Author's response to reviews

Title: Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood

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Editor,
BMC Women’s Health

Dear Editor,

Thank you for your letter of May 30, 2008, requesting revisions to our manuscript entitled: “Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood”. The reviews were invaluable in reshaping the work into a stronger manuscript, and we hope you will find our revisions and responses to the reviewers’ comments adequate.

Of note, one of the major revision requests for both Reviewer #1 and #2 involved reshaping the scales; however, as is explained in detail in the response below, the present analysis involved exploratory factor analysis, and thus the resulting scales were a product of the analysis. Therefore, moving items from one category to another would not be appropriate in this case. An alternative approach, which could also be used subsequently to test the present categories, would use factor analysis to test the hypothesized categories. As this is a completely different approach to the one used here, we have not re-done the analysis. If this does not sufficiently address the concerns of the reviewers, and you are unable to accept our manuscript, we understand. However, we felt that our approach was a legitimate one, and rather than changing this approach, we have attempted to clarify the manuscript so as not to confuse readers in the way we frame the discussion of items before and after the factor analysis. As indicated in the title and discussion, these are preliminary scales that would require further testing (such as the hypothesis driven approach mentioned above) before wide-scale use.

In response to the questions posed in your letter, this research project had IRB approval from the University of British Columbia, Behavioral Research Ethics Board. The doctors affiliated with the research were not involved in recruitment or data collection for the study, and the consent form included statements assuring the women that refusal to participate in either the survey or the STD testing would in no way impact their receipt of health care at the clinic or their participation in the women’s evening program. These facts have been detailed in the manuscript (Pages 7 and 8).

Please find our response to the reviewers’ comments detailed on the following pages.

Regards,

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Response to Comments from Reviewer #1

1. The reviewer found the question posed to be well defined.

2. Minor Essential Revisions to the methods:
   a. As per comments from all three reviewers, the program from which the sample was obtained has been more fully described.

Methods, page 6/7: “A survey was carried out among 126 women attending a weekly program exclusive to women (including transgendered individuals) held at a local community health clinic in Vancouver’s Downtown Eastside. This region is disproportionately impacted by issues including substance use, mental illness, homelessness and poverty. Compared to the rest of the province, census data from 2006 indicated higher levels of income assistance (4.1% vs. 0.6%), higher levels of low income households (23.9 % vs. 12% of families earning < $20,000 CDN), and inferior health outcomes (life expectancy at birth 75 vs 81 years)[16]. Due to the concentration of injection drug use and sex work in this high risk neighbourhood, the region also exhibits high prevalence of HIV and other STIs[19-21]. The women’s program is open to all women, and sees anywhere from 20 to 60 women in one evening (for more detailed information on the program and population, see Rusch, et al., in press [22]). The weekly, three-hour program offers women a safe place to access food and health care, as well as to socialize with other women, and take part in various activities including free haircuts, foot baths, art projects, and movie nights. There is also access to doctors and nurses, counselling services and massage therapy. The program is advertised through fliers at the clinic and other community organizations frequented by women.”

b. While the original sample included transgendered women, most of whom were male-to-female (although this was not ascertained), there were two few to allow comparisons (N=3) and these three individuals were not used in the subsequent analyses. This point has been clarified in the methods.

Methods, page 8: “While transgendered individuals were not excluded from participating in the study (N=4), they were not included in the present analysis.”
c. As noted by the reviewer, the urine screening is not particularly relevant to the present analysis, but was conducted as part of the larger study. It remains a point in the methods as a benefit to participation, but its relevance to the present analysis has been clarified.

Methods, page 8: “As part of the larger study, participants had the option of providing a urine sample for Chlamydia and gonorrhoea screening; however, this was not a requirement for taking part in the study. The clinic provided follow-up care for participants testing positive.”

d. The measurement tool is now referred to as the ‘interviewer-administered structured interview’ at its first use and as the ‘structured interview’ throughout.

Methods, page 6: “An interviewer-administered structured survey was carried out among 126 women attending a weekly program exclusive to women (including transgendered individuals) held at a local community health clinic in Vancouver’s Downtown Eastside.”

