Author's response to reviews

Title: Oral Health-related Cultural Beliefs for four racial/Ethnic Groups: Assessment of the Literature

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Author's response to reviews:

To
The Editor
BMC Oral Health

Thank you for the comments from the reviewers. The manuscript has been checked for grammatical errors, typos, incorrect citations and such like, and where necessary, corrected. Responses to reviewers’ specific comments have been listed below:

H. Asuman Kiyak

1. The review presented here was not limited solely to systematic studies. As noted in the article, letters, comments, brief reports, and other publication types were included if they discussed at least one oral health belief or lay practice for a named or otherwise clearly specified group belonging to four broad population categories.

2. A rationale for including studies on homeland populations or on migrants resident outside the US was included in the text, on page 5, and again on p. 8. As noted, cultural beliefs and practices change far more slowly than the behaviors surrounding them (This can also work in reverse, so to speak. For example, there are many non-Chinese in the US who readily seek and accept acupuncture or herbal therapies yet the vast majority of these people do not know of or believe the theories behind such treatments. They are happy to find relief and do not worry about the conceptual framework explaining why or how the therapy worked). Hence, studies on (oral) beliefs in the nation of origin provide insight into underpinning ideas still important and having an influence in the new environment.

3. While it is true that many of the same ideas occur in more than one group (e.g., that primary teeth are less important than permanent dentition), the intent of the manuscript was not to compile or compare oral health beliefs and values across ethnic groups. Mere compilation of one or two ideas in isolation from all
the other beliefs and values of a particular group provides very limited insight into
the way in which oral health beliefs comprise a coherent system of ideas that
guide care-seeking behavior in that group. This article’s intent is to collate and
assess the extent of information available on cultural beliefs of four racial/ethnic
groups.

4. References have been added to the manuscript for the statement “tooth loss
is old age is commonly accepted as a norm in all four cultural groups” as
suggested and other statements as appropriate.

5. Filipinos were chosen as an ethnic group because it is one of the fastest
growing Asian ethnic minority populations in one of the largest states (California)
in the US. Unfortunately, much of the data on American Indians or Native
Americans would fail to meet the inclusion criteria for this review. As we point out
on p5. of the text, over 500 named, distinct, federally recognized tribes and
bands of American Indians exist in the US today, each with its own set of beliefs
and values. Most reviews of their health status and health beliefs, however,
simply aggregate this information and do not link it to a specific group.

6. The section on Hispanics recognizes the one study on Puerto Ricans and now
reports that information as such rather than generalizing to all Hispanics/Latinos.

7. Works by MacEntee and colleagues at UBC are not included because (a) they
were not identified by any of the PubMed search strategies we adopted, and (b)
although they discuss oral health beliefs among elderly, the abstracts do not
mention the specific ethnic minorities studied or reported.

Stella YL Kwan

1. Reasons to include articles from other countries and acknowledge that
information from other countries on cultural beliefs is important to the US
situation, the rationale to include these are presented on Page 5 and Page 8 of
the manuscript.

2. Quantitative epidemiological studies were excluded if they reported on oral
health status or disparities but did not report on the precise cultural belief(s) that
contributed to the creation or maintenance of these disparities.

3. The second paragraph on Page 8 now includes information regarding methods
employed for data synthesis and analyses.

4. Numbers in the text and figure have been checked and typographical errors
corrected.

5. The comment on numbers of studies that were not read in full derived from
Figure 1 is not well understood. We would appreciate if the reviewer could
elaborate more so that we are able to respond appropriately.

Aubrey Sheiham
1. Conclusions in the abstract have been deleted, and conclusions in the main body of the text have been rewritten.

2. The opening paragraph on page 5 has been deleted.

3. The last sentence of paragraph 2, page 5 has been deleted.

4. The first sentence of paragraph 3, page 5 has been deleted.

5. The second paragraph, page 6 has been deleted.

6. The Results section has been reorganized as suggested.

7. The first paragraph from the Discussion has been deleted.

8. The discussions on implications have been condensed and are now reported under the heading Implications for future research.

Clemencia Vargas

1. Indeed, economic status is intimately intertwined with and has a strong impact on oral health status as well as dental care-seeking practices and utilization. Especially for migrant groups, socio-economic status of the majority, along with geographic location, access to education, and social norms and expectations, has an impact on people’s exposure to new ideas and knowledge, retention of beliefs and behaviors from their homeland, and ability to change.

2. We did not intend to dismiss the idea that acculturation happens or has important effects. Rather, we point out that acculturation to a new environment happens but unevenly over time, with practices and behaviors changing long before central cultural beliefs and ideas. Thus, it is important to not assume that acculturation happens within a short time of migration, nor necessarily is it complete within a generation.

3. For the reasons stated above with respect to acculturation we disagree with the reviewer on this point. Culture is simply not a geographically-bounded phenomenon but is a characteristic of the people in a specific group. When that groups moves they do not leave their cultural ideas behind and adopt wholesale new ideas and beliefs, but rather gradually over time, shed some ideas from the homeland and adopt new ones.

4. For each group, results are presented (when discernable) for each of the five domains identified in the early part of the paper.

5. When possible, the first domain has been related to oral health although, of course, many groups they do not see oral health as distinct from systemic health but, rather present one conceptual overarching framework the encompasses both (as in TCM).

6. We agree that there are occasionally within the broader literature, some discussions of conceptual frameworks relevant to oral health. Recall, however,
that we were interested in assessing the literature in PUBMED, which is most easily accessible to clinicians without access to specialist libraries. Aguirre-Molina, Molina and Zambrana¿s (2001) book Health Issues in the Latino Community is simply not indexed by PubMed and therefore not eligible for inclusion in this systematic literature assessment.

7. Please see discussion above for Kiyak and other reviewers regarding this point.

8. The section on TCM has been modified and shortened as requested and includes TCM as it relates to dental beliefs and remedies.

9. The second paragraph on page 25 under the discussion section has been deleted.

10. A paragraph on CBPR has been included in the discussion section on Page 26.

11. The 3rd and 4th bullets have been deleted.

12. Page 8, in the methods section has been modified as requested.

13. First sentence under the African American heading has been deleted and the paragraph rephrased.

We look forward to your comments.

Sincerely,

Yogita Butani BDS, MS Jane A Weintraub DDS, MPH Judith C Barker PhD