Author's response to reviews

Title: Perspectives on child diarrhoea management and health service use among ethnic minority caregivers in Vietnam

Authors:

Thilde Rheinländer (thtr@sund.ku.dk)
Helle Samuelsen (h.samuelsen@anthro.ku.dk)
Anders Dalsgaard (ad@life.ku.dk)
Flemming Konradsen (flko@sund.ku.dk)

Version: 3 Date: 1 July 2011

Author's response to reviews: see over
Letter to Editor of BMC Public Health

We hereby resubmit a revised version of the manuscript now entitled ‘Perspectives on child diarrhoea management and health service use among ethnic minority caregivers in Vietnam’ (new title) to BMC Public Health. The manuscript has been revised taking into consideration the comments provided by the three reviewers. We appreciate all comments provided by the reviewers and have carefully revised the paper to accommodate all considerations and recommendations. The reviewers’ comments are shown below and answers provided in italics. Changes made in the text are indicated with page numbers.

The focus of the paper remains on the ethnic minority caregivers and their perspectives on illness management and health services. But discussions on issues of gender roles, the private drug market and ethnic minorities’ relation to Government-run health services have been strengthened in the paper. We therefore feel that the paper adds to the overall public health debate on government health policies and minority groups’ access to and use of health services.

The revised version of the paper is submitted only to BMC Public Health with the consent of all authors.

On behalf of all authors,
Ms. Thilde Rheinländer, PhD. (Corresponding Author)
Department of International Health, Immunology and Microbiology
University of Copenhagen, Denmark

CSS, Øster Farimagsgade 5, Bld. 9
DK-1014 Copenhagen, Denmark
Phone secretary +45 35 32 76 26
Mail: thtr@sund.ku.dk
Reviewer 1: Helle Rydstrøm

Reviewer's report:

1. The paper needs to introduce more carefully the Vietnamese context in which the study was conducted. More details should be provided about the health care system, how it works, and official strategies regarding child health care.

   Additional text and references have been added to this background section, to elaborate on the health system and ethnic minorities’ use of health services (p.3 and 4)

2. A more comprehensive overview of the health care situation of ethnic minority groups in Vietnam should be provided.

   Additional text and references have been added to the background section, to elaborate on the poor health status of ethnic minority children and people living in the northern uplands of Vietnam (p. 3 and 4).

3. Similarly, more information should be offered about the socio-economic living conditions of the various ethnic groups which often differ radically from those of the Kinh (i.e. majority group).

   As proposed by the reviewer we have text and some references about this to highlight the socio-economic situation of that ethnic minorities – and children in particular (p.3 and 4)

4. Over the years, ethnic minority groups in Vietnam have been subjected to a variety of political initiatives, studies, projects, etc. In this particular study, it seems relevant to consider how political integration initiatives might have accentuated or minimized discrepancies between the minority groups, on the one hand, and the established health care system, on the other, as regards understandings of illness and treatment.

   We thank the reviewer for this observation and strongly agree with the reviewer about the importance of discussing the political environment and ethnic minorities in the Vietnamese context. The section on ‘an Asian explanatory model of disease management (p. 19-20) has therefore been revised with additional references to studies about political initiatives targeting ethnic minorities and their health seeking practices.

5. More data are needed about the ways in which a pervading neo-liberal market economy in late-socialist Vietnam facilitates a continuous flow in medical products that easily can be obtained despite the very same products elsewhere demand a prescription. As described in the paper, procuring medication at the local pharmacy is informed by household theories, fortune tellers, or local pharmacists. The paper, however, would be improved if discussing the arbitrariness of medical consumption in more detail.

   We agree that the issue of drugs, over-prescription and a very liberal drug market in Vietnam are indeed very important to discuss. The text has been expanded and the issue is now addressed in two sections of the manuscript (p. 16-17 and p. 20-21).

6. The particular socio-cultural traditions and beliefs of each of the ethnic groups studied in this paper influence how the human body, health, and illness are rendered meaningful. Products (including medication) usually are considered along the lines of “hot”/“cool” or “sour”/“sweet” (as also mentioned in the interviews) in accordance with which people would attempt to maintain a certain balance in their own body as well as in the body of their children. The paper thus should highlight the ways in which local cosmologies translate into ideas about body, health, and treatment in respect to diarrhoea in children.

   As stressed by the reviewer, the results of the study are exactly highlighting a ‘local cosmology’ evolving around the concepts of hot/cold, sour/sweet and the ‘compatibility’ of drugs, foods and climate. This has
now been further stressed in the Results section (p. 14) and as part of an ‘Asian explanatory model’ of disease (p. 19).