3. There appears to be a misconception in the way the scales were developed which is evident in the reviewer’s comments regarding why certain items were included in the different scales. The grouping of items in Table 1 (prior to scale development) was related to the placement in the survey, not to presupposed categories. While the original items were developed from the literature and the existing theories, the analysis was an exploratory factor analysis, allowing the scales to emerge without any pre-existing notion of how they should group together. The final scales were therefore not hypothesized and subsequently tested, they were the result of the analysis. Having said this, one would expect the resulting factors to somewhat reflect the theories from which they were drawn, but the resulting three scales were driven by the data, not by theory, nor were they forced into a particular category. A subsequent study would hopefully allow the use of these presupposed categories in a theory-driven factor analysis, whereby the theorized groups would be tested against the data; however this was not the analysis which was performed here. As both Reviewer #1 and #2 were confused by this, the methods have been expanded to ensure that this approach is apparent to the readers. In addition, to avoid confusion, the results section no longer refers to items as part of pre-existing groups during the scale development, but rather refers to each one individually.
Methods, page 8/9: “While the items were developed and selected based on the pre-existing theories and literature mentioned above, the analysis was exploratory rather than theory-driven and therefore did not presuppose any categories or groupings of the items.”

Results, page 10: “Table 2 outlines the STI-related stigma items. Items included feeling dirty, feeling violated, knowing (and conversely, not knowing) that an STI was present, being able to hide an STI from others, feeling guilty, feeling embarrassed, perceiving those with an STI as having low intelligence, bad character and specifically, bad character as judged by clinic staff. Four items incorporated concepts introduced by Nack (2000, 2002) elucidating what women perceived to be the “type of woman” who gets an STI: 1) being ‘damaged goods’, 2) being promiscuous, 3) being at fault as “women should ‘know better’” and 4) being at fault for not being “careful enough”. Lastly, four items were included to encompass discretion of clinic setting and clinic staff, concern regarding community gossip, and fear of repercussions from partner disclosure.”

Results, page 10: “Using the discrimination index, four items were flagged, including items 4 and 6 (being able to hide an STI and not knowing an STI was present), item 10 (staff discretion) and item 16 (staff morals). Using p<0.20 as the cut-point for internal consistency, another two items were initially flagged, including item 3 (knowing an STI was present) and item 17 (partner disclosure).”

The overlap of the moral and physical categories noted by Reviewer #1 was thus an outcome of the analysis and was the reason for which we renamed this category ‘internal stigma’. The reason for which ‘damaged good’ factored together with the other ‘tribal stigma’ items is not entirely clear, although one might hypothesize that this sort of permanent designation for someone with an STI may be more closely related to the sorts of lables given to women with STIs in the other ‘tribal stigma’ items, as opposed to the less permanent internal stigma items (guilt, dirty). As for the positioning of ‘bad person’ in the social stigma scale, I think this probably occurred as a result of how the item was phrased – the ‘bad person’ item was phrased in a more general way, reflecting how other people might think of a woman with an STI; however, the four items that made up the tribal stigma scale were phrased as female-specific moral statements (i.e. “Women who......). Thus the items that held together to make up the ‘social stigma’ scale were items reflecting how the women thought other people viewed someone with an STI, whereas, the items that held together to make up the ‘tribal stigma’ scale reflected how the women themselves viewed the characteristics of a woman with an STI. The reason for the difference in phrasing of ‘bad person’ as a more general statement, was because it was felt to be less specific to the female moral character as the other items. The results now reflect these insights in order to help clarify the resulting factors.

Results, page 11: “The remaining 14-items factored together in three final scales – female sexual stigma, social stigma and internal stigma – shown in Table 2. The four items that factored
together in the first scale were derived from the work by Nack[3,6], surrounding the ‘tribes of womanhood’ and included moral judgement statements typically imposed on women as opposed to men, resulting in the name ‘female sexual stigma’. All the items that factored together in the second scale referred to how the participants felt others perceived someone with an STI, prompting the name ‘social stigma’. Finally, both moral and physical stigma items factored together in the third scale; however, in examining the wording of these items, all four were directed at how participants would feel about themselves if they were diagnosed with an STI, thus prompting the name ‘internal stigma’.

The reviewer does point out that two of the items may be measuring feelings regarding this particular medical facility, rather than stigma perceptions in general. The factor analysis was re-run, eliminating these two items. The results were similar to those presented here, with three main factors emerging, the only difference being the absence of the aforementioned items in the ‘social stigma’ scale. However, a second possible outcome, removing these two items from the analysis has been added as a footnote in Table 2, and the potential reasons for inclusion or removal of these items are stated in the results.

