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Title: Healthcare providers' perspectives on challenges and opportunities for intercultural healthcare in diabetes and obesity management: a qualitative study
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Reviewer 1: Louisa Ells
Institution: Leeds Beckett University
General comments (author response in bold)

A short, well written, appropriate referenced and informative introduction is provided. My only comment is whether there would be any merit in providing further international context in terms of the impact of obesity and diabetes globally for a wider international readership?
We have added information on the impacts of diabetes and obesity globally (Introduction: paragraph 1)

And likewise, it might be helpful to be clear that the description of management context, is for Canada as this does vary globally.
We have included additional information to indicate the management context is in Canada (Introduction: paragraph 1 (lines 9 – 13); paragraph 2; and paragraph 3.)

I also wondered whether some further background context around the size of the immigrant and refugee population in Canada, and some background around the impact of current health inequalities within these populations might be helpful?
We have added some information on the immigrant context in our introduction and in the description of the study setting. (Introduction: paragraph 3; Methods: Study design and setting: paragraph 2)

Methods were clearly described and appropriate for the research questions posed. My only question is the methods were described as interpretive qualitative approach – however it looks like you followed the principles of reflexive thematic analysis described by Braun and Clarke, should that be referenced earlier to reflect this? Good to see justification for data saturation included.
A reference to Braun and Clarke was already included in our data analysis section. We have also added the Braun and Clarke reference in the study design section. (Methods: Study design and setting (references 29); Data analysis (reference 29))

Typo: p7 line 40 – supports (remove the s); p8 line25 – barrier should be barriers
Typo corrected (Results: Relationships and navigating cultural distance: paragraph 2, line 238; Pg 7: paragraph 4, line 272)

A useful and constructive discussion is provided. However, I would have really liked to have seen a section on next steps for policy, practice and research, and also some further international context would be great to see, as there is a good body of evidence around the importance of peer-to-peer health interventions which may also be applicable.
Thank you for this comment. We recognize that there are diverse interventions with varied outcomes around supporting immigrant health. In this paper, we

identified two key challenges healthcare providers face that impact intercultural care for chronic diseases, namely cultural distance and the non-medical challenges of immigrants and refugees. In the literature approaches to support healthcare providers include education programs and training and tools to enhance their cultural competence and patient-provider communication, albeit with varied outcomes in different contexts. However, within the findings of the larger research project we conducted and the literature around cultural brokering, we realise that there is a gap that cultural brokering can fill in supporting the formal healthcare system to address cultural distance and the non-medical needs of patients from immigrant and refugee backgrounds. This is what we focused on in our discussion and we have made some edits to clarify this. (Discussion: paragraph 3: lines 381–401)

p12 line 24 is a very long sentence and doesn't read well.
That line has been taken out. (Box 2. Supporting quotes for Theme 2: Relationships and navigating cultural distance: Last illustrative quote (P9))

Reviewer 2: Erica Barbazza
Institution: Department of Public and Occupational Health, University of Amsterdam
General comments (author response in bold)

Abstract - the background lacks context and could almost apply to internationally, across Canada or specific to Alberta. Suggest to specify
We have modified the background to link it to Canada. (Abstract, background)

Abstract - Interpretation: "Exploring opportunities…." Feels vague despite concrete reflections in the discussion section. I suppose this is an issue of word limit but would challenge the authors to bring concrete examples from the findings here to avoid ending on a generic statement.
We have modified the interpretation section. (Abstract, interpretation)

Introduction

Line 17 — "to help fit care" – as in align?
Sentence has been modified (Introduction, paragraph 2, line 19–21)

Line 29 – From "Understanding nuances…." Appears to merit a new paragraph as it is the start to introducing the specific focus of this study.
Because we have made other additions to the introduction, this sentence now fits well within paragraph 3. (Introduction, paragraph 3, line 40)

Methods

a) Setting and design --- there is mention this work is part of a larger project and monthly/bi-annual meetings during the project. Can a time frame for this be added?
This section has been modified (Study design and setting, paragraph 2, line 82–87)

b) -This first subsection despite, its titling, doesn't really describe the setting. It reads more as a listing of actors that were engaged with. Is it the case that the setting/sampling of providers was limited to Edmonton? Despite that some actors are provincial? Why was Edmonton selected as the setting for sampling? I imagine for

reasons related to the diversity of the population, but this should be elaborated on and clarified for a clearer understanding of what was defined as the setting.
A similar comment was expressed in the editors' comments. We have re-organized the Study Design and setting section in acknowledgement of the comments. (Study Design and Setting)

c) Participants, data collection – suggest to title as "Participants and data collection"
The two sections have been separated (Participants; Data collection)

d) -we specifically sought out healthcare providers" – a definition here or listing of the range of healthcare providers considered within scope would be helpful.
The section on participants has been updated (Participants)

e) -How was the interview guide developed? Did it draw from existing questions or was study-specific? Was it piloted? Including this as an annex could be considered.
We have provided information on how the interview guide was developed. The interview guide focused the interviewer on our areas of interest. The interpretive qualitative approach aims to capture complexities and significance in experience as perceived by the participant and therefore uses broad guiding questions to allow participants to elaborate. The interviewer then prompts further depending on the participants' narrative. The interview and analysis process is iterative and intertwined so it allowed for the interviewer to add and modify questions as needed if they were important to answering the overall questions. (Data collection, lines 129–132; Supplementary interview guide)

f) -It's clear that sampling was conducted until saturation, but was any target or minimum set-in terms of the expected number of providers? Perhaps related to the geographic representation (pending what was the setting targeted?) and/or to ensure a sufficient mix in profile of informants (e.g., to have a sample that was not exclusively physicians?).
There was no target number set as this is not consistent with the interpretivist qualitative research methodology. The focus was to give a rich, detailed and deep description of the experiences of healthcare providers in intercultural care. So we presented described the context of the types of healthcare providers who participated in the study.

