PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Barriers and enablers to healthcare access and use among Arabic-speaking and Caucasian English-speaking patients with type 2 diabetes: a qualitative comparative study
AUTHORS	AlZubaidi, Hamzah; Mc Namara, Kevin; Marriott, Jennifer

VERSION 1 - REVIEW

REVIEWER	James Green University of Otago, New Zealand
REVIEW RETURNED	07-Jul-2015

GENERAL COMMENTS	The research presented here is solidly designed and well written, justifying its publication. However, it would benefit from some additional explanations, and potentially some re-writing. The authors have chosen to make this an explicitly comparative study, including not just the Arabic-speaking immigrants who are the focus of the study, but also a Caucasian/English-speaking group. Though the manuscript mostly avoids this, at times it strays into deficit language, where the Arab speakers are described as deviating from the “correct” behaviour of the English-speaking participants. I think the main findings from the research would be clear without the explicit comparison. However, obviously the comparison data exists, so I don’t recommend removing it, only dealing with it more carefully. This project also exists at the outer limits of what I’d consider qualitative research. Some of the limitations discussed would not be considered relevant to a qualitative project. “Data saturation” is a vague concept, but 100 participants for a qualitative study is huge. There are quantitative claims in the results. For example: “… more participants in the English speaking group than the Arabic-speaking group…” (p.10). Without more robust sampling, this type of comparison is not valid. Finally, with in excess of 40 hours of interview data and 100 participants, were there no other themes emerging, or are these to be presented separately? When considering the different treatment seeking behaviour, there is little discussion of how experience of healthcare in participants’ home countries might influence their behaviour in Australia. For example, in many Middle Eastern countries, health systems are more pluralistic, with a wider variety of treatments typically sought. Even within the realm of western biomedicine, restrictions on prescription only status are frequently not so well enforced, and so many things that in Australia would necessitate a visit to a GP can be easily bought from an untrained staff member in a shop or pharmacy. This is perhaps an example of a concrete disadvantage

	to the Anglo/English comparison group. Understanding the behaviour of the Arabic-speaking immigrant might be more illuminated with a comparison of what would occur in their country of origin. MINOR More context in the title and abstract objectives, probably including "Australia". This is not to diminish the value of the results, but enables the reader to be clearer on what they are to be reading. Focus groups are sometimes referred to as "group interviews" – keep terminology consistent. Consider spelling out abbreviations (eg EMG and HP, OHA never glossed). As cognitive scientist, Stephen Pinker, notes in his book on writing, the cognitive cost to the reader usually exceeds the saving in the text. Justify use of parallel translation rather than back-translation (p.8) A female researcher was used for female focus groups, but was one used for interviews with females? Explain why focus group size seems mismatched between ethnic groups. Expand on the some of the really interesting stuff on religion and diabetes (p.13) TYPOGRAPHICAL Abstract: "Unique barriers … have been identified" – writing what the barriers are would be much more informative Table 2 is referred to before Table 1 in the text Mention of informed consent is duplicated in Research Design and Setting and Recruitment

REVIEWER	Alexander Bischoff Département de médecine communautaire, de premier recours et des urgences Service de médecine tropicale et humanitaire Hôpitaux Universitaires de Genève
REVIEW RETURNED	20-Jul-2015

GENERAL COMMENTS	Only a few suggestions: - Since, the topic of significant othering is mentioned many times, I recommend introducing and defining it in the intro section, including refs dealing with this. - I wonder whether table 4 is really needed; I find the presentation of the results well substantiated. - p 12 unqualified community members: I find this a harsh qualifier (probably not intended by the authors) - p 13 subtheme 2b...: participants: you are referring probably to Arabic patients. Should be stated.

	- p 15: "This is the first study": I don't like as a first statement in the discussion (even if it could be true). But that's just my opinion. The recommendation about significant others is the only reason why I recommended minor revision (instead of accept).