Results, page 12: “It is possible that two of the items (items #9 and #10) addressing women’s perceptions of staff and clinic discretion may be measuring characteristics of this particular clinic, rather than of women’s general perceptions, and may not be warranted in a stigma scale for wider use. Thus, an alternative analysis was run eliminating these items. The results were identical, with the exception of the social stigma scale, which now consisted of only four items and had a Cronbach’s alpha score of 0.647.”

4. The reviewer did not have any comments regarding relevant standards for reporting and data deposition.

5. The reviewer had no comments regarding the discussion and conclusions.

6. Limitations:
   a. The limitations have been clarified to indicate to what population of women we are referring.
Discussion, page 16: “Second, the sample was a convenience sample of women already connected with community services – therefore, we cannot generalize findings to the broader community of women in this area who may not be accessing services in any capacity.”

b. As indicated in the covering letter, the role of the investigators has been clarified to assure readers of the absence of coercion and the truly voluntary nature of participation in the survey.

Methods, page 8: “Regular clinic staff and doctors were not actively involved in the recruitment or interviewing, and the consent included a statement reassuring participants that if they chose not to participate, there would be no consequences to their involvement with the clinic or the women’s night program, nor their normal receipt of care at the clinic.”

7. See response to point #9 below.

8. Title and abstract:

a. The term ‘high risk neighbourhood has been defined in the methods.

Methods, page 6/7: “This region is disproportionately impacted by issues including substance use, mental illness, homelessness and poverty. Compared to the rest of the province, census data from 2006 indicated higher levels of income assistance (4.1% vs. 0.6%), higher levels of low income households (23.9% vs. 12% of families earning < $20,000 CDN), and inferior health outcomes (life expectancy at birth 75 vs 81 years)[18]. Due to the concentration of injection drug use and sex work in this high risk neighbourhood, the region also exhibits high prevalence of HIV and other STIs[19-21].”

b. The terms ‘moral scale’ and ‘sexual stigma’ have been cut from the abstract. The sentence has been re-worded to clarify the thought.
Abstract, page 2: “In many societies, women tend to be judged more harshly with respect to sexual morals, and would therefore have a different experience of stigma related to sexual behaviours as compared to men.”

c. The population sampled has been clarified in the abstract, taking out the reference to the specific geographical area, although the more lengthy description of the region remains in the methods (see above point #2).

Abstract, page 2: “Women attending a social evening program at a local community health clinic in a low-income neighbourhood with high prevalence of substance use were passively recruited to take part in a cross-sectional structured interview, including questions on sexual behaviour, sexual health and STI-related stigma.”

9. Writing:

a. Page 2: Sexually transmitted infections has been written out at first use.

b. Page 4: Citation to Nack 2002 has been added.

c. Page 5: Citation to Nack 2000 has been changed to Nack 2002.

d. Page 5: The terms discredited and discreditable were defined and cited on page 4.

Introduction, page 4: “In addition, for any one individual, STIs could also blur the boundaries of the discredited – one who is overtly stigmatized – and the discreditable – one who may be able to conceal their stigmatizing feature – depending on the nature of social interaction at any particular time [1,3].”

e. Page 5: The citation for Lichtenstein (2003) is now present.

Introduction, page 5/6: “A similar study in the southern U.S. outlined four important concepts of stigma that surfaced from qualitative focus groups, including religious ideation
of health care workers affecting their views of ‘promiscuous’ women, privacy fears among men, racial attitudes and stigma transference or fear of being labelled [11].”

f. Page 11: As none of the authors are familiar with this literature, I don’t feel I have the time to properly add a well-written, brief discussion on this point. While I have found some references, I feel I am ill-informed and would not do this point justice at present. If desired, this point could be addressed with more time for revision.

g. Reference has been made to several papers on the historical targeting of women of color as the ‘vectors and vessels’ of sexual disease in the final paragraph of the discussion, including Davidson (1994), Luker (1998) and Mahood (1990).

Discussion, page 15: “Given that minority women have historically been singled out as ‘vectors and vessels’ of STI transmission, the higher STI-stigma scores among Aboriginal women may represent a compounding of cultural stigma felt by these women[24-26].”