g) -This data collection section appears to miss some key details on the process. E.g. When were interviews/focus groups conducted (this is in abstract but not main text it seems). How long were interviews versus focus groups? Which authors conducted these?
Similar comments were expressed in the editors' reviews. Additional information has been added in the Data collection section. (Data collection)

h) -Was there any member checking (return of findings to participants?)
No, there was not member checking. By the time we completed the data collection, COVID lockdowns were in place and given the pressure on healthcare providers, it was not feasible to get back to the participants to review study findings. However, our interdisciplinary research team, community and policy advisory groups included healthcare providers who were able to review our findings and provide feedback.

Results

a) Table 1 could be improved upon for readability. E.g., 'Gender' could be made two columns (Male; Female) and a number put in each column as it pertains to each interview/focus group (e.g. Focus group 3 currently does not offer info on how many of the 8 were male versus female, only that both were present. For tallying purposes, the number of participants column could also include '1' for each professional; and sub-total rows added for interviews and focus groups; total row added for all informants.
In line with this and other reviewer comments, Table 1 has been deleted and the information has been incorporated into the Participants section. (Participants)

b) -in the results, years of experience comes up in one of the themes. I was curious that this was not part of the sampling strategy, to have a mix of young and experienced professionals. Was that considered? If its applicable/feasible, the age (under 50 / over 50 or similar) could be added as a column to gauge if this sample was balanced.
Given that this qualitative study was in part exploratory, in that we did not know before hand the range of healthcare providers who would be available for this study, we did not use years of experience as a sampling strategy. However, we have included some information on years of experience and the impact in the 'Results' section. (Results: paragraph 1: lines 169–173; Results: Importance of and limitation in identifying and addressing root causes and barriers: paragraph 2: lines 304–307)

c) -Are the codes assigned based on the numbering of the table? E.g., Focus Group 1 in the table is 'FG1'? If so, this could be noted when the codes are introduced; or if the codes are random, that should also be made clear in the methods
Yes, the codes are assigned based on the numbering in the table which is based on the order in which the interviews and focus groups were conducted. This is clarified in the 'Data analysis' section. (Data analysis: last sentence: line 159–161)

d) -throughout the results the Boxes are not introduced in text.
We have included a sentence under results to introduce the boxes. (Results: paragraph 1: line 179)

e) -please review the formatting of direct quotes throughout, these are sometimes in italics, sometimes not in text
Correction has been made

f) -Pdf page 11 – line 47 reads "Cultural distance in this work refers to differences……" The next 4-5 lines are not really a result and actually seem more like background text that could be better suited for the introduction.
This section has been re-worded (Relationships and navigating cultural distance: Paragraph 3)

Discussion

•The reflections here are really interesting; I wondered if it may be helpful to begin line 25 "Potential solutions include continued education…" as its own paragraph that really dives into solutions available. The next section also touches on the topic of 'solutions' noting health navigators. It would be practical for readers to have these recommendations/solutions as its own paragraph, so it is easier to find. I would also challenge the authors to consider other solutions available in primary care. E.g., are we

using the increasingly digital patient records optimally? I wonder if there are untapped opportunities to really use this tool for targeted follow-up and support to the patients described in a practice panel. Is Canada using PREMs and other measures effectively to also get tailored feedback from this patient group?

Thank you for this comment. We recognize that there are diverse interventions with varied outcomes around supporting immigrant health. In this paper, we identified two key challenges healthcare providers face that impact intercultural care for chronic diseases, namely cultural distance and the non-medical challenges of immigrants and refugees. In the literature approaches to support healthcare providers include education programs and training and tools to enhance their cultural competence and patient-provider communication, albeit with varied outcomes in different contexts. Within the findings of the larger research project we conducted and the literature around cultural brokering, we realise that there is a gap that cultural brokering can fill in supporting the formal healthcare system to address cultural distance and the non-medical needs of patients from immigrant and refugee backgrounds. This is what we focused on in our discussion and we have made some edits to clarify this.

This research grant included an element of working to use patient records. This paper is part of this overall grant which included the feasibility of using EMR data, however ethnicity is not a routinely collected data element in Canada. This content is not directly related to this paper and discussion of this here is beyond the scope of our paper.

Swaleh R, McGuckin T, Myroniuk TW, Manca D, Lee K, Sharma AM, Campbell-Scherer D, Yeung RO. Using the Edmonton Obesity Staging System in the real world: a feasibility study based on cross-sectional data. CMAJ Open. 2021 Dec 7;9(4):E1141-E1148. doi: 10.9778/cmajo.20200231. PMID: 34876416; PMCID: PMC8673483. (Discussion, paragraph 3)

Limitations

Pending the response to the study setting flagging above, perhaps it is relevant to reflect on the representativeness of the sample.

As mentioned previously, we were not looking to sample for generalizability. In line with the interpretivist qualitative research methodology the focus was to give a rich, detailed and deep description of the experiences of healthcare providers in intercultural care. So we presented a description of the context and types of healthcare providers who participated in the study.