Author’s response to reviews

Title: Inherent illnesses and attacks: an ethnographic study of Acute Respiratory Infections (ARIs) in children in Manhica, Southern Mozambique

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Author’s response to reviews: see over
RE: MS1225844773423317

Dear Editor,

We are grateful for the opportunity to revise this manuscript.

We have made many changes which we hope will strengthen this paper, and improve its readability. We have highlighted the content changes in yellow, but have not highlighted the grammar or syntax changes.

Please find below, responses to the points made by the reviewers.

We look forward to the response from you.

Yours faithfully,

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Response to comments

1.0  Gustavo Nigenda

1.1  *It is important to strengthen the description of the social context of the population under study as well as the options that the population have to search for medical care particularly the supply of traditional medicine. It is not clear in the paper if all the population in the locality uses hospital services or only those under study. It would be good to know whether the findings of the study are also applicable in the rest of the population.*

The background and settings section of the paper has been expanded to include:

- description of admissions and deaths caused by malaria and pneumonia in the study population (p.3)
- current policy and management (p.4)
- increased detail about the DSS (p.6)
- comment on how representative Manhiça is to Mozambique and other African settings (p.6)
- Use of the hospital (p.6)
- Use of traditional healers and religious leaders (p.7)

1.2.  *Based on the previous point, the article deserves a theoretical framework referring to the use of language (and its interpretation) as an expression of particular ways of understanding life, health and disease and the interaction with health providers in local communities. This is important for the interpretation of data.*

We have used a grounded theory approach to develop our description of local interpretations of illness. More explanation is now provided in the paper (p.9)

1.3.  *Provide more explanation about the reasons to select the four localities that were chosen.*

Study setting section expanded (p.7)

1.4.  *Authors should explain broader how the information from different sources was systematized and analyzed and how the contrasting (triangulation?) of information was carried out.*

The methods section has been expanded (p.9)
1.5. *Authors should provide details of the translation process from local language to Portuguese to English and what type of process was carried out to guarantee that meanings from one language to the other were not modified.*

Methods section expanded to include this (p.9)

1.6. *At the beginning of the results section, information about the proportion of boys (68%) and girls (32%) in the population under study is presented but left without interpretation. Is this the proportion biased on purpose? Are more boys than girls taken to the hospital due to a cultural bias? How this is related to the understanding of Xifuva or other diseases in the community? (The theoretical framework would be useful in the interpretation of this information)*

- Description of sample has been extended (p.8)
- Comment in results section (p. 10)
- Comment in discussion (p. 23)

1.7. *The fact that nurses seem to be engaged in non-biomedical concepts is a demonstration that they are part of the community? Is this important in the provision of culturally-appropriate health services?*

This is a useful comment and we have integrated it into the discussion (p.21)

1.8. *Besides, very little is said about the implications of the findings in the production of formal biomedical services. Implications are focused particularly to, "health education programmes addressing ARIs could focus on developing understanding by adopting local concepts as well". Understanding is only one stage in this process, the other one is acting according to populations’ expectations but also being able to provide effective care. There is no reference to other issues that are important to the provision of services. For example, there are several experiences that have tried to integrate biomedical and community knowledge and practices with different degrees of success. According to authors, is this issue relevant in the community where the study was carried out?*

We think this is an important point to take on board which we had not considered in this paper. We have included in the discussion (p. 22):

“Similarly, explicitly incorporating local concepts and language into hospital care could help to promote the hospital as a source of care for all xifuva attacks, not just severe ones.”
2.0. Gretel H. Pelto

2.1. *It would be good to have information on number of refusals, but this is not essential. Why the gender difference in the sample? It would be useful if the authors offered some comment, even if it is speculative, about why there are more males and than females. Is this differential care-seeking?*

See point 1.6

2.2. *The explanation (p. 17) for why the respondents could not identify the illness (based on the symptoms presented by the investigators) is thoughtful and insightful. It illustrates another point that the authors could also make: namely that what investigators think they are asking (which may seem very straightforward) is often interpreted differently than the investigators intend. In this case, the distinction made by the respondents between an attack (with specific symptoms) and an underlying illness not only explains the respondents’ difficulty in answering, but also shows that they interpreted the question differently than the investigators intended because the investigators actually wanted to understand the illness concepts and thought they were asking about these.*

We have further expanded this point (p.17/18)

“This also highlighted that as researchers with a biomedical or scientific perspective, the questions we thought we were asking did not fit into the local schema of health understandings.”