Response to Comments from Reviewer #2

Compulsory Revisions:

1. Rationale:
   
a. The rationale for this particular analysis has been clarified in the final paragraph of the introduction, while the rationale for the larger study has been clarified in the methods.

   Introduction, page 6: “The purpose of this study was to develop a stigma scale specific to women, which encompassed a broader range of the stigma experience associated with sexuality and STIs. The present paper outlines the preliminary development of such a scale, and assesses the demographic and behavioural characteristics associated with the resulting scales.”

   Methods, page 8: “The purpose of the larger study was to determine the characteristics and risk levels of the women attending the program in order to help inform program planners and to help tailor outreach initiatives for those women missing from the demographic, as well as to assess potential barriers to sexual health care among this population of women.”

2. Sample:
   
a. A new table has been included in the manuscript that illustrates the demographics of the participants. In addition, the methods have been clarified to indicate why the women were attending the clinic.
Methods, page 7: “The weekly, three-hour program offers women a safe place to access food and health care, as well as to socialize with other women, and take part in various activities including free haircuts, foot baths, art projects, and movie nights. There is also access to doctors and nurses, counselling services and massage therapy. The program is advertised through fliers at the clinic and other community organizations frequented by women.”

3. Comments:
   a. We agree that the term ‘tribes of womanhood’ may be confusing, and, after discussing the origin of the idea in the introduction, have moved to calling the emerging scale female-specific moral stigma, in order to reflect the idea of sexual morals that are placed specifically on women.

   b. See response to Reviewer #1, point #3 above.

Minor Essential Revisions

1. Tables:
   1) Table 2 (now table 3) was not referenced and has now been indexed in the text.

      Results, page 12: “In Table 3, item-total item correlations and alpha co-efficients if deleted for the three emergent factors are shown, along with scale statistics and cronbach’s alpha.”

   2) The specific column headers have been added in the appropriate locations in the first column of Table 3. Rather than adding ‘Item’ as the header, which may be confused with the specific scale items referred to in the first two tables, the categories of demographics and risk behaviours being compared have been included.

2. Writing:
   1) Abstract changed to read ‘judgement by others’.

   2) Sexually Transmitted Infections has been written out on first use, both in the abstract and in the introduction.

      Abstract, page 2: “While a variety of stigma scales exist for sexually transmitted infections (STIs) in general; none incorporate these gender-specific aspects.”

      Introduction, page 4: “The topic of sexually transmitted infections (STIs) presents a good example of the dynamic and socially fluid nature of stigma, as opposed to the stationary, objectified definition it is sometimes given [2].”

   3) Foundational has replace seminal on page 4. Paragraph 2 has been re-written to avoid awkward phrasing.

      Introduction, page 4: “Sexual morals have typically had a gender imbalance, leading to a strong social stigmatization of women. Many societies and cultures view promiscuity
among men favourably (e.g., as a measure of virility or status), while promiscuity among women is viewed as undesirable and immoral [3,5,6]. In the late 19th and early 20th centuries, the social and medical standpoints on the spread and prevention of STIs were influenced strongly by these gender stereotypes. For example, in World War I STI prevention flyers were used to warn soldiers away from the ‘dirty’ women who would infect them with STIs, which they might then pass on to their ‘good’ wives [7].“

4) The century being referred to in the introduction has been specified.

Introduction, page 4: “In the late 19th and early 20th centuries, the social and medical standpoints on the spread and prevention of STIs were influenced strongly by these gender stereotypes.”

5) The Nack reference on page 5 has been corrected.

6) Page 11, para 2: effected has been changed to ‘affected’.

Discussion, page 14: “The perception of any stigma will invariably be affected by both the previous experiences of an individual as well as their current situation.”

7) Page 12, para 1: the second ‘this’ has been removed.

Discussion, page 14: “This may reflect an ‘accommodating’ phenomenon whereby women who already view themselves as ‘bad’ girls (i.e. active drug users, highly active sex workers) are less concerned with societal views and stigma.”

8) The last sentence of the conclusions has been re-worded.

Discussion, page 18: “Sexual stigma is a deeply rooted construct in our society; however, this should not be seen as an insurmountable barrier to creating programs and policies that work to change the damaging and disproportionate impact of STI-related stigma on women.”