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1 Reviewer Name James Green Institution and Country University of Otago, New Zealand	
The authors have chosen to make this an explicitly comparative study, including not just the Arabic-speaking immigrants who are the focus of the study, but also a Caucasian/English-speaking group. Though the manuscript mostly avoids this, at times it strays into deficit language, where the Arab speakers are described as deviating from the "correct" behaviour of the English-speaking participants. I think the main findings from the research would be clear without the explicit comparison. However, obviously the comparison data exists, so I don't recommend removing it, only dealing with it more carefully.	The Results section has been modified to remove negative comparisons between the two groups while still presenting the differences between the two groups' views and approaches.
This project also exists at the outer limits of what I'd consider qualitative research. Some of the limitations discussed would not be considered relevant to a qualitative project. "Data saturation" is a vague concept, but 100 participants for a qualitative study is huge. There are quantitative claims in the results. For example: "… more participants in the English speaking group than the Arabic-speaking group…" (p.10). Without more robust sampling, this type of comparison is not valid.	Results reported in this paper are part of a large data set and other findings have been reported separately in other journals. The authors considered that 'data saturation' had occurred when no new ideas were being presented. They continued to interview additional participants to ensure that this was the case. Quantitative inferences have been removed.
Finally, with in excess of 40 hours of interview data and 100 participants, were there no other themes emerging, or are these to be presented separately?	As the reviewer rightly observed with the large amount of participants there were many important themes that emerged. This paper deals with one important topic as all themes could not adequately be discussed in a single paper.
When considering the different treatment seeking behaviour, there is little discussion of how experience of healthcare in participants' home countries might influence their behaviour in Australia. For example, in many Middle Eastern countries, health systems are more pluralistic, with a wider variety of treatments typically sought.	There is some indication of the Arabic-speaking participants experiences with the healthcare system in the Middle East presented - "This notion seemed to be reinforced by experiences with primary care prior to migration to Australia. Two participants recounted negative

Even within the realm of western biomedicine, restrictions on prescription only status are frequently not so well enforced, and so many things that in Australia would necessitate a visit to a GP can be easily bought from an untrained staff member in a shop or pharmacy. This is perhaps an example of a concrete disadvantage to the Anglo/English comparison group. Understanding the behaviour of the Arabic-speaking immigrant might be more illuminated with a comparison of what would occur in their country of origin.	experiences when presenting with initial symptoms to doctors in the Middle East. Both encountered doctors who were openly critical of their presenting with issues that were deemed to be trivial". The interviews were centred on patient beliefs and experiences around the time of diagnosis and current experiences of treatment. Beyond the comments above the issue of comparing health systems did not arise further and was not a focus of our work.
More context in the title and abstract objectives, probably including "Australia". This is not to diminish the value of the results, but enables the reader to be clearer on what they are to be reading.	We have added "in Australia" in the abstract objectives as recommended. We feel the current title is adequate, given the location is clearly articulated in the 'study setting and design' section, however we are willing to change it to -"Barriers and enablers to healthcare access and use among Arabic-speaking and Caucasian English-speaking patients with type 2 diabetes in Australia: a qualitative comparative study" if the editor wishes.
Focus groups are sometimes referred to as "group interviews" – keep terminology consistent.	The term 'focus groups' has been changed to 'Group interviews' throughout the article.
Consider spelling out abbreviations (eg EMG and HP, OHA never glossed). As cognitive scientist, Stephen Pinker, notes in his book on writing, the cognitive cost to the reader usually exceeds the saving in the text.	All three abbreviations have been spelled out (eg EMG and HP, OHA) throughout the manuscript
Justify use of parallel translation rather than back-translation (p.8)	The original interviews were conducted in Arabic and translated into English by an independent, certified translation company. To ensure the rigour of the translation process, parallel translation was used to check the accuracy of this translation as thematic analysis was performed using the English translation, rather than the original Arabic. Back translation is not applicable for our data because the original data for Arabic speaking patients is Arabic, not English. Therefore we are only looking to translate the data (for analysis in English), not to back-translate to Arabic. English-language analysis was chosen so as to make outcomes more comparable to those from analysis of the English-speaking group.
A female researcher was used for female focus groups, but was one used for interviews with	Participants were given the option of an individual interview or group interview. The gender of the

