Author's response to reviews


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Version: 2 Date: 9 November 2010

Author's response to reviews: see over
Reviewer's report


Version: 1 Date: 7 August 2010

Reviewer: Irving Rootman

Reviewer's report:

The question posed by the authors is well defined and the methods used are appropriate and well-described. Although there are some limitations of the data which are noted by the authors, the data that are presented appear to be sound.

The manuscript adheres to relevant standards for reporting.

It is not clear from the paper, how the data will be deposed.

The data, methodology and educational materials that were developed will be tested in the Indo-Asian community (for knowledge gain). Furthermore, the methodology will be used to adapt and develop future educational materials developed by the Canadian Hypertension Education program [CHEP] and Hypertension Canada.

The discussion and conclusions are well-balanced and adequately supported by the existing data as well as the literature and the limitations of the work are clearly stated. The authors reference work that that they are building on. The title and abstract do accurately convey the findings and the writing is clear and acceptable. Moreover, the paper is a worthwhile contributions to the relatively small literature on health literacy among ethno-cultural populations and therefore merits publication.

There are however afew typos that should be corrected (e.g. p. 5, l.1 (drop "the" before Canada; p. 6,l.20, "is data" should be "are data". Also, Table 1 is not referred to in the text, andTables 2 and 3 might include percentages.

These edits have been addressed.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests
Reviewer's report


Version: 1 Date: 6 September 2010

Reviewer: Joke Haafkens

Reviewer's report:

1. Compulsory Revisions

General remarks

In many Western countries hypertension and hypertension-related complications and mortality are more prevalent among some ethnic minority than among the host population. In order to remove potential barriers to optimal care it is now generally accepted that public health agencies should provide health care messages that fit the level of health literacy and the cultural background of the target group. However, tailoring generic health information to the characteristics and the need of a specific target group is not easy and the literature provides few examples of hypertension pamphlets that are adapted to the level of health literacy of a target group. For that reason this paper addresses a relevant topic: the aim of the study was to develop a culturally tailored hypertension public education pamphlet for Indo-Canadians and to “field test” the acceptability.

In my view the most interesting and relevant part of this project for a public health audience is the first part of the study, where the authors developed and translated a standard pamphlet on hypertension for Canadians into a culturally tailored pamphlet for Indo-Canadians, using a step by step method. However, in the “results section” the authors only report the results of the second part of their study: the evaluation of the acceptability of the pamphlet after 8.5 months. This evaluation has some important weaknesses which may be understandable given
the context and the small group in which the pamphlet could be tested. In my view, the authors can improve the quality of their paper, by adding some of their relevant findings on the development of the culturally tailored pamphlet as part 1 in the results section. For example, I would like to get some information about the following questions:

How did the original generic pamphlet look like?

This section has been expanded to include more details on what the original (see pages 6 and 7 of revised manuscript).

What are the major things the researchers have adapted in this pamphlet? How does the new pamphlet look like?

More detail on the changes made to the original English pamphlet are documented in the first part of the results section on pages 11 and 12.

Some of this information is provided in the discussion section of the paper but these findings are really a result of the first part of the study. The way in which the data and the conclusions are presented in the current paper suggest that the authors conducted an evaluation study. Better designs, using control groups are needed for true evaluation studies. However, in fact, the authors developed a pamphlet in a systematic way and conducted a qualitative evaluation without a control group in the end to test how the information works. This is a legitimate approach and I think this should be reflected in the description of the outcomes.

**Major compulsory revisions**

Background: The authors provide general background information on ethnic disparities in cardiovascular morbidity and mortality between White Canadians and Indo-Canadians. The project focuses on hypertension. Are the authors able to provide data on the prevalence of hypertension and the associated
hypertension-related cardiovascular morbidity and mortality for these groups in?

If yes, please insert these data. If no, the absence of these data should be noted

in the discussion because this would be a quite surprising finding in and of itself.