2.3. *There are some small problems with English grammar and choice of words that should be cleared up before publication.*

We have edited the paper, made style corrections and tightened the flow, so the paper now reads better.

2.4. *The following statement is not clear and should be rewritten: “As well as health status not being so clearly categorised into an either/or opposition,...” Similarly, the meaning of the following statement is obscure: “Whist distinctions are useful to explore differences, the dependence of determined binary opposites would have been limiting. “ In trying to avoid jargon the writers seem to fall into the trap of using jargon. Most readers will have great difficulty understanding the point that is being alluded to, and the vast majority won’t care or find this persuasive.*

We agree that the point made was not clear or interesting and have re-written this section of the discussion (p. 21):
2.5. The discussion section contains some redundancies with the section describing the results. The paper could be “tightened up” by saving some of the points that are made in the results for the discussion. Some readers would, undoubtedly, prefer a tighter presentation. However, this is a matter of judgment.

We have edited the paper, particularly the discussion, to avoid repetition.

3.0. Lenore Manderson

3.1. Context. While the authors note that the research was conducted in a rural area near Maputo, the epidemiological and policy context is not explained, and consequently the significance of the study is unclear. It is noted that malaria and pneumonia are leading causes of mortality and morbidity in children under five years old, and that there is confusion between the two conditions, we need to know (approximately) how many cases and deaths occur annually in this age group, how important the confusion of symptoms are to outcome, whether confusion affects home-based care, whether confusion affects timely help-seeking advice, whether health workers share the same confusion. We do not know what policy has been implemented locally, what kind of health education/MCH outreach occurs to improve early diagnosis, care and emergency treatment, nor do we know anything of variation in access to care and treatment.

See point 1.1

3.2. I assume that ARI and malaria are leading causes of morbidity and mortality in the country as a whole – is this true for the DSS site as well?

See point 1.1

3.3. Are there specific interventions in the DSS for these conditions?

See point 1.1

3.4. How often does the DSS conduct a population census, and how has child illness changed over time? (When was the DSS established?)
- It is not possible to quantify how child illness has changed since the DSS was established but the impact of trials and surveillance in the area is now discussed
- Paper states that the DSS was established in 1996 (p.6) and now also states

“The DSS has established a permanent population census, updated on a biannual basis”

3.5. *The methods section as currently written could be tightened considerably – with less detail about specific methods (since all are available in the FES manual) – but we need more information about who collected the data, how many ‘community members’ were interviewed as well as caretakers, age of caretakers and breakdown of biological/social mothers and others. How many of all children in the clinical sample died? How many of them who died were cared for by others? Did they die from ARI, or malaria, or another cause? How many community members (30??), and how many doctors and nurses were interviewed. How were data managed and analysed – bit more detail than provided in the current paper.*

- See point 1.5 and 1.4
- Details of the specific methods have been removed
- Table one includes the breakdown of the study tools used and the number of participants for each tool.
- Text inserted to results section (p. 9):

  “In total, 57 caretakers of children under five participated in this study *(27 interviewed at the hospital, and 30 interviewed in a community setting)*”

- Age of mother was not collected so it not included in this paper.
- More information about cause of death of children that died has been included (p. 10)

“An estimated 10% of all children recruited to the clinical study died. Among the 27 children in this social study that were admitted to hospital, there was one death during the clinical study period and one delayed study-related death (the child was well on discharge from the clinical study but died 18 days later).” The first death was due to sepsis, caused by acute diarrhoea and accompanied by severe respiratory symptoms. The second child died from AIDS related problems according to the verbal autopsy. Both children were cared by their mothers.”
3.6. Why is there such a difference in boys and girls? Does this reflect a gender preference (i.e. boys are more likely to receive medical treatment?) or population level differences (DSS data will answer this, but the ratio is dramatic)? What happens to children at home? If mothers/others recognise chest-indrawing, how do they explain this? Is there a term? Or have they learnt this from health workers? The authors argue that health promotion addressing ARIs in children could draw upon this concept and terminology of xifuva – in what ways?

