PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Journey to vaccination: a protocol for a multinational qualitative study
AUTHORS	Wheelock, Ana; Miraldo, Marisa; Parand, Anam; Vincent, Charles; Sevdalis, Nick

VERSION 1 - REVIEW

REVIEWER	Kirsten McCaffery The University of Sydney Australia
REVIEW RETURNED	03-Dec-2013

GENERAL COMMENTS	Setting: The authors say the research is conducted in rural and urban areas but then list a series of cities (i.e. urban) - where are the rural areas? Sampling & recruitment: Participants are sourced from phone directories. Is initial selection of potential participants from directories at random? At the sentence 'For consistency, a minimum of 20 participants are recruited per country[12]' I don't understand why this reference is given. Is it meant to justify sample size? Qualitative methods: the qualitative methods need more explanation and justification. What is the epistemological and ontological position of the researchers (see Carter & Miles Qual Health Res 2009)? How does this influence the chosen methodology and method. The qualitative 'journey mapping' approach described derives from marketing / consumer research and appears not to have been applied in health previously. Can the authors give more information and justification about why this approach is appropriate. Regarding the description of coding, it is unusal for qualitative interviews to be 'double coded' unless semi quantitative content analysis is being conducted. Usually researchers will just ensure that interviews are coded by different team members who discuss the coding framework in detail and ensure they have consensus on the coding methods. It is also unusual in a research team to have only one researcher analyse the transcripts. This is often done in a group in health research with discussion about different interpretations between researchers used to resolve differences in opinion. This can be helpful to bring broader perspectives to the analysis and interpretation. Table 1: What does 'eligible chronic condition' mean? The authors say they will 'prioritise' unvaccinated participants without definite intentions for/against vaccination 'as these attitudes are representative of the majority of the non-vaccinated population.' Could the authors be more specific about this screening/ prioritising

	process - does it mean excluding anyone who does not satisfy the condition? And is there some reasoning behind this approach along the lines of people answering in the middle of the scale are more liable to change behaviour than those at the extremes? Funding: it is currently not clear where the research costs for the proposed study are being funded from. Please could the authors make this clear.

REVIEWER	Francine M Cheater Faculty of Medicine and Health, University of East Anglia'
REVIEW RETURNED	02-Dec-2013

GENERAL COMMENTS	A well written and interesting protocol for a study that is offering a reasonably novel angle on the social/psychological influences of adult vaccination decision-making. This is publishable in current from with minor adjustments. On p. 5 the issue regarding risk communication does not acknowledge the range of ways clinicians can draw on to discuss vaccination/disease risk with patients. P. 7 not really accurate to say that previous qual research has not explored individuals' context, personal circumstances and past experiences- many qual studies have done so (and well). I think the more novel aspect is relating these factors to influences on vaccination decisions over time. The issue of asking older people (where recall more likely to be poorer than in younger people) to reflect back on their decision making processes in the previous 12 months is not addressed. Even with this type of interview approach it seems likely there will still be some post-hoc rationalisation. Not sure why rural/urban criterion for sampling is not included for UK and France.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1: Francine M Cheater

A well written and interesting protocol for a study that is offering a reasonably novel angle on the social/psychological influences of adult vaccination decision-making. This is publishable in current from with minor adjustments.

On p. 5 the issue regarding risk communication does not acknowledge the range of ways clinicians can draw on to discuss vaccination/disease risk with patients.

◊ We have acknowledged the above and added an appropriate reference on p. 5 (Alaszewski A, Horlick-Jones T. How can doctors communicate information about risk more effectively? BMJ 2003;327(7417):728)

P. 7 not really accurate to say that previous qual research has not explored individuals' context, personal circumstances and past experiences- many qual studies have done so (and well). I think the more novel aspect is relating these factors to influences on vaccination decisions over time.

◊ We understand the point raised by the reviewer – we have now clarified that it is the time dimension that was largely lacking from previous studies: "A key shortcoming of these approaches is that the impact of individuals' personal circumstances and past experiences on vaccination decisions over

time is seldom explored".

The issue of asking older people (where recall more likely to be poorer than in younger people) to reflect back on their decision making processes in the previous 12 months is not addressed. Even with this type of interview approach it seems likely there will still be some post-hoc rationalisation.

