Reviewer’s report

Title: Ethnic minority women prefer strong recommendations to be screened for cancer

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Reviewer: Anke Woudstra

Reviewer's report:

Comments to the author:

This manuscript is well written and addresses an important issue in the context of informed decision making in cancer screening. This study is about the decision making preferences of ethnic minority women in the context of cancer screening. While it is increasingly recognized that people should be able to make an informed decision about participation in cancer screening, less is known about how invitees themselves would like to make a decision. Understanding the people's preferences might be especially important for people with lower socioeconomic status, those with lower health literacy or ethnic minority groups. This issue is under-researched and this manuscript is therefore a most welcome and interesting contribution to the international audience. However, I do have several concerns, these are explained below. I therefore recommend major revisions.

Specific issues:

Introduction

- The introduction could benefit from a more extensive elaboration on informed decision-making.

- First paragraph on informed decision making (IDM): different countries have different views on how IDM should be defined and when IDM is reached. For example, the view on IDM in the United States (focused on screening uptake) is very different from the view on IDM in the Netherlands (focused on IDM). I think that the difference in countries needs to be pointed out in order to gain a better understanding of why there is such a difference between cancer screening invitations and to explain the context in the UK, where this study was performed.

- Knowledge and attitude-uptake consistency are common constructs within IDM. However, others reported IDM is as a process including a deliberation of pros and cons. Considering the theme of this paper, it would be worthwhile to elaborate on this more broader approach of IDM.
You introduce the concept of health literacy (p 85-95). Health Literacy is generally defined beyond the ability to understand health-related information, which is specifically relevant for this paper. See for example: Sørensen K, Van den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, Brand H; (HLS-EU) Consortium Health Literacy Project European. Health literacy and public health: a systematic review and integration of definitions and models. BMC Public Health 2012;12:80.

Moreover, you mention that health literacy can be a barrier in IDM, but an explanation on how this mechanism might work is lacking. You refer to a study of Davis in 2002. In the past decade several studies have been performed on IDM and low SES/HL. The authors might find it helpful to use the following systematic reviews to gain more insight:


Fourth paragraph on strong provider recommendation (95-96): This could also mean that the information is not accessible (i.e. too difficult to understand well enough to make decisions) for all populations), including ethnic minority groups. The authors might find it helpful to use the following references:


The study is performed in the context of cervical cancer screening. I think it would be relevant for the reader to know more about the procedure of cervical cancer screening in England in the introduction (e.g. how are invitees invited? At what moment is a health care provider involved?).
Methods

- P. 4 (112): Need to clarify the selected age-range (30-60 years old). Why was this age-range selected? Is it possible to specify the 'African' background?

- What information was provided to the study population on cervix screening? How was the voluntariness of the screening presented? And what knowledge did these women already have about the screening? It is important for the reader to know, since this could be an important determinant on preferences for screening recommendation. The authors mention this in the discussion as a limitation, but it should be clearly stated in the methods as well.

- A rationale for measuring acculturation is not provided in the introduction. P.4 (131): More information is needed on the multi-lingual interviewer. Is the interviewer part of the research team? Was the interviewer trained? Was the interviewer female? Were all ethnic minority groups interviewed in their preferred language?

- P. 5 (145-147): More information is needed to describe the socio-demographic factors that are being measured.

- P.5 (Literacy and Health literacy): Just like the literacy questions, it seems that the health literacy questions were asked only to women who reported a main language other than English. If this is not the case, this needs to be specified.

- More information is needed on the reliability and validity of the two HLS-EU items. Why were these two items chosen? Were these items used in previous studies to indicate levels of health literacy? From the results it seemed that these items only measured understanding of information, while health literacy usually also refers to applying information to make health related decisions. This is not measured by these two items.

- In think that the term 'strong recommendation' should be specified more clearly. What exactly does 'strong recommendation' mean? Is this part of a shared decision making process?

Discussion

You conclude that the preference for a recommendation is not primarily driven by comprehension of health information materials. However, actual comprehension of cervix screening materials was not measured. I think it is incorrect to draw these conclusions based on the two HLS-EU items. It would be better to describe these measures as self-reported comprehension of health information materials.

Discussion:
- P. 8 (256-260): In addition to 'developing cancer communication materials and decision aids that take into account the broader cultural context in collaboration with stakeholders from ethnic minorities', tailoring of information could also improve communication. I think that the discussion needs to discuss 'tailoring' more in detail. Does a strong recommendation mean that the recommendation is tailored? How should an invitee receive a recommendation when there is no direct involvement from a health care provider? This remains a bit unclear to me. I would like to see more practice implications in the discussion.

- This study indeed has serious limitations. It raises the question what these results actually contribute to the field of decision-making? Without knowing exactly where these preferences are based on, what women's considerations are and which knowledge these women have, the conclusion that ethnic minority women prefer strong recommendations to be screened for is not valid. I would recommend to either add qualitative data or at least results from other studies to confirm the conclusion or adapt the conclusion.

**Are the methods appropriate and well described?**
If not, please specify what is required in your comments to the authors.

No

**Does the work include the necessary controls?**
If not, please specify which controls are required in your comments to the authors.

Unable to assess

**Are the conclusions drawn adequately supported by the data shown?**
If not, please explain in your comments to the authors.

No

**Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review?**
If an additional statistical review is recommended, please specify what aspects require further assessment in your comments to the editors.

I recommend additional statistical review

**Quality of written English**
Please indicate the quality of language in the manuscript:

Not suitable for publication unless extensively edited

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