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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Author's response to reviews: see over
Editor,
BMC Women’s Health

Dear Editor

Thank you for your letter of July 30th, 2008, inviting a further review of our manuscript entitled: “Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood”. We hope that we have now adequately addressed all of the reviewers’ concerns and that you will find the manuscript suitable for publication in BMC Women’s Health.

Please find attached a point-by-point analysis of our response to the reviewers’ latest comments.

If there is anything else needed, please let me know.

Regards,

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1. The reviewer makes a strong point with respect to the practical use of the scale, which may be conceptually relevant, but serve no real purpose, as few significant differences were found. We have included this point in the discussion, along with an expanded discussion of the issue of power, which was lacking in such a small sample (this also address point 3e below). We have stressed in our discussion of potential implications, that these are only theories based on marginal differences which may or may not be reflected in a larger sample of women.

"With few significant differences in stigma scores among sub-groups of women, the question of the practical use of such scales arises. Comparisons beyond demographics and behaviors, such as contact with health care providers, access of testing and treatment programs would provide a better picture of how these stigma measures may influence sexual health. Further, although the findings presented here lacked sufficient power to detect smaller differences, the suggested increased levels of female-specific moral stigma, social stigma and internal stigma among sub-groups of women is theoretically plausible and should be further evaluated in a larger population. As mentioned above, the presence of cultural differences indicates the necessary evaluation of the potentially different meanings and interpretations of STI-stigma, female sexual morals, and social perceptions held by different cultures."

"This is also true as the study sample size presents a limitation with respect to the ability to detect differences of less than 2.0 units in the scale scores. It is difficult to say whether the marginal results seen with differences of only 1.0 unit would become significant in a larger sample; however, the potential implications of these differences are presented and discussed as theories requiring further evaluation."

2. As pointed out, the scales would be more easily interpreted in the reverse. This has been changed throughout.

3. Edits have been made to address the mistakes found in the tables:
   a. Table 3 (cont) changed to Table 4 (cont)
   b. All non-significant findings have been unbolded
   c. The reference to ‘tribal stigma’ in the title for Table 4 has been changed
   d. N’s have been added to Table 4; however, the associations were assessed using non-parametric comparisons of means, not regression (this has been clarified in the methods), therefore R-squared statistics are not given.

   "Associations of the three final scales with demographic and behavioural characteristics were assessed using the Wilcoxon rank-sum test."

   The N and R-squared statistic for the multivariate model mentioned in the results text have been included.

   "In a multivariable linear regression model, Aboriginal ethnicity (β=-1.63; p=0.002) and less than a high school education (β=-1.27; p=0.010) remained significantly associated with internal stigma score, adjusting for age, commercial sex work and injection drug use (N=110, R-squared=0.180)."

   e. As pointed out, the 0.10 significance level is not highly rigorous, but as discussed in the limitations, power was low for detecting differences less than 2.0 units.
Reveiwer #1

1. We would like to thank the reviewer for drawing our attention to the limitations of our research in acknowledging and incorporating culturally-specific meanings of feminine sexual morality – which, as mentioned, would be an important step in helping to interpret findings related to the stigma scale. We also appreciate the reviewer’s understanding in our own limitations for providing a useful discussion on this point, and for providing an alternate solution. While not being fully informed on the qualitative literature surrounding traditional meanings of female sexual morality in Aboriginal cultures, we have attempted to offer a few references on the subject while still noting the limitations in interpretation given the lack of a more thorough review in the discussion section as suggested.

“Aside from this, there are other cultural factors which may be influencing the way in which the stigma scale is interpreted. The traditional meanings of female sexual morality in Aboriginal cultures may shape the way these specific stigma items, most which reflect a Western definition of feminine morality rooted in Christianity, are felt. For example, in many Aboriginal cultures, sex and sexuality are taught as being a gift, although a powerful one which needs to be respected [28]. The central idea of balance and the holistic views of health are also important and theoretically cultivate a healthy view of sexuality, as opposed to Western views which tend to stress the association between sexuality and sin [28]. In addition, in matrilineal clans female gender did not reflect lower status, and many ancient stories venerated strong, powerful female figures [29]. Despite these traditional meanings, the rise of residential schools which removed Aboriginal children from their families in order to ‘educate’ them in Western and Christian ways, introduced, or forced, these ways of thinking onto their existing cultures. This, coupled with Western perceptions of Aboriginal women as either “the glorified ‘princess’ or the denigrated ‘squaw’”[29], make it difficult to predict how this history may influence the present interpretation of stigma items.”

“As mentioned above, the presence of cultural differences indicates the necessary evaluation of the potentially different meanings and interpretations of STI-stigma, female sexual morals, and social perceptions held by different cultures. Importantly, the interpretations given here can only be seen as suppositions, and are limited by the lack of a priori investigation into these cultural influences and meanings.”