Author’s response to reviews

Title: Informing the design of a national screening and treatment programme for chronic viral hepatitis in primary care: Qualitative study of at-risk immigrant communities and healthcare professionals

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Author’s response to reviews: see over
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Dear Editor:

We are pleased to resubmit for publication the revised version of MS#1488646798136921-‘Informing the design of a national screening and treatment programme for chronic viral hepatitis in primary care: Qualitative study of at-risk immigrant communities and healthcare professionals.’

We are grateful for the opportunity to resubmit our manuscript and we thank the reviewers for providing insightful comments for its improvement. We have addressed each of these comments in turn in the following pages. Two of the reviews indicated that the paper was “an article of outstanding merit and interest in its field”. We hope that you will be satisfied with our responses and revisions.

Yours sincerely,

Lorna Sweeney (corresponding author)  
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Andrew Beharry  
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REFEREE 1

Abstract

1. Discretionary revision: Please add analysis procedure in methods section

We agree that the method of data analysis ought to be referenced in the abstract. In the resubmitted manuscript we have included the following sentence in the methods section of the abstract [lines 43-45]:

“The datasets from each phase were analysed separately using the Framework method of qualitative data analysis, and findings were used to progressively focus the research.”

Other qualitative papers published within this journal reference the specific method of qualitative data analysis used in the abstract, but do not elaborate at that point about the steps that were undertaken for the analysis.

2. Major compulsory revision: Please explain in brief “how” your output informs the intervention model, for example mentioning that a collaborative work including language and treatment support has been raised by the study as well as consideration of service capacity and efficacy/confidence.

We have rewritten the Conclusion section of our abstract (page 3, lines 57-63) to more closely reflect how the research findings can inform the development of screening/treatment programmes:

“Strategies to reduce the burden of chronic viral hepatitis in immigrant communities will need to consider how levels of understanding about hepatitis B and C within these communities, and barriers to healthcare, may affect capacity to engage with screening and treatment programmes. Services may need to work with community groups and language support services to provide information and wider encouragement for screening. Primary care services may need ongoing consultation regarding their support needs to deliver hepatitis screening and treatment programmes.”

Methods

3. Discretionary revision: It may be useful to know how many focus groups you have held for each community (this could be added in table 2), and the average number of people in focus groups.

In the revised Table 2 we have indicated how many focus groups were held per community.

In the revised text in the Methods section we have stated that we conducted:
“12 focus groups with 95 people from the target immigrant communities (groups ranged from 6 to 10 participants, with an average group size of 8 people)”

4. Discretionary revision: You mention gender specific groups, could you provide a reason for it and detail if, and how, you think this influenced the output of the discussions.

We originally decided to conduct gender-specific focus groups because we thought that any discussion of the sexual transmission of viral hepatitis that may arise within the group discussions could cause discomfort and unease for participants within mixed-gender groups. In fact we were strongly advised by the organisation for Roma communities that this would be the case for their communities. However, we were advised by the organisation for African communities that mixed-gender groups would be appropriate for the French and English-speaking members of their communities, so we organised the groups in accordance with their advice. In the revised manuscript we have explained this on page 7 (lines 155-160).

5. Discretionary revision: It would be also desirable to explain if you chose to recruit from more isolated or vulnerable groups, or if not, why? And any difficulties you had with recruitment.

One could argue that our study did make an effort to recruit from isolated groups- we organised bilingual facilitators so that participants who did not speak English could participate in the research, and we also recruited participants from the Roma communities, whose perspectives on health issues have been almost entirely absent from research in the UK to date. We recognise that we did not ask community organisations to specifically attempt to recruit participants from more vulnerable groups within the immigrant communities for the research. On page 27 of the original manuscript we acknowledged as a study limitation the potential selection bias of those who were recruited by the organisations:

“Those recruited were generally known to the organisations, thus were more likely to be people with relatively high health literacy who actively engage in community health events”.

In the revised manuscript we have also included a suggestion for future research alongside this (lines 688-694):

“Future research ought to widen data collection within each immigrant community to include the views of community members who are perhaps more isolated from health and community support services, and whose perspectives and experiences may differ from those that are represented in our focus group data. Snowball sampling could perhaps be used, where people known to organisations could be asked to inform other friends and relatives who are not linked in with services about the research”.
The support we received from community organisations in recruiting participants for this study greatly reduced potential difficulties with contacting immigrant community members. In the revised manuscript on page 6 (lines 148-153) we have provided greater detail about the recruitment process:

“Recruitment was facilitated by community health organisations, who had established trust and support within the local immigrant communities that we hoped to reach. These organisations approached community members about focus group participation and written and verbal information about the study was provided in the preferred language of participants. No difficulties with the recruitment process were reported to the research team, though we acknowledge that some sensitivities may not have been readily shared”.