This data has been included in the background section (page 4 second paragraph), “Recent studies in the Indo-Asian community of Calgary Alberta [7,8,9] have determined that nearly one quarter of adults (>45 years of age) presenting for community-based screening have diabetes, 78% have dyslipidemias and 55% hypertension. Of significance, the control rates for hypertension and dyslipidemias in those screened were 50% lower than those reported for the general Canadian population (Wilkins K, C. N. (2010). Blood pressure in Canadian adults. Statistics Canada). There is clearly a need for culturally appropriate initiatives that address the prevention and control of such modifiable risk factors.

Methods: Order of the methods used: I am bit lost in the first part, describing the methods;

It jumps from how the pamphlet was tested to how it was constructed and back;

Could the authors rearrange this part by describing which steps they took

consecutively?; First construction, then testing. This makes it easier for the reader to follow (and possibly repeat) their methods.

E.g., Only in paragraph 3 and 4 describe we get some information on how the pamphlets were constructed. This paragraph should be placed before the section where the authors describe how it was tested.

The methods and results sections have been edited to address the noted concerns: specifically, the methods section now details the sequential steps (pages 6-11), details on the original pamphlet (pages 6 and 7) and specifically what was altered in it are detailed in the results section (pages 11 and 12)

Paragraph about evaluation: Why did researchers choose for such a long period (median 8.5 months) to evaluate materials? Wouldn’t this affect recal?
Methods: Page 10 “This time between screening sessions allowed for participants to visit their physician and for changes to risk factor management and lifestyle changes to be undertaken.

Page 16, discussion: Additionally, the average 8.5 months between receiving and evaluating the materials may have affected recall and be responsible for those that did not provide a response or answered “Not sure why” to the question (Table 2), “Please tell us what part was difficult” or “Do not know what” to the question (Table 2), “What information specifically was missing?”; although participants made no mention of this being a problem.

Z and t tests: The authors say they used z and t tests to analyse quantitative data on demographics and CVD risks. I didn’t see any of such computations in the results section. You just report characteristics of your study population and percentages. This should be removed.

Z test has been removed and included at the bottom of table 1 (associated with the demographics data).

Results: Results on construction of pamphlet should be moved to results section if you want to answer the first part of your research question. (see general comments above)

As noted above all the details on the construction of the pamphlet and the detailed changes made in the adapted and translated versions of the pamphlets have been moved to the results section as suggested.

Response rate: Of the 375 people who received a pamphlet, 99 people attended a follow up meeting evaluating the pamphlet and 89 had read the pamphlet. This should be mentioned in results section.

Non response: Are you able to say something about the characteristics of the people who did not attend the meeting?

Response rate: On page 13 of the results section, the response rate and the comparison with the group that did not attend has been clarified by the following phrases. Of the 375 participants originally screened, 248 qualified for a follow-up screening (age > 45, hypertension or one other risk factor) and 100 returned for repeat screening. Ninety-nine of the 100 participants that attended follow-up sessions agreed to participate in this study. There were no significant baseline demographic, risk factor or language preference differences between
this group that returned for follow-up screening (and evaluated the materials) vs. the other 148 that qualified for recall screening but did not return for follow-up screening.

A small group had HBP; Only 45.8% (group1) and 56.7% (group2) of the patients had “HBP or related medication use”. Yet the pamphlet was about HBP. Why did people without HBP participate in testing the pamphlets? As this may effect reactions to the pamphlet the N and % of people with HBP should be mentioned in the results (paragraph 1)

On page 6 in the methods it states that the purpose of the educational materials are for awareness, prevention and management of HBP. The authors therefore feel it very important that the participants evaluating the acceptability of the materials include those whom may benefit from this advice in order to prevent the onset of HBP.

Page 16 of the discussion, “Despite this, 55/99 or 55 % not report having hypertension or related medication use and less than 10 %, reported having experienced any CVD events. This mixed group therefore represents an ideal target group for these educational materials that promote improved awareness, increased preventative measures along with management of their modifiable CVD risk factors”.

Table 1: What is your definition of high blood pressure? (diastolic and systolic). In this Table, are you referring to “self-reported” HTN of as diagnosed/reported by a health professional? What is your definition of “blood pressure above target”? Please add these definitions in notes below the Table.

Table 1: The definition of hypertension and dyslipidemia is now included below Table 1.

