unable to attend a focus group, but that the same interview guide was used. Please refer to question 6 above in which we delineate the various code and collapsing of codes that was done during analyses.

Finally, in our results and conclusions section, we did link our original data with our conclusions and attempted to cross-reference the two within the discussion.

8. I would like to see a clear and concrete description of how the 4 basic ethical principles were handled throughout the whole study both for focus group participants and those interviewed individually by telephone.

We are unsure as to which basic ethical principles the reviewer is referring to with this statement. The Georgetown mantra, autonomy, beneficence, non-maleficence and justice do not really apply to our research study as we are not dealing with patient care directly, and furthermore, we are not providing any guidance or direct patient care to the study participants. However, our study aimed to do good in that we wanted to develop a better understanding of diabetes self-care in order to better inform gender counseling and care in patients with diabetes. All patients at the DEC who met inclusion criteria were contacted for potential participation in order to ensure justice and equal opportunity to participate. Finally, all participants had the right to participate or withdraw consent at any time during the interview, and their autonomy was respected at all times in terms of decisions to answer or not answer any specific questions.

We also respected the following practical ethical principles: obtaining informed consent, ensuring confidentiality and anonymity, providing the right to withdraw and minimizing the risk of harm. When the research assistant contacted DEC participants to notify them about the study, the study purpose, methods, intended analysis and possible outcomes were provided to participants. We also made sure to tell participants that if they wanted to participate in a focus group, they would be required to return to the DEC for a meeting but that a honorarium would be provided to cover costs of travel to as to minimize inconvenience on their part. Confidentiality was respected as once the interviews were transcribed, all identifying information was removed and the analysis was completed using only letters and numbers for identification (i.e. FG2, M1), but participants were told about the limits to their confidentiality because this could not be guaranteed in a focus group format. The participants were also told that in the reporting of the results, no identifying information would be used. All participants were notified that they had the right to withdraw participation at any time during the study and that this would have no impact on the care they would receive at the DEC in the future. Finally, there was very little risk of harm in this study, but we attempted to minimize potential risk of psychological harm by supporting a non-judgmental atmosphere during the focus groups and use of supportive phrases in response the participants’ comments. Perhaps the editor would like to direct us to what section of our answer he/she would like us to add to the methods section of the paper, if any at all.

9. From the Discussion part, it is told that a secondary analysis was made but this is not told about in the Methods second, why not? What does it mean to the results?

Please refer to page 3, lines 13-16, underlined text:

"Of note, this study was initially undertaken to examine differences in diabetes self-care among users and non-users of the Diabetes Education Center. While our study results are drawn from a secondary analysis we feel as though they can provide meaningful contribution to the current body of literature."

10. Are the data sound? And be aware of that there is an imbalance in the Results section between what is said under the themes and the support with quotations. In many places there is a lack of quotations supporting the text. It seems that more quotations have been chosen from males than females. Another example is on page 7, second paragraph there is no
support for the two difference strategies. Needs to be changed so that there are illuminative quotations describing the pattern found and also that the text under each theme is in concordance with its content. Under Identity and Disclosure for example, there is also reporting of reactions on the Diagnosis?!

While completing the data analysis for this paper, we chose to identify illuminating quotes that represented our five overarching themes. During the drafting of our paper, we believed it was sometimes more efficient to provide written summaries of the quotations that would better recapitulate the general themes from the data (as expressed by multiple participants) rather than providing quotations that were sometimes lengthy and/or grammatically incorrect. We did this to improve the flow of the results section and to avoid making the manuscript excessively wordy. The quotations that were used were selected because they really captured the essence of the experiences, expression or ideas that were identified during the data analysis and showcase the theme well.

Please also note that we have included more quotations in the Results section that might better highlight the general differences that were noted in our analysis and discussion [pages 5 (lines 16-17), 6 (lines 31-32), 7 (line 16), 9 (line 26) and 10 (lines 9-10) all with bolded text]. With the addition of these quotes, every statement in the Results section is now supported by a direct quotation from the transcripts.

Please note that we had previously included a small section about differences in how men and women reacted to the initial diagnosis of diabetes because it was an interesting difference that we noted during our analysis. Based on our literature review, it may be that men felt more attacked by the new diagnosis of diabetes given strong masculine gender roles in comparison to women at the time of initial diagnosis. We chose to include it in the Results section to help illuminate some of the affective differences between men and women but did not feel as though the difference was significant enough to warrant its own independent theme in the final analysis but it rather aligned well with the first theme of self-identification and disclosure of diagnosis.

Perhaps the editor could comment as whether they feel the new quotes are helpful in the Results section.

11. Does the manuscript adhere to relevant standard for reporting and data deposition? It is okay but could be improved by adding subheadings in the Methods section such as Design, study population, data collection, data analysis, ethical considerations.

Please note that these subheadings have now been added to the Methods section (please see pages 3-5 for the Methods section and sub-headings).