◊ We agree with the reviewer with regards to broad recall limitations and residual post-hoc rationalisation and have further specified this at the end of p. 13 (we used "minimise" instead of "avoid"). Thus far, however, we have not detected significant age-related differences in participants' recall. A possible explanation is that older participants are generally retired and less overloaded by work/parental duties. We will certainly address these potential limitations when we report the actual findings of this study.

Not sure why rural/urban criterion for sampling is not included for UK and France.

◊ Due to the quality and coverage of public health services in these two countries, few people are affected by access issues associated with living in remote rural locations. We did, however, include participants living in small towns or fringe areas in the UK and France. We have included this information on p. 10-11 and as a footnote in Table 1.

Reviewer 2: Jolyn Hersch and Kirsten McCaffery

Setting: The authors say the research is conducted in rural and urban areas but then list a series of cities (i.e. urban) - where are the rural areas?

◊ We have included and updated all the regions were the data collection took place (p. 10).

Sampling & recruitment: Participants are sourced from phone directories. Is initial selection of potential participants from directories at random?

◊ Yes, potential participants were selected at random from current telephone directories. We have added this information on p. 10.

At the sentence 'For consistency, a minimum of 20 participants are recruited per country[12]' I don't understand why this reference is given. Is it meant to justify sample size?

◊ Thank you for noticing the error. The reference has been amended.

Qualitative methods: the qualitative methods need more explanation and justification. What is the epistemological and ontological position of the researchers (see Carter & Miles Qual Health Res 2009)? How does this influence the chosen methodology and method.

◊ This is a very good point. We have provided further details under Conceptual Framework (p. 6).

The qualitative 'journey mapping' approach described derives from marketing / consumer research and appears not to have been applied in health previously. Can the authors give more information and justification about why this approach is appropriate.

◊ We have provided more information and a reference on p. 7.

Regarding the description of coding, it is unusal for qualitative interviews to be 'double coded' unless semi quantitative content analysis is being conducted. Usually researchers will just ensure that

interviews are coded by different team members who discuss the coding framework in detail and ensure they have consensus on the coding methods. It is also unusual in a research team to have only one researcher analyse the transcripts. This is often done in a group in health research with discussion about different interpretations between researchers used to resolve differences in opinion. This can be helpful to bring broader perspectives to the analysis and interpretation.

◊ We agree with the reviewer. As noted in the Data analyses section “To ensure reliability of coding and interpretation all the transcripts will be analysed by one academic researcher (AW) and 50% of the transcripts will be double-coded independently by a second researcher. Differences will be resolved through dialogue until consensus is reached. Using thematic analysis, an initial categorising system will be developed based on the study objectives and the topics explored”. By “double-coded” we meant “analysed” by a second researcher. To avoid misunderstandings we have used the latter term instead.

Table 1: What does 'eligible chronic condition' mean?

◊ We have specified this in a footnote in Table 1.

The authors say they will 'prioritise' unvaccinated participants without definite intentions for/against vaccination 'as these attitudes are representative of the majority of the non-vaccinated population.' Could the authors be more specific about this screening/ prioritising process - does it mean excluding anyone who does not satisfy the condition? And is there some reasoning behind this approach along the lines of people answering in the middle of the scale are more liable to change behaviour than those at the extremes?

◊ Previous studies have found that absolute “vaccine refusers” are less than 2%. As our sample size was limited, due to the qualitative nature of the study, and included different sub-groups (Table 1), the research team agreed to prioritise participants whose attitudes toward vaccines were representative of the majority of the population (98%). Therefore, we screened out people who stated that “they will never vaccinate”. We have added a reference to further support this point and have also clarified that we are also including non-vaccinated participants who state they will definitely vaccinate, as follows: “We prioritise unvaccinated participants who state that they will either definitely or probably get vaccinated against flu or tetanus “one day” or that they will probably not get vaccinated against flu or tetanus, as these attitudes are representative of the majority of the non-vaccinated population”.

Funding: it is currently not clear where the research costs for the proposed study are being funded from. Please could the authors make this clear.

◊ Under Funding and competing interests we have specified that “The fieldwork and associated research costs are funded by Sanofi Pasteur”