Table 2 and 3::I find it difficult to understand the added value of the category “understanding of hypertension” in the framework of this study. You only chose to report post-pamphlet data about the understanding of hypertension. The patients also participated in an intervention. Why do you think their understandings of hypertension would be linked to the pamphlet, and not to the intervention? Do
you also have access to any comparable data on the understanding of HBP for patients from other groups: e.g., those who received the intervention but not the, or those who did not read the pamphlet. Do you have any data by which you can illustrate that the understandings of hypertension among these groups any different? Why are the entries in Table 2 and 3 different?: For instance Table 2 does not contain an entry “which part of the pamphlet you like best?” while table 3 does. This is could also be interesting information for Table 2. Why is it lacking?

The category of “understanding of hypertension” has been removed as the authors agree that with no control group that did not receive intervention, these conclusions cannot be verified.

The entries in tables 2 and 3 are different as the objectives of the related questionnaires were different. As explained at the bottom of page 8 and top of page 9, “Additionally, the first tool (Table 2) was designed to be administered to English speaking participants who had read both the original and adapted English materials included extra questions with the objective of comparing the two versions. The second tool (Table 3) was to be administered to non-English speaking participants who had read (or had the pamphlet read to them by a family member). The final question in each tool invited general comments about the pamphlets such that participants could express concerns or comments not addressed in the questionnaires.

Discussion: Your main conclusion is: “Recall at up to one year, and understanding of the concepts of hypertension, were excellent for respondents who evaluated both English and translated versions. I don’t think you can draw this conclusion on the basis of the data you reported. I didn’t see any specific data about recall after one year. Furthermore, I am not sure if you can make the claim that people’s understanding was “excellent.” (see also Table 3) As I said before, from this data we cannot say if people’s understanding of hypertension is due to the pamphlet. You should be more modest. Yet, you do have information about how people perceived the pamphlet and which information they wanted to keep or change. My suggestion would be to limit your conclusion to these issues. They are interesting as such. You should not try to make claims about the impact of the pamphlet on behaviour change (understanding of HPB), because you did not study this.
The data and discussion comments on recall and understanding have been removed from the tables and discussion and conclusions.

Please explain: you say 99% of the CHAMP participants agreed to participate. This is difficult to understand if 375 pamphlets were distributed.

This sentence has been clarified as follows, “Ninety-nine percent of the 100 CHAMP follow-up program participants agreed to evaluate and 90% had read the educational materials, suggesting a willingness to learn and play a role in program planning.”

Please explain: why you see your respondents as “an ideal group” for evaluating a pamphlet about HBP given the fact that half of them did not have HBP.

As mentioned above, the purpose of the educational materials is not only for management of hypertension, but also for the prevention of hypertension. Therefore it was important to include individuals that had documented hypertension in addition to those at risk for hypertension.

I would suggest to put more information about the process of cultural tailoring in the results. (see above)

Much more detail on the process of cultural tailoring has now been included.

2. Discretionary revisions


The original English pamphlet was developed by the Public Education Task Force of Hypertension Canada to educate English and French Canadians, and as such this framework was not used.

Research ethics: Is a reference to ethical approval document needed?

As stated on page 11 at the end of the methods section, “This study was approved by the Conjoint Ethics Committee of the University of Calgary”.

Discussion: Limitations: You describe that some respondents may not have been able to read
or understand English well (limitation 1). How did those respondents succeed in filling out the evaluation forms and questionnaires for the ICA-CHAMP project and your own project (limitation 2). Were these questionnaires also “culturally tailored”?

As indicated in the methods section on page 10, “The evaluation tools were administered in the participants’ language of choice by trained bilingual CHAMP volunteers at follow-up CHAMP sessions…” On page 9 the following addressed the “cultural tailoring” of the questions in the questionnaires, “Each evaluation tool was assessed by a focus group composed of 5 volunteer members of the target Indo-Asian community who had read the pamphlets. The groups were instructed to review the questions in the tools to ensure that the themes of concept validity, acceptability, and comprehension in the pamphlets were clearly being assessed. Additionally, focus groups evaluated whether the questions being asked would be understood by other community members, particularly those whose preferred language was not English. Minor revisions were made accordingly.”