Author's response to reviews

Title: Diabetes Care and service access among older Vietnamese with type 2 diabetes

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Author's response to reviews: see over
This paper has now been revised in the spirit of both reports. For the purposes of clarity, reviewers' comments and suggestions are in normal text, responses are in red and revisions are highlighted in bold. Changes in text are also highlighted in bold.

**Reviewer 1: Mark Harris**
This focus group study involving 15 Vietnamese participants with type 2 diabetes in Melbourne, Australia, sought to describe experiences living with diabetes and access to health care. The methods are well described and appropriate.

**Major Compulsory Revisions**
1. The introduction states that the is very limited research with this group in Australia. However a number of studies on this group are not reported, such as:

   - Swerissen et al Patient Educ & Couns 2012;
   - Rose et al Diabetic Med 2012;
   - Tran et al Asia Pac J of Pub Health 2013.

**Response**
The literature review has now been extended and research from the suggested authors has been included. A particular thank you for the early view in press references which were not otherwise difficult to locate.

**New section:**
Nonetheless, despite this high prevalence of T2DM and large numbers of Vietnamese migrants in Australia, research on diabetes in Vietnamese populations in Australia, remains limited. A small body of literature was located [1-4] and Tran et al., [3, 4], for example, investigated both the prevalence of type 2 diabetes among the Vietnamese born population in New South Wales, and the impact of acculturation on type 2 diabetes rates. Similar to international studies, these authors found much higher rates of T2DM in the Vietnamese born population compared to the Australian born population (14.7% vs 7.4%) [4]. Rose and Harris [1] who conducted qualitative interviews among Vietnamese speaking participants with T2DM found that this group experienced a number of challenges with their diabetes self-management, including poor social support and minimisation of diabetes by friends and family. On the other hand, Swerisson et al., [2] who investigated the efficacy of a chronic disease self-management program, among different ethnic groups with a range of chronic diseases, found that the Vietnamese speaking participants responded well to the intervention, reporting significantly higher levels of self-efficacy and self-rated health, compared to the control group. Although there is no clear consensus in the literature, the suggestion is that that the Vietnamese encounter a number of challenges in accessing services and managing their diabetes.

2. The results presented are very descriptive. It is surprising that so few cultural factors were found in terms of their conceptualisation of health (although "health is gold" which has a specific cultural meaning in the Vietnamese culture is referred to in one of the quotes). Similarly in terms of diet (eg concepts of "hot" and "cold" foods), physical activity (including taboos) body image (especially in males). What were the arrangements for food preparation? Who decided what was available and who got first choice? The relationship with doctors could also be analysed in more depth. For example what was the continuity of relationship? What were the interactions between traditional and western medical practices especially in self-management? What were the kind of questions they would have liked to ask about referrals? Why did they not ask? Was there enough time to talk
Response
The purpose of this exploratory study was to gain some understanding of the experiences and concerns of different ethnic groups, including Vietnamese groups, attending community health services for their diabetes type 2 care. The focus groups were exploratory in nature and questions were generic (see box 1 below). Focus groups were conducted over an hour and there was little time to follow up on interesting and emerging questions. It is clear from the findings that much more work needs to be done in this area. As a result, we are recommending future in-depth interviewing of this group, with an emphasis on many of the questions outlined above by reviewer 1.

<table>
<thead>
<tr>
<th>Category</th>
<th>Questions for focus groups</th>
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| **Meanings, beliefs, personal values** | 1. What does feeling healthy mean? Why?  
2. How has diabetes affected your health?  
3. How has it impacted on your day-to-day life?  
4. What made you take action in managing your diabetes?  
5. What is most difficult about managing your diabetes? |
| **Access to information and services** | 1. Who do you currently see/go to for your diabetes care?  
2. What are your expectations of health service providers/GP/person providing you with diabetes care? Are you happy with the service/care you receive? Why? Why not?  
3. How did you or do you find out about services and information about diabetes?  
4. Do you need more information? On what topics?  
5. Whose job is it to inform the patient about all the service options (for multidisciplinary holistic care) which may be available to them? GP? Practice Nurse? Diabetes Educator? Specialist?  
6. Do you have difficulties accessing your local diabetes services? Why? What would help you access those services?  
7. Would you like to receive information in your own language?  
8. Have you ever been offered information in your own language? If so, types of information offered and from where? |
| **Feedback and suggestions** | 1. What advice would you give someone who has type 2 diabetes?  
2. Some people are reluctant to access services. What do you think would assist these people to access diabetes care? |