7. Much information about gender seems to be enveloped in this study. If caregivers mainly are women, readers should know why it might be so. Only little information is provided about the gendered ways in which life is organized in the ethnic groups studied. 
*We agree with the reviewer that gender norms and the gendered ways of life is of major importance in relation to ethnic minority mothers’ and their opportunities to seek health services. The issue of gender has therefore been expanded in the Results section (p.10-11) and is also discussed in more details (p. 21).*

8. The authors acknowledge the work upon which they draw. However, more references to socio-cultural and gender specific research on Vietnam would strengthen the paper. 
*More references to studies of social and health policies targeting ethnic minorities’ have now been included in the discussion section to strengthen the discussion of local explanatory disease models versus use of government health services (p. 19).*

9. The criteria for comparing communities as different as Vietnam, Thailand, and “a variety of African countries” (p. 40) should be explained.
*The reference to African communities has been deleted. However, we feel that references to mainstream Vietnam and ethnic minority groups in similar settings (Thailand) are still of relevance (p. 19 top).*

**Reviewer 2: Mathias Altmann**

**Reviewer's report:**

**Major Compulsory Revisions**

**Qualitative vs. quantitative methodology:**
At the beginning of your results, you stated you found some differences in treatment seeking and health care choices between the most poor and remote highland communities (Dao and Xá Phó) and the richer and more centrally located communities in the lowland (Tày and Giày). You stated then that “these differences were closely related to socio-economical conditions”. However, your data do not support these affirmations as they are formulated. You could justify these differences by adding quantitative data and analyses. Moreover, it would be very interesting to add some quantitative data in the table 1, like the number of caregivers “seeking treatment at the CHS”, “kind of treatment given”, “succeed of the treatment strategy”, and socio-economic data in each groups (Highland and lowland). Otherwise, you should write these first statements with more precaution or start your results directly with the two ethnographic descriptions. Because your methodology is qualitative, you should always be careful, not to be too empirical in your statements.
*We agree with this observation and have therefore deleted the first section of results, which will start with the two ethnographic descriptions. The differences observed between the two ethnic groups (Lowland and highland) are instead addressed under the subsequent sections and phrased in more qualitative words.*

**Logistical constraints:**
One of the observed differences between highland and lowland villages is the logistical constraints to access the CHS. However, in your discussion, you do not suggest how to improve this particular issue for the highland villages. Do you think that improving cross communication skills of the staff will resolve this
particular problem? Or does the staff have to organize out-reach-visits in the highland villages, better train the VHWs?

The issue of distance and not using VHWs is now addressed in the discussion section (page 18-19). It was clear that even though VHWs were the closest health providers, they were not considered to hold any helpful competences by caregivers. Problems of distance to health services might therefore be lessened by upgrading services at community level, e.g. increasing skills and competences of VHWs in remote communities to perform effective health promotion and basic treatment.

However, the present study focused mainly on investigating the perspectives of the caregivers, while not going into details on constraints of the health system in the study area. This issue could be investigated in future studies.

Constraints at the CHS level:
In your discussion, you suggest the health system to change their approach to marginal population groups in Vietnam. You further write that “all types of health staff working in ethnically diverse populations must understand patient’s actions and perceptions of disease as expressions of their social realities (…)”. However, you did not analyse constraints at the CHS level, like the lack of doctors and the quality of care for example. You should discuss the feasibility and the impact of your recommendation in view of the other constraints at the CHS level. You should also discuss your results regarding VHWs, who are part of the system.

We agree with the reviewer that this is an important aspect of understanding delivery and use of health services in remote areas of Vietnam. However, the present study focused mainly on investigating the perspectives of the caregivers, while not going into details on constraints of the health system in the study area. This issue could be investigated in future studies (p. 21 top)

Minor Essential Revisions
Abstract Background:
I am not sure whether the term “strategies” is appropriate for caregivers (I thought it was more for institutions than for people). Perhaps is the term “behaviour” better?

We feel that the term ‘strategies’ fits the aim well of describing the complexity and rationales of caregivers when evaluating and choosing among different health care practices and systems incl. home-based, private and government services.

Abstract Results:
- The term “different medical regimes” is not clear, especially because these “strategies” are not always “medical”. Please precise if you speak about drugs, diets…it could be in brackets.

The term 'medical regimes' has been substituted with the term 'health care systems' in accordance with medical anthropological studies.

BACKGROUND:
First paragraph: Precise what do you mean with “anti-diarrhoeal drugs”? Over-the-counter drugs, not appropriate?

As suggested, the text now mentions the specific types of anti-diarrhoeals (analgescic and antipyretics).

Second paragraph:
- Please define VHWs? It is only defined later.