- See point 1.6
- We were unable to determine recognition of chest in-drawing though this is part of the FES techniques. Limitations of the FES techniques are already discussed and now include (p. 24):

“In some cases, we were unable to collect the information that we sought. For example, the use of the tools did not help us to understand how caretakers talked about or recognised chest in-drawing.”

- Regarding the point about how concepts of xifuva could be used in health promotion, the paper already argues in the discussion, conclusion, and abstract, that health promotion messages should focus of referring to types of xifuva attacks, to stress the importance of hospital care seeking for different ‘types’ of xifuva, as well as seeking hospital care even if the caretaker has had xifuva diagnosed in her/his child.

3.7. The use of the term “inherent illness” in the abstract and throughout the paper, needs to be considered. It is not necessarily the case, it seems, that it is ‘inherent’ in the sense that is it natural or inherited at birth, but rather that it is a fundamental, underlying and untreatable condition. More work is needed to make this clearer.

We have considered a range of words but inherent (in the sense of “existing in something, esp. as a permanent or characteristic attribute” (OED, rather than “natural” or “inherited”) describes what we are trying to bring across best. Being inherent, it is also underlying, and we use this term as well. We have rewritten much of the text in order to bring out this meaning more clearly.

3.8. Page 29, the authors write “For example, Einsburg makes the distinction between “disease” (what the doctor treats) and “illness” (what the patient experiences)” – the author is Eisenberg. Also, not “medical syncretism” but “medical syncretism.” There are also irregular use of italics, capitalisation and quotes for local terms (Mavabyi ya Wheti (illness of the moon), xifuva, etc., even in the same sentence. Syntax and grammar need attention, and the abstract especially needs to be better written. The limitations section is less important than a strong conclusion of the value of the paper. I suggest that the authors explain
more clearly how understanding xifuva as a permanent illness with attacks might affect the management of illnesses with respiratory distress in children, and how this might influence morbidity and mortality.

- We have made the grammatical changes suggested and re-edited the paper.
  We have edited the abstract.
- We feel that the limitations section is important to the paper, but have strengthened the purpose and conclusion of the paper so that it is clearer that understanding xifuva within the local context, has important implications for the mortality and morbidity of pneumonia in children. (p.25):

  “In the case of respiratory infections, this conception of sickness can lead to poor clinical management if it results in hospital care not being promptly sought. This could ultimately lead to avoidable morbidity and mortality among young children”

4.0 Editorial Requests

4.1 Please ensure that your revised manuscript conforms to the journal style (http://www.biomedcentral.com/info/ifora/medicine_journals). It is important that your files are correctly formatted. Specifically, we ask you to restructure your abstract so that it adheres to the format described at http://www.biomedcentral.com/bmcpublichealth/ifora/#abstract

The abstract now conforms to the BMC format.

4.2 We recommend that you copyedit the paper to improve the style of written English. If this is not possible, you may need to use a professional copyediting service. Examples are those provided by the Manuscript Presentation Service (www.biomedes.co.uk), International Science Editing (http://www.internationalscienceediting.com/) and English Manager Science Editing (http://www.sciencemanager.com/). BioMed Central has no first-hand experience of these companies and can take no responsibility for the quality of their service.

We have copyedited the paper and hope that the style of language is sufficiently improved. Content changes are highlighted in yellow. We have not highlighted grammar, syntax or other editing changes.

4.3 Please ensure your manuscript adheres to the guidelines laid out in our checklist for reporting qualitative research, found here: http://www.biomedcentral.com/info/ifora/rats
We have checked the paper against the guidelines and feel that the points listed in the checklist are all now included in the paper as appropriate.