12. Table 2 – Can you use % in the column of total as concerns age? Strange to have decimals when talking about age.

Please note several changes that were made to Table 1, including the average age of male and female participants. The decimal values for age were used, as it was a numerical average since there was a fairly broad distribution of ages, the average values were not round numbers, but rather decimals. In order to avoid using decimals, we have rounded the values off to the nearest whole number.

13. Figures either do not reach 100% or is above 100%!? With these small numbers I think it would be better to just give numbers and no percentages. Missing data would be better to report directly in the table.

Please note the changes made to Table 1 as we have now included the raw number of participants that answered each question, removed percentages and included a category in the table of ‘unreported’ to identify how many participants did not respond to a given question and the number of unreported participants in each category (highlighted rows in yellow).

14. Appendix 1 - Number 9 – “Summarize the general themes of the focus group and ask:” has this really been used for the interviews? Realistic interview question?

Please note that even during the individual interviews, a summary was made at the end of the interview in an attempt to recapitulate the main ideas that were discussed during the interview. We believe that this was an appropriate step to take towards the end of the interview in order to ensure that the participants had a chance to add or correct any ideas or statements that were previously brought up.

15. Are the discussion and conclusion well balanced and adequately supported by the data? Why isn't the authors discussing their findings in relation to previous studies that have been summarized in the background and on which the study is based?

We do feel like our Discussion and Conclusion statements are well-balanced and supported by the data. Our discussion focused on our findings and we used relevant literature to support and elaborate upon our findings. We did not cite the studies that were cited in the Introduction in our discussion because our study findings were different and were based on our emergent themes and our results do demonstrate new findings and differences from previously cited literature. Our goal was to provide more in depth understanding of our findings in regards to gender differences in diabetes self-management and how our results might be used to tailor gender sensitive counseling and support for men and women with diabetes.

16. I do lack a connection to Charmaz "good days and bad days.." as well as to literature by Koch et al and Hjelm et al. See further above under 1.
We are unsure as to the statement by Charmaz “good days and bad days” as we did not cite this statement in the manuscript. Please kindly clarify this for us and we will try to address that comment.

The background literature in the Introduction citing Hjelm et al. was meant to provide an understanding of the current literature and provide context for our research objectives and methodology (page 2, lines 15-16, underlined text).

17. On page 10, last sentence in paragraph 2 “Given that women appear to rely on a wider net work...”. On what is that statement built? Literature?

Please note that in our analysis, women repeatedly made references to support for their diabetes self-care activities came from multiple people in their lives. Many women talked about the important women in their lives, including sisters, female friends and daughters. These were people to whom they had disclosed their diagnosis and helped them to stay on track, including encouraging healthy foods and increasing their amount of exercise. This was in sharp contrast to men who basically reported support for adherence to diabetes self-care primarily from their spouse. Please note that we have cited an article (page 11, lines 25-27, underlined text) with provides support for our finding, and a quote has also been added (page 10, line 16-17, bolded text):

   My friends are pretty supportive...when we go out to dinner or something, they say, 'maybe we can share a dessert'...and they remind me, 'maybe you shouldn't have that or whatever'. [I,F10]

17. The conclusion is strange as it just focuses on SMBG, are there not a lot of other important differences that need to be told about? Strange focus in conclusion.

Please note that this has been removed so the Conclusion includes more general statements rather than specific recommendations. We have also included a statement in the Conclusion, which summarizes the main findings of the paper and ties in with the potential relevance of our findings (page 13, lines 29-33).

18. Are limitations of the work clearly stated?

Please note that we have included the mixed ethnic origin as one of our limitations (page 13, lines 10-15, underlined text). This is something that would be interesting to address in a future study. In terms of mixed focus group interviews and individual interviews, there are potential differences that might occur due to this sampling strategy but using difference methods can be a strength: for example, participants might mention more private problems or struggles that might not come up in a focus group, whereas focus groups allow for open discussion and interaction which builds upon discussion of meaningful experiences. Thus, we did not consider our sampling strategy a serious limitation to the paper.

19. Do the authors clearly acknowledge any work upon which they are building, both published and unpublished? Please see above under 1, 2, 5 and 6. Important is to connect the literature to the aim and to use methodological literature that is presenting the methods used/choosen.

Please note that we have cited all relevant literature that was used throughout the paper and have a complete list of references at the end of the paper. We chose to write our Discussion as more of a synthesis of our results and integrate literature that would help to explain some of our findings and illuminate gender differences within the context of self-care of diabetes.

Please clarify if there are further edits to be made or if we misinterpreted the reviewer's comment.

20. Sentence starting with "Thematic analysis was used ..." is incomplete and needs to be changed.

We are unsure as to where this sentence is being used – please clarify and we will address this incomplete sentence.

21. Please add number of respondents and their age range.

Please note that we have included the total number of participants both in the Abstract and the Results section in the previous draft. Please refer to page 1, line 4, underlined text and page 5, line 5, underlined text.

Thank you for re-considering our paper for publication. Please do not hesitate to contact us if there are any further questions or concerns.

Rebecca Mathew, MD, HBSc
Physician Resident
Department of Internal Medicine
McMaster University
Hamilton, Ontario