3. The discussion identifies a number of the issues emerging from the findings and relates these to the literature well. However there were a number of questions left unanswered. For example why, when they were so interested in their health, was their diabetes control so poor?

Response
I am a bit puzzled by this comment, as there was no real indication in the study that participants’ diabetes control was very poor and no information was gathered about current health status. I think the perception might relate to the dramatic way in which participants explained the impact of diabetes on their lives, and I have tried to tone this down a bit.

4. Were there negative implications of their concern about complications?

Response
Again, the data doesn’t support this possibility, though we plan a follow up study to address these many unanswered questions.

5. In research in London, Greenhalgh and others have found patients became fatalistic and exhibited denial in the face a fear of amputation.
Response
Thank you for this reference. I have read some of Greenhalgh’s interesting work with Bangladeshi populations in London, and I think there are very possibly parallels in the Vietnamese populations.

6. In relation to patients expectations about access and information was there enough time in the consultations for this?

Response
As above, there wasn’t the flexibility in the focus group questions to pursue an independent line of enquiry, although that would have been interesting. Additionally, this study was funded by the health service, as an evaluation exercise primarily. As such, it was driven by the health services questions which were developed at a community level with input from primary care health professionals and consumer groups. My personal opinion is that there were too many questions and this factor impacted on the time available for discussion. This point has now been included as a limitation.

Reviewer 2 Comments to the authors

This research study is very worthwhile. It potentially contributes to the body of knowledge about patients perceptions towards personal experiences of living with type 2 diabetes (diabetes), diabetes self-management and provides implications for quality of diabetes care in Vietnamese Australians. However, there are a number of major concerns in relation to cohesion and interpretation of data that I suggest the authors to attend.

1. Overall aim
It is unclear whether the overall aim of the study is to explore difficulties in accessing health services or to explore patients perceptions about self-control of diabetes. The abstract and discussion (page 9, last para) appear to address the former but the stated aim (page 3, last para) and presented data are in line with the later. Access to health services and self-control of diabetes are two different constructs.

Response
As in 2 (reviewer 1) above, the purpose of this study was to gain some understanding of the experiences and concerns of different ethnic groups, including Vietnamese groups, attending community health services for their diabetes type 2 care. The focus groups were exploratory in nature and questions were generic and split over a number of domains, including experience of T2DM and access to care. See box 1 above
I understand the reviewer’s point and in a larger study it would be possible to separate these different constructs. In this case however, I feel they can be dealt with in one publication, as the two constructs overlap and the nature of the data is exploratory.

2. Abstract:
- The aim stated in the background “difficulties Vietnamese patients experience when accessing care for their type 2 diabetes mellitus ……” is not consistent with presented results “…..together provide some insight into the experiences of living with diabetes and accessing ongoing care and support….”, reflecting the lack of cohesion.

Response
I have aimed to clarify the study aim as:
The aim of this project was to gain a deeper understanding of the difficulties Vietnamese patients experience when accessing services and managing their type 2 diabetes mellitus, and to identify factors that are important in promoting health service use.

- The Conclusions: some parts of the conclusions would fit the result section better, for
example ‘a fear of medication complications”, being treated with respect, having their questions answered and having access to interpreters and information in Vietnamese.

Response
These concepts were explored in the final theme of the results section, as below. I have now added a comment about interpreters, which was not included in the original entry.