females?	interviewer/facilitator was made clear to participants prior to choosing their preferred format. Those females who opted for the individual interview were assumed to be happy for this to be conducted by a male as they could otherwise have opted for a group interview.
Explain why focus group size seems mismatched between ethnic groups.	We are unclear if the reviewer is concerned here with the total number of participants overall in focus groups, or the average number of participants per individual focus groups. Hopefully the following offers adequate explanation: Responses from Arabic speaking groups were more heterogeneous and theirs was also the narrative of principal interest. This required a greater degree of investigation with larger numbers of Arabic speaking participants. It was not part of our investigation to determine why more Arabic speakers opted to attend group interviews, but it may indeed reflect some cultural preferences. Group interviews were conducted a time to suit the participants and group size was not a consideration. The two sentences may have been misleading and this has been amended to read: "A total of twenty-eight face-to-face individual semi-structured interviews (14 Arabic-speaking and 14 Caucasian) were conducted and 14 group interviews (8 Arabic-speaking and 6 Caucasian) involving the remaining 72 participants."
Expand on the some of the really interesting stuff on religion and diabetes (p.13)	We have expanded on religion and diabetes with the addition of the following on page 13 Having poor health, therefore, was appealing for some. These beliefs appeared to act as a barrier to seeking medical care. Those individuals who adopt fatalistic belief-system appeared to have a strong external locus of control and believed events in their life, including health challenges, were primarily pre-determined by Allah (God) and not necessarily from their own actions or environmental influences. They were therefore less motivated to participate in diabetes self-management.

Abstract: “Unique barriers … have been identified” – writing what the barriers are would be much more informative	“Unique” has been changed to “Four” to reflect the wording in the Principal Findings section
Table 2 is referred to before Table 1 in the text	This has been fixed. Tables are now cited, within the text, in numerical order
Mention of informed consent is duplicated in Research Design and Setting and Recruitment	The following statement has been deleted from Setting and Recruitment “Prior to study commencement, written consent was obtained from each participant.”
Reviewer: 2 Reviewer Name Alexander Bischoff Institution and Country Département de médecine communautaire, de premier recours et des urgences Service de médecine tropicale et humanitaire Hôpitaux Universitaires de Genève Avenue de Beau-Séjour 22 CH - 1211 Genève 14 Switzerland	
Since, the topic of significant othering is mentioned many times, I recommend introducing and defining it in the intro section, including refs dealing with this.	The term significant others has been expanded when first used in the results to: “significant others (identified by our participants as spouses, parents, children with carer responsibilities, close friends and, only in the case of Arabic-speaking participants, religious advisors)”. The authors feel that mechanisms and extent to which significant others influenced participant decision-making is beyond the scope of the paper.
I wonder whether table 4 is really needed; I find the presentation of the results well substantiated.	The authors would like to retain Table 4
p 12 unqualified community members: I find this a harsh qualifier (probably not intended by the authors)	This has been changed to “Lay community members” which is less harsh
p 13 subtheme 2b...: participants: you are referring probably to Arabic patients. Should be stated.	‘Arabic-speaking’ has been added prior to ‘participants’ on page 13 subtheme 2b.
p 15: "This is the first study": I don't like as a first statement in the discussion (even if it could be true). But that's just my opinion.	The first statement in the discussion has been amended and ‘to our knowledge’ has been added. Now it reads: “This is the first study, to our knowledge, that explored barriers to access and use of healthcare services among immigrant Arabic-speaking patients with T2DM.”