6. Discretionary revision: It would be important to mention the age spread as a limitation in terms of older or younger people representation.

We acknowledge that there was a wide age range within our focus groups and we have inserted a piece in the limitations section to recognise this and make a recommendation for future research (page 29, lines 696-702):

“There was a wide age range in our focus groups. We did not stratify by age, which may have affected the findings. For example, younger Roma women contributed relatively little to group discussions, perhaps because of a cultural tendency to defer to more senior members. Our data suggested that younger people within immigrant communities were perceived to have greater access to health information and to be more open to testing for sexually transmitted infections than older ones, but may be less likely to perceive a need for screening if they feel healthy. Future research could explore these issues in greater depth using stratification by age or generation.”

7. Discretionary revision: Please provide brief information of the ethnic composition and characteristic of GP practices (of the interviewees), you mention some are involved in Asylum Seekers Health but do not specify how many and whether they are located in London or Bradford.

We have included this information on page 8 (lines 191-199) of the Methods section in the revised manuscript:

“Individual telephone interviews were conducted with six GPs (four based in London and two in Bradford) to explore experiences with hepatitis screening and treatment with patients from immigrant communities, and perceived acceptability of the ‘HepFree’ intervention in primary care. The London-based GPs worked in areas with high social disadvantage and ethnic-diversity. One was based in a practice with a large patient base from Pakistan and one worked in a practice that specifically worked with recent immigrants, asylum seekers and refugees. The two Bradford-based GPs worked in the inner city of Bradford. Both worked in
practices with a high proportion of South Asian (mostly Pakistani) patients, and one also worked in an additional practice for asylum seekers and refugees, mostly from African countries.”

8. Discretionary revision: The data provide good examples of information regarding factors that may inform the proposed intervention. The data are varied and a number of groups are analysed together, would your research have shown particular needs of the different cultures that may require careful thought?

In the original manuscript we outlined that our study focused on building a picture of knowledge and awareness of hepatitis B and C, and barriers to screening and treatment services, across community groups (page 27). We focused our study in this way because the targeted screening in the HepFree study is being offered to all at-risk communities in the same way, and any national hepatitis screening programme for immigrant communities would likely operate similarly. However, we acknowledge that there were some variations in the data between communities in this study. We did not explore these variations in depth within the scope of the current study, because there were a limited number of groups conducted per community, and because this was not a key focus of our research. To acknowledge this limitation and make a suggestion for future research we have included the following section on page 27 (lines 672-677):

“Whilst we found differences in understanding and folk models of viral hepatitis between the community groups, this study was specifically oriented to informing the design of a standardised intervention to be rolled out in a multi-ethnic community locally (and, we anticipate, nationally). Furthermore, our sample was too small to draw confident conclusions about inter-group differences. Future research targeted at particular communities could further explore culturally-specific influences on hepatitis screening behaviour”.

9. Discretionary revision: Although authors state limitations; these are not fully acknowledged as limitations; this may originate in their familiarity with quantitative research where limitation may reduce the value of a study. I encourage the authors to rephrase limitations addressing how they could be improved and how have they influenced the data, as this is an important part of a qualitative paper assessment of quality and methodological rigour.

In order to address comments 5, 6 and 8 above, and comment 2 of Referee 2, we have acknowledged or elaborated on study limitations within the revised manuscript and we have made suggestions for how future research could improve on the design of the current study and expand on the knowledge that it contributes.
On page 29 (line 704) we have also stated that a “key limitation” of the current study is that we cannot extrapolate from participants’ hypothetical responses to a screening invitation to estimate actual attendance rates.

**REFEREE 2**

1. **Minor essential revision: As the authors acknowledge in the “study limitations” section, it is not possible to ascertain to what extent the view of the participants can be generalisable to the entire target populations. For example the observed range of view on the stigma associated with chronic viral hepatitis is a case in point – this may be due to the topic itself, but is likely compounded by the fact that the size of the group and (understandably) finite number of FGDs sessions did not allow topic saturation. This fact may need reiterating in the Discussion.**

In response to comment 8 of Referee 1 above, we have acknowledged in the revised manuscript that the current study did not explore in depth the variation in the data between community groups that may be attributable to cultural differences, due to the limited number of groups per community.