**Improving services and information access**
In the final theme, issues of services and information access are explored. Participants attended a number of healthcare professionals for their diabetes care, including family doctors, medical specialists, diabetes educators, podiatrists, ophthalmologists and dieticians. For the most part, participants were satisfied with the care and information they received. Some suggestions were nonetheless offered for improvement and are included in the three elements of this theme: (1) a desire to be treated with respect; (2) availability of interpreters and information in their own language; and (3) a request for reminders, prior to appointments and important tests.

3. Background
- Page 3, line 2: should insert year ...the total burden of disease in year?
  **Response**
  Although the publication is 2008, the total burden of disease refers to year 2003 and this figure is now included in the text.

4. - Page 3, the sentence “This form of diabetes, which mostly affects older adults, and is linked to obesity and sedentary lifestyle, is also strongly associated with a number of serious health complications, such as: heart disease; stroke; chronic kidney disease; peripheral nerve damage, micro and macro vascular changes; and visual impairment [1]. “ is too long and complicated. Also the listed complications are consequences of micro and macro vascular changes in people with diabetes.
  **Response**
  This sentence has now been changed to:
  
  This form of diabetes, which mostly affects older adults is linked to obesity and sedentary lifestyle. It is also strongly associated with a number of serious health complications, which occur as a result of micro and macro vascular changes.

5.- Page 3, 1st para: . It is unclear what is meant by ‘set to continue’, prevalence or underestimation of prevalence?.
  **Response**
  For the sake of clarity, this sentence has now been changed to:
  
  Rates in Australia have more than doubled during this period [5] and evidence suggests that this prevalence is underestimated at the same time as rates of T2DM continue to rise [6, 7].

6. - Page 3, second para: It is inaccurate to say migration is a risk factor of T2DM. Ethnicity is a risk factor. Also, people in the Middle East and Southern Europe have high prevalence of T2DM. It might be misleading to mention only Asian countries.
  **Response**
  This sentence has been amended as per the reviewer’s suggestion:
  
  Risk factors for T2DM include obesity, sedentary lifestyle and poor diet, and **ethnicity** from world areas of high diabetes prevalence, such as: South East Asia (principally Vietnam and
Philippines); the Middle East [8]; South Europe [9] and South Asia (Indian subcontinent) [10].

7. - Percentages of Vietnam-born populations should be given throughout.

Response: The following information has now been included in the manuscript:

- The extent of this increased prevalence is evident in a recent study conducted by Ta et al., (2010), in Ho Chi Minh city, Vietnam, where rates of T2DM were found to be 10.8% of men and 11.7% of women, compared to approximately 7% in Australian populations [6].
- Similar to international studies, these authors found much higher rates of T2DM in the Vietnamese born population compared to the Australian born population (14.7% vs 7.4%) [4].
- and in 2011, the number of Vietnamese born in Australia was 180,000 [11].

8. - Suggest to insert economically to read “most socially economically disadvantaged suburbs”

Response
This change has been made

9. - It is unclear by “Our project is different from earlier initiatives”. earlier initiatives should be further explained.

Response
This section has been expanded as below:

Our project is different from earlier studies as it sought out and specifically recruited elderly migrant health consumers with limited English skills. These groups are underrepresented in research [12-15], and reasons for this underrepresentation includes: an unwillingness on the part of would be participants, due to language difficulties, a lack of knowledge about research studies /consent processes and a lack of understanding about health promotion[15]. Difficulties reported by researchers include difficulties of access to minority communities and high attrition rates from research projects [16]. At the same time as being underrepresented in research, these groups suffer disproportionate rates of diabetes complications

10.- Further strengthened rationales of the study would be beneficial.

Response
I was not sure exactly what was required here. I have aimed to strengthen the literature review based on earlier comments and to strengthen the aims of the study as above (2, 3)

4. Methods
- Unfortunately I can’t locate the Box 1 and Table 1.

Response
I have reloaded these to the website

- Some data about how many patients were approached would be good.