Discretionary Revisions

We agree with the reviewer that a comparison between those who had previously had an STI would be interesting; however, previous diagnosis was not asked directly; the survey only asked about previous testing or treatment, which does not really get at the impact of a diagnosis. A more thorough review of the relationship of the scales with accessing sexual health care (which previous testing and treatment would measure) has been done and is being published in a separate manuscript (see Rusch et al., STD, in press).

**Response to Comments from Reviewer #3**

Major Compulsory Revisions:
1. The reviewer has pointed out the incorrect use of the term ‘gendered’ with regards to the stigma scale, which gives the impression that there is a comparison. The wording has been clarified throughout the text to indicate the scale was developed specifically for women, and was not developed for the purpose of comparing or accounting for differences in gender.

Abstract, page 2: “While a variety of stigma scales exist for sexually transmitted infections (STIs) in general; none incorporate these female-specific aspects. The objective of this study was to develop a scale to measure the unique experience of STI-related stigma among women.”

Abstract, page 3: “Quantitative researchers examining STI-stigma should consider incorporating these female-specific factors in order to tailor scales for women.”

Introduction, page 4: “Sexual morals have typically had a gender imbalance, leading to a stronger social stigmatization of women.”

Introduction, page 6: “The purpose of this study was to develop a stigma scale specific to women, which encompassed a broader range of the stigma experience associated with sexuality and STIs.”

Discussion, page 14: “In this paper, three distinct STI-related stigma scales emerged from a pool of items addressing STI issues including physical stigma, moral stigma, judgment by community and by healthcare workers in particular, as well as female-specific sexual categorizations of ‘good’ and ‘bad’ girls.”

2. The reviewer correctly points out the importance of not ignoring STIs and STI-stigma among men. For the present study, we were interested in developing a scale that incorporated the historical categories specific to women, and therefore did not consider sampling a male population; however, it is true that a comparison would be interesting. Both measuring the male response to the current items, as well as creating an alternate scale to determine whether men respond similarly to these types of statements, even though the outward social constructs for male sexuality are very different, would be interesting. The limitations now note the importance of STIs and STI-stigma in men, and outline potential future research with the scales in a male population.

Discussion, page 17: “Lastly, the current study only sampled women. While we developed our female-specific items from an extensive literature outlining the unique sexual categorization of women, we did not directly compare the endorsement of the items among women to similar items among men. Of note, STIs and barriers to care, including STI-related stigma, are just as important among men, and while the measure may be very different, scales that assess these experiences among men should also be developed.”

3. The introductory text referring to other STI stigma scales now included reference to Fortenberry’s work.

Introduction, page 6: “There are, however, few scales that examine stigma in relation to STIs (notably, Fortenberry’s stigma and shame scales[16,17]) and none that incorporate female stereotypes related to sexual morals, as well as the perceptions of both the community in general and health care professionals in particular.”
4. As per both Reviewer #2 and #3, the ‘tribal’ stigma scale has been relabelled to ‘female-specific moral’ stigma throughout.

5. A new Table 1 has been added to illustrate the demographics of the population.

6. As pointed out by the reviewer, the scales did not need to be standardized, and Table 3 now lists the unstandardized scores for easier interpretation.

Minor essential revisions:

1. Abstract:
   a. The acronym used in the abstract (STI) have been spelled out.
   b. The acronym DTES is no longer in the abstract, but has been spelled out in the methods section.
   c. The methods section now contains information on the study region and on the meaning of ‘passive’ recruitment.

   Methods, page 7: “An interviewer-administered structured survey was carried out among 126 women attending a weekly program exclusive to women (including transsexual individuals) held at a local community health clinic in Vancouver’s Downtown Eastside. This region is disproportionately impacted by issues including substance use, mental illness, homelessness and poverty. Compared to the rest of the province, census data from 2006 indicated higher levels of income assistance (4.1% vs. 0.6%), higher levels of low income households (23.9 % vs. 12% of families earning < $20,000 CDN), and inferior health outcomes (life expectancy at birth 75 vs 81 years)[16]. Due to the concentration of injection drug use and sex work in this high risk neighbourhood, the region also exhibits high prevalence of HIV and other STIs.”