The text about VHWs has been merged into one section to fit the recommendation (p. 3).
- In the following sentence: ‘CHS refer to larger (...)’. Please add ‘CHS refer PATIENTS to larger inter-communal (...)’
The text has now been changed as recommended by the reviewer.

Third paragraph:
- To emphasize your objective: ‘(...) in Northern Vietnam IN ORDER TO improve health services (...)’
The text has been changed as suggested.

METHODS
Data collection:
- Why did you choose to include caregivers of children below 6 years and not below 5 years of age, as below 5 is internationally used as age groups (see the Millennium Development Goals indicators of the WHO)? You should argue your choice.
The study focused on pre-school children, with many highland children of six years and below not being enrolled in school yet.

- Rephrase: “The main informant was the adult caregiver, most often the child’s mother or grandmother and rarely the father, who had attended to the child during sickness. This sentence should be in the RESULTS section.
The sentence has been rephrased.

- Change: “During seven of the interviews (...)” by “For seven of these interviews, more than one (...).” This sentence is also a result.
The information provided in the sentence remains in ‘methods’, but the text has been rephrased to explain more clearly that several caregivers were sometimes interviewed together instead of individually, in order to make them more comfortable with the interview situation.

RESULTS
Change in the first sentence: ‘(...) comparable perceptions of diarrhoea causes (...)’ as it is formulated in the METHOD section.
The sentenced has been changed as proposed.

DISCUSSION
Economic and logistical factors when choosing health provider: In this paragraph, you summary all constraints, including economic and logistical factors, as well as cultural or social constraints, such as older family member’s permission and gender roles. Therefore, I would rename the tile of this paragraph, like “Socio-economical factors when choosing health provider”. Missed opportunities for improved health promotion and trust in health systems
The title of the sub-section has been renamed as proposed.

You should be clearer about the terms “danger signs” and “diarrhoea symptoms”. Do you mean that caregivers know the definition of diarrhoea, as you define in the method section? By danger signs, do you mean “severity” of the case? Perhaps it is better just to write that caregivers apply various treatments when they perceive their children to be sick.
The text has been rephrased to indicate that caregivers are able to estimate the severity and recognize the symptoms of the disease.

CONCLUSION
As you mentioned in your results, logistical and socio-structural constraints, including distance to the CHS and financial constraints of caregivers, may also be important limitations in seeking health care at the CHS.
We agree with the reviewer and have added text on distance to services, gendered norms and upgrading of VHWs to the concluding section.

Reviewer 3: Nguyen Quynh Hoa

Minor Essential Revisions

RESULTS
- Participant observations were used (now page 5), but it is not clearly described which results were investigated from the observations.
  The text now specifies where these observations were used in the study (p. 8: results and p. 10: gender constraints). The two ethnographic descriptions (Table 2 and 3) as well as observations on distance, living conditions and detailed observations on gender issues are drawing on these observations.
- In some parts (e.g. page 9), the authors stated that the result was underlined by the number of interviewees (six of 19 caregivers). What do authors mean when highlight this number?
  Even though this study is not based on a representative sample of caregivers, these numbers are included to indicate whether statements and observations are mirroring common finding or rare cases.
  Also, as pointed out by Roger Sanjek (1990) making ‘the path of the ethnographer’ known to the reader is a necessary measuring stick to assess the validity of qualitative research. We therefore believe that such ‘quantifications’ of the data is important in making the data as transparent and accessible as possible for reviewers and readers.

METHODS
In this paper the authors have provided information about data collection and how they were derived. Though the authors stated that "Recordings were transcribed, cross-checked and translated ad verbatim into English by the two assistants", no guarantee that the English version conveyed exactly and fully the meaning in Vietnamese, especially in this paper there is no Vietnamese author.
This study was part of an international research project (SANIVAT) including Vietnamese as well as European researchers. The study was followed closely by Vietnamese researchers and study design, preliminary results, and the manuscript was read and commented on by the Vietnamese research group.

However, the study was conducted mainly by the first author, being a Danish researcher, assisted by two Vietnamese research assistants. The two Vietnamese research assistants both had high proficiency level of English (one being an English teacher, the other trained as a journalist) and were systematically cross-checking and discussing each other’s transcriptions in the presence of the first author. We believe that this process has ensured a solid quality of research including translation.

DISCUSSION
Page 16. The authors stated that triangulation of methods was used, but it is not clear to me how triangulation was applied in this study.
Observational and interview data was obtained from health clinics as well as households and in-depth interviews with caregivers (explained in methods p. 6). These data sources are all being referred to in the two cases (table 2 and 3) as well as throughout the results section of the paper. This has now been clarified in the introductory text on page 8. Also, triangulation was performed on data obtained from the two different settings of lowland and highland, where the main differences were found in relation to logistics and accessing health facilities, gender and poverty.