Response
A total of 30 patients were approached. This information is now included in text.

- Was any qualitative analytic software used?

Response
No software was used. Transcripts were analysed by hand in the following manner:
Data was transcribed and processed using the following steps, commonly used in thematic analysis:

- Familiarisation with the transcripts. This was achieved through reading and re-reading the transcripts until researchers were confident that they were familiar with the content
- Seeking out common concepts, ideas and perceptions
- Classification of concepts into units of meanings
- Ensuring reliability of analysis. Co-researchers independently reviewed the data and drew up lists of concepts and ideas
- Meeting of co-researchers and discussion on themes until agreement was met
- Merging of categories and headings as analysis proceeded
- Returning to the data to seek alternate meanings for the emerging themes

- What is the unit of analysis?
  Response
  This term is used most often in quantitative analysis as the “who” or the “what” that is being analysed for the study [17]. Using this definition, the units of analysis in this study would be the Vietnamese population and diabetes type 2.

5. Results
- Suggest to use the term ‘duration of diabetes’ (page 5, 2nd para).
  Response
  Now re-worded as:
  **Duration of T2DM varied from more than one year (n=6) to more than 5 years (n=9).**

- Given 11/15 did not complete high school, ‘highest educational attainment’ is inappropriate
  Response
  This sentence has been rephrased as:
  **Highest educational level was high school certificate (n =2) although the majority (n=13) had not completed high school (see table 1).**

- The themes presented currently are lack of self-explanation. It is hard to understand what these themes really mean without further reading.

- Being healthy has a broad meaning, while the data presented are more about patients perception about the value of being healthy.
  Response
  This theme has been re-named- **the value of being healthy**

- The theme ‘controlling diabetes’ and ‘stay healthy’ are largely overlapping (diet). These are all about self-control/management of diabetes.
- Health information barely relates to control of diabetes in this context
- There are a few occasions that the authors discussed about ‘fear of complications’, why can’t this be a theme? In fact, this ‘fear’ would drive the behaviours of patients.
  Response
  Although the concept of fear appeared in the data it was not one of the main concepts/themes

- Data (quotes) presented don’t support well the ‘reminder’ sub-theme. In the context of chronic disease management, the term ‘reminder’ does not imply reminding through media channels.
Response
The quotes referring to media have been removed for clarity.

6. Discussion
- Page 10, 3rd para, ‘In common with other studies of Vietnamese migrants, participants in our study were also from a disadvantaged area....’ this is not the finding of the study, it is the fact that these participants living in low SES areas were recruited. Also, in this and the next paragraph, have authors considered the effects of selection bias and acculturation?

Response
This was not presented as a study finding but a point of comparison in the literature. However, for the sake of clarity, I have re-worked this section as follows:

Participants in our study were from a disadvantaged area, and similar to other studies of Vietnamese migrants, they presented with low educational backgrounds and with limited English language skills.

- It is unclear what is meant by “medical model of care” (Page 11, 3rd para) . It is Australian guidelines that multidisciplinary diabetes care is provided to people with T2DM.

Response
The following sentence has been amended for clarity:

This finding of considerable reliance on doctors is surprising, as at the same time, participants described receiving information from a number of other sources, such as diabetes educators and community centres.

- No discussion about limitations of the study.

Response
The following section on limitations has now been expanded:

There were however, some limitations to the study and the number of participants (n=15) was relatively small, as a result of difficulties accessing participants and also the cost of recruitment, conducting focus groups in Vietnamese, and use of interpreters and translating facilities. The exploratory nature of the focus groups and the pre-determined questions are other limitations, as they prohibited more in depth discussion of the experiences and concerns of participants. For the future, we would recommend that focus groups are dedicated to a single focus, such as experience of diabetes self-management or access to services.

New references:

In closing, I would like to thank both reviewers for their helpful comments, which I believe have strengthened the paper without compromising its original intent.

Many thanks

Mary Carolan-Olah