Author's response to reviews

Title: Understanding Critical Health Literacy: A Concept Analysis.

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Author's response to reviews: see over
Dear Dr Kruk,

Many thanks for your consideration of our article ‘Understanding Critical Health Literacy: a concept analysis’. The feedback received has been very useful and has been considered carefully. Following this, revisions have been made throughout and responses to the comments are listed below.

Editorial Requests:
1. Authors’ qualifications have now been removed.
2. ‘Methodology’ has been changed to ‘methods’.
3. A Figure Legend Header has been added.

Response to second submission feedback.

1. The reviewer questions the style of the paper. The paper has been read and discussed further with a Professor of Statistics with a specialist interest in public health but who does not have an expert knowledge of critical health literacy. Following this, amendments to the style have been made throughout and in particular to the methods section.

2. The reviewer suggests that most of the practitioners are likely to have been exposed to Nutbeam’s work. However, while all those interviewed had an identified interest in the field of health literacy only a small minority indicated that they had read Nutbeam’s work or knew where the term originated from. Although they were familiar with the term it was not a term they used in their work or heard other colleagues using on a regular basis. It is true to say that they will have drawn meaning/invented an explanation with regard to the concept that is consistent with their field and it is these interpretations that the study is interested in capturing. As Rodgers and Knafl (2000) point out, concepts do not reflect objective facts, but reflect all the contextual forces that shape their development and variation in their use in daily life as well as in a disciplinary knowledge base. Thus to understand a concept there is a need to understand how it has come to be interpreted and synthesized in its various uses, including the different disciplines, as well as to understand how it is presented in theory.

3. The authors fully agree with the reviewer that the contexts within which a concept is used affects the attributes, antecedents and to some extent consequences that the user would prioritise:

   ‘...concepts are subject to continual change and definitions and characteristics of a concept may vary according to contexts such as time, place,'
discipline and theoretical perspective. Rodgers offers the example of the concept of
‘health’ which is understood very differently according to contexts and has in some
contexts of time, culture and discipline focused on the absence of disease while in
other contexts alludes to more positive understandings associated with well-being.’
(page 7)

It is for this reason that the Evolutionary Concept Analysis process, developed by
Rodgers, with its commitment to contextual analysis, something that most other
concept analysis techniques do not include, was chosen. In line with this the position
of the analysis has not been to see concepts as having a strict definition applicable
across contexts but rather to work from the position that
‘they do not have a strict set of attributes but rather a cluster of attributes that
are assessed in relation to their resemblance to a concept rather than because they
strictly correspond to it.’ (page 8).

The references in the Findings and Discussion section to the contextual
analysis are designed to show these very variations. Concept analyses that do not use
this evolutionary approach typically draw from literature across disciplines and
analyse it as one sample with no contextual differentiation. Concept analyses of
concepts which could be said to overlap with Critical health literacy such as
empowerment (Gibson 1991) cultural competence (Eunyoung 2004) and critical
media health literacy (Wharf Higgins and Begoray 2012); all draw on data from the
fields of public health, health promotion/education, nursing, social work, psychology
and education and conclude with lists of attributes that make no reference to
contextual variations. A sentence to clarify this has been added on page 18.

4. The UK Health Literacy Group is funded by the Department for Health
(England) and the Dept for Innovations, Universities and Skills (England) and is a
special interest group for the Society for Academic Primary Care. The group is UK
wide and consists of ‘people interested in building the evidence base for Health
Literacy and its impact on people and their lives, and in supporting national policy to
reduce inequalities.’ (http://www.healthliteracy.org.uk/about-us). Membership
primarily consists of practitioners and providers from health care providers and non-
governmental organisations, policy makers and academics. While members inevitably
have a professional interest in health literacy they are not by virtue of their
membership to the group, inevitably committed to critical health literacy. The group
was chosen as a sample point as participants needed to be familiar with ideas around
health literacy. Academics were screened out of the membership list as the academic
perspective had already been captured in the theoretical analysis. All of the remaining
practitioners and policy makers (30 practitioners and 9 policy makers) were then
contacted twice and asked to participate. All those who responded were interviewed.
Practitioner in this context refers to those working in a health context directly with
members of the public through the provision of projects or services. Policy maker
refers to those working at a strategic, planning or policy level either locally or
nationally. Statements have been added on page 9 to clarify these points.

Additional points regarding the strengths and weaknesses of the method have
been added on page 17.

5. Clarification of inclusion criteria for the colloquial sample has been added
on page 9.
6. Bringing colloquial and theoretical data together in a concept analysis is an innovative technique and there is no established guidance in research literature as to best practice in doing this. While there may be a much larger set of theoretical data, the inclusion criteria is simply that they discuss critical health literacy. While some articles do so in depth, others may dedicate only a few sentences to it. The interviews on the other hand, while small in number, discuss only the concept of critical health literacy and do so in depth – often providing a much richer data. The differences in the nature of the data sets mean that they clearly cannot be analysed as one. Conclusions have been drawn based on qualitative research principles of combining both formal inductive analysis techniques and the insight and understanding gained from interpretation rather than on a more quantitative approach of apply a numerical weighting scale system. The use of the combined data is not so much driven by an interest only in identifying commonalities but with exploring different perspectives and how they do or do not converge. It is for this reason that the contextual analysis described in the findings identifies where the differences in these perspectives lie.

While the reviewer suggests that the colloquial sample should consist of individuals who do not ascribe to the ‘health literacy agenda’, the authors felt it important that they had an identified interest in health literacy. This has been clarified on page 9. Clearly the academic authors of the theoretical data set have an interest in the area or wouldn’t have published on the topic. Therefore to ensure that the colloquial sample were equally able to converse on the area rather than to ensure they ‘ascribed to an agenda’ it was important that a common reference point demonstrating interest could be identified – membership of the UK HL group offered this.

The interviews were carried out in a systematic manner. They were semi-structured and the interview schedule was designed carefully to represent the same areas of inquiry that was used to interrogate the theoretical data. Each interview was recorded and transcribed. More detail on this has been included on page 10.

7. The reviewer suggests that the backgrounds/disciplines, experience/seniority and departments/sections of the interview participants should be presented. However, the public availability of membership of the UK Health Literacy Group from which the participants is drawn would mean that such details would compromise the anonymity guaranteed to participants. It is hoped that the additional detail given around the nature of the group (page 9) and clarification of the terms practitioner and policy maker (page 9) addresses this concern.

8. The reviewer questions whether some of the interviewees were patients. As described, all interviewees were either practitioners or policy makers. Clearly all of these are also consumers of health information and services at some points in their lives. This participant was reflecting on their own experience as such. This has been clarified in the text.

9. The reviewer requests that methodology be changed to methods. This has been done.
10. The reviewer requests that the discussion of concept analysis as a method is removed from the introduction. This has been done. As requested the Web link on p7 has been removed and references to other fields edited.

The reviewer also states that the discussion of the methods section is labored. This section has been significantly revised in order to reduce repetition with the flow diagram of the methods outlined in fig 1.

11. Weblinks have been added to relevant references as requested.

We hope that this sufficiently addresses the points raised and look forward to your response.

Yours sincerely

Susie Sykes