2. **Minor essential revision: The GP interviews provided interesting perspectives on capacity issues in general practice which are essential for a population-level intervention, although the representativeness of the informant group may be again a relevant issue.**

In the original manuscript we have already stated on page 27 that “there is likely to have been a selection bias in the sample of general practitioners interviewed, who reported that they actively support their patients undergoing hepatitis treatment”.

We have now inserted a further piece alongside this in the revised manuscript (lines 710-718) to acknowledge:

“There were also limitations with our GP data collection. A small number of GPs were willing to be interviewed; some of those who did not participate indicated that they already had too many constraints on their time. The representativeness of our GP informant sample therefore requires consideration, thought the current study does not claim that our findings regarding the capacity issues that may affect a primary care-based intervention for chronic viral hepatitis are representative of all GP practices that may be approached to participate in delivering such an intervention. Further qualitative research at a later point in the ‘HepFree’ study with primary care practices who do participate in delivering the intervention may uncover different GP perspectives on negotiating the time and resource demands of research.”
3. **Minor essential revision:** Upon reading the paper it is unclear what the proposed intervention comprises. Reference is made on page 29 to a community-based screening and treatment program; does this entail GPs sending high risk patients a letter of invitation to screening (i.e. a “medicalised” screening model), but no reference is made to community engagement and education and/or GP support. The inclusion (or not) of such information may have a significant bearing on the responses received.

On page 5 (lines 110-113) within the Introduction of the revised manuscript we have explained that the HepFree study “involves GP practices sending screening invitation letters to their patients from at-risk immigrant communities.”

On page 7 (lines 175-177) of the original manuscript, we explained that the vignettes presented to focus group participants “were used to invite participants to respond to the hypothetical story of a gender-appropriate character from their community who had received a letter from his/her GP inviting him/her for hepatitis B and C screening” and we have now clarified that in the revised manuscript that these vignettes “reflected the design of the ‘HepFree’ study intervention”.

The HepFree study was presented to key informant, focus group and GP participants as one which involved GP practices sending hepatitis screening invitation letters to their patients from at-risk immigrant communities and that some practices would also offer treatment within the local practice to patients found who tested positive. Community engagement and/or GP support were not presented as features of the intervention.

4. **In the Results section, authors may consider replacing “confluent” data with “convergent” on line 208.**

We have made this replacement within the text.

5. **Similarly line 591 – the “affirm” may be replaced with “confirm” or “validate” or “corroborate”.**

In the text we have replaced ‘affirm’ with ‘corroborate’.

6. **Tables 1 and 2; the third row 3 refers to “mean (range) age (yrs)” – but as no range is included, is it referring to median age?**

Table 1 in the original manuscript mistakenly referred to ‘range’, but actually referred to standard deviation. We provided the standard deviation for ages in order to give the reader a sense of the spread of ages. The third row of Table 1 now refers to standard deviation.
**REFEREE 3**

1. Minor comment: Mixing hepatitis B and hepatitis C together may not appropriate for health professionals. For example, in one of the GP interview question: “What do you think about providing treatment for hepatitis at GP practices”. Given the treatments for hepatitis B and hepatitis C are so different, it may potentially bias the results.

We agree with this point and have acknowledged it as a limitation of our GP data collection on page 29 of the revised manuscript (lines 722-724):

“We also acknowledge that asking GPs about a single question covering their approach to hepatitis B and C may have reduced our potential to explore differences in their management of these two different diseases.”

2. Minor comment: The results section is too lengthy. Authors should try to develop a table similar to Table 3 to summarize their findings.

Instead of creating another table, we have expanded the first column of Table 3 to include more detail of the findings. In this way the findings of the study are summarised alongside their implications. We have introduced Table 3 as a summary of the research findings and their implications early in the Discussion, page 23 (lines 560-561).

3) Minor comment: In the discussion section, authors should spend more words on discussing the potential service and policy implications. Just mentioning in Table 3 is not enough, and it appeared too late in the text, I would suggest a sub-section to discuss about the implication and provide some recommendations.

In the revised manuscript, within the Conclusions section, we have included a sub-section (page 31, lines 750-781), ‘Implications for targeted hepatitis screening and treatment services’, which summarises the main implications of the research for services and policy.