   Methods, page 7: “Women were passively recruited through an announcement at the start of each evening inviting women to take part in the study.”

   d. A statement regarding IRB approval has also been included.

   Methods, page 8: “This study was approved by the University of British Columbia Behavioural Ethics Review Board.”

2. Main text:
   a. STI has been spelled out at its first usage in the Introduction.

   Introduction, page 4: “The topic of sexually transmitted infections (STIs) presents a good example of the dynamic and socially fluid nature of stigma, as opposed to the stationary, objectified definition it is sometimes given [2].”

   b. The women’s program is more fully described in terms of its purpose and the general clientele, although part of the purpose of the present work was to identify who was accessing the program (this piece of the work is in press in the Canadian Journal of Public Health). The community in which the clinic operates has been described, both in general terms and with census-level statistics (see above, point #1c).
Methods, page 7: “The women’s program is open to all women, and sees anywhere from 20 to 60 women in one evening (for more detailed information on the program and population, see Rusch, et al., in press [17]). The weekly, three-hour program offers women a safe place to access food and health care, as well as to socialize with other women, and take part in various activities including free haircuts, foot baths, art projects, and movie nights. There is also access to doctors and nurses, counselling services and massage therapy. The program is advertised through fliers at the clinic and other community organizations frequented by women.”

c. The associations seen were marginal (as mentioned in the results on P10/11), whereas the discussion focuses only on the statistically significant findings (p<0.05), rather than any of the marginal associations. However, we understand that the way this is wording may be confusing, and have therefore changed the wording of the discussion around this point.

Discussion, page 13: “The resulting female-specific moral stigma scale was not found to be significantly different among participants; however, there were marginally higher scores among Aboriginal women, IDUs and women with lower education levels.”

d. It was our understanding that the Spearman-Brown Prophecy is traditionally used with split-half reliabilities to correct for the reduction in the number of items from the true scale (with split-half reliabilities, the resulting alpha-scores are based on only half of the total items), since the alpha scores are inherently impacted by the number of items. Thus, for scales with very few items, this technique would help ‘adjust’ for the inherent penalization in the alpha score. However, the SB correction is not an integral part of the analysis or discussion and has been removed from the text.

e. In the development of the stigma scales, all participants who did not respond to all stigma items were dropped. However, once the three scales were finalized, and it was determined that they did not correlate sufficiently to combine into one larger scale, alpha-scores were calculated for the scales including women who answered at least all the items in that particular scale. This is why the N’s differ at the bottom of Table 2. This has been clarified in the results.

Results, page 12: “As the stigma-related items were positioned at the end of the 27-item structured interview, a few women did not complete all of the questions and nine women were excluded due to incomplete answers in the stigma section of the structured interview. However, subsequent to the factor analysis and determination that the three scales did not correlate sufficiently to combine into one large scale, women who answered at least all of the stigma items represented in any one scale were included in the final calculation of Cronbach’s alpha-scores shown in Table 2.”

f. N’s have been added to the tables.

g. The conclusion contains an additional statement regarding the general directions that should be undertaken for the further development and use of this scale. Unfortunately,
there is currently no direct continuation of this work; therefore no specific statements can be made. In addition to the excerpt below, see point #2 under Major revisions above.

Discussion, page 16: “In addition, the scale categories (female-specific moral stigma, internal stigma, social stigma) that emerged from this exploratory analysis should be tested in a larger population using an hypothesis driven factor analysis (i.e. comparing the pre-supposed categories to the data).”

Discretionary revisions:

1. Multivariate results were mentioned briefly in the discussion text, but were not focused on as the primary purpose of the manuscript was to describe the scale development. However, the results now contain a mention of this model.

Results, page 13: “In a multivariable linear regression model, Aboriginal ethnicity ($\beta=-1.63; p=0.002$) and less than a high school education ($\beta=-1.27; p=0.010$) remained significantly associated with internal stigma score, adjusting for age, commercial sex work and injection drug use. There were no significant associations in multivariable models for either the female-specific moral stigma or social stigma scales.”

2. We are grateful for the reviewer’s guidance and suggestions and have revised the concluding sentences.

“Discussion, page 18: “Sexual stigma is a deeply rooted construct in our society; however, this should not be seen as an insurmountable barrier to creating programs and policies that work to change the damaging and disproportionate impact of STI-related stigma on women.”