Diabetes, Metabolic Syndrome and Obesity

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LETTER

# Thoughts about "Assessment of Quality of Diabetic Care in Teaching Hospitals in Ethiopia: In Comparison to International Guidelines" [Letter]

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## Dear editor

We thank Akale et al[1] for their insightful study assessing the quality of diabetic care within Ethiopia at the Yekatit 12 Hospital Medical College, where they compared the local practices against international guidelines. We commend them for their invaluable contribution to diabetic care in Ethiopia. As medical students in the UK who have interests in public health and improving patient outcomes, this study has provided insight into the current suboptimal level of care and the prospects of future studies to implement mediums to spread awareness.

The study conducted a cross-sectional study well and directly applied established international standards, the American Diabetes Association and the International Diabetic Federation, as validation tools.[1] However, the results could have been more generalisable if they had adopted a multi-centre study, allowing an increased diverse pool of participants and resulting in a more representative population within Ethiopia as approximately over 2.5 million individuals had a diabetes diagnosis.[1] Given the study's[1] relatively small sample size (n=250), predominantly with type 2 diabetes, it may not be representative of the population of individuals in Ethiopia with diabetes. Therefore, future studies could entail a larger participant pool and implement stratified sampling to ensure that subgroups (such as type 1 vs type 2 diabetes, varying socioeconomic status, urban vs rural residence) are adequately represented. Also, adopting a longitudinal approach or extending the data collection period can provide greater insight into the progression of care quality or provide more generalisable results by mitigating factors such as seasonal variation in glycaemic control.[2]

We commend Akale et al[1] for conducting interviews to collect quantitative data. However, the interviews could create social desirability bias, as the interviewees might have altered their responses due to not wanting to be judged or felt like it was a test of what they understood about their condition.[3] Henceforth, we recommend adopting a mixed-method study – for example, using an anonymous questionnaire to collect intimate information. Furthermore, within Tables 1 and 2,[1] smaller ranges (eg age intervals) would provide more significant information, identifying more specific risk factors of variable relationships with diabetic care outcomes. Furthermore, we appreciate that comorbidities and lifestyle risk factors such as smoking or alcohol intake were recorded.[1] However, having more specific variables, such as the hypertension stages[4] or smoking pack years,[5] could be more beneficial. This data would also aid in providing increased information about the relationship between each identified risk factor and type 2 diabetes in Ethiopia.

As data was collected in 2022,[1] future research can look at current advancements in diabetic care within Ethiopia. Additionally, research can investigate the impact of targeted interventions in providing practical solutions to improve diabetic care. Overall, in hindsight, we thank Akale et al[1] for providing insight into the current level of diabetic care and, consequently, providing the rationale for the need for interventions to improve patient outcomes.

## Disclosure

The author(s) report no conflicts of interest in this communication.

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