Author’s response to reviews

Title: Sex work stigma and non-disclosure to health care providers: data from a large RDS study among FSW in Brazil

Authors:

Ines Dourado (ines.dourado@gmail.com)
Mark Crosland Guimarães (mark.guimaraes@gmail.com)
Giseli Nogueira Damacena (damacenagn@gmail.com)
Laio Magno (laiomagnoss@gmail.com)
Paulo Borges de Souza Júnior (pborges1@gmail.com)
Celia Landmann Szwarcwald (celia_ls@hotmail.com)

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To the Editors of BMC International Health and Human Rights

Dear Academic Editor – IHHR

We genuinely thank the journal for the review of our manuscript. We found the reviewers’ insights very helpful and have revised our text to address the points highlighted by the reviewers. We have thus conducted a major review of the manuscript. Further, below are the specific comments from the reviewers with responses to each of their queries. Thanks for the opportunity to revise our manuscript.

EDITORS’COMMENTS: Author’s Response

(1) You should have your manuscript reviewed by someone who is fluent in English.
Author’s Response: The manuscript has been revised accordingly

REVIEWER 3 COMMENTS: Joanne Csete - The manuscript is improved.
Further comments  Author’s Response

(1) Copy-editing-type comments: Author’s Response: The manuscript has been revised accordingly

(2) I think the authors still need a clearer explanation or at least speculation on the matter of the relationship between non-disclosure of SW status with and poor uptake of services.

Author’s Response: We speculate that more preventive health services are offered to women who are considered “at higher risk for IST” such as FSW. Thus, health services personnel will pay more attention to those that disclose their FSW status. Consequently, those that do not disclose will potentially have poorer uptake of health services. We have clarified this point and indicated that further research is needed.

Revised text included in Lines 280-285 of Discussion session:

We speculate that more preventive health services are offered to women who are considered “at higher risk for IST” such as FSW. Thus, health services personnel will pay more attention to those that disclose their FSW status. Consequently, those that do not disclose will potentially have poorer uptake of health services. Perhaps the anticipated stigma may explain this association, to the extent that the FSW cannot access these services by anticipating some kind of discrimination or violence experienced by themselves or by other known.

(3) Here is a logical inconsistency: If people are not disclosing their status, how are they experiencing discrimination? If this is anticipated stigma or if there is an association because of past discrimination, that needs to be better explained.

Author’s Response: Thank you for this comment. We did revise the analysis and the manuscript and no longer included in the univariate analysis (Table 3) the association analysis between “discrimination perception in health services for being a FSW” with “non-disclosure of FSW status to health care staff”.

This study design is a cross sectional one and from the interview questionnaire and dataset we cannot assume that the association could be explained by anticipated stigma or past discrimination.

Line 202, Data analysis- we excluded “and discrimination variables”

We included a revised Table 3
We also described Table 2 results in more detail:

Lines 234-237 included:

More than half of the women never disclosed their FSW status (51.5%) to health care providers and 21% felt discriminated against or were treated worse than other people for being FSW. Finally, 14.7% and 12.1% reported shame of revealing their FSW status as the reason for never having had a Pap smear exam or HIV testing, respectively (Table 2)

(4) Line 205, data analysis

This is univariable or bivariable? How could there be a p value for univariable statistics?

Author’s Response: We have already answered this comment in our previous reply. Often, different Journals (and the Epidemiologic literature) use different terms with the same meaning. For some, univariate (univariable) indicates a descriptive analysis, i.e., ONE variable, and bivariate (bivariable) the association of one exposure with one event. For others, univariate (univariable) means the association ONE exposure with ONE event, and descriptive analysis refers to describing the distribution of one variable. Nonetheless, because there is no clear instruction on this issue and in a brief search of articles published in this Journal none used bivariable, we used the univariable term for assessing the association of one exposure with one event. However, we are ready to change to bivariable if specific instruction by the Editor indicates so.

(5) Line 246 – “inverse association with perception of discrimination in health services was even greater after controlling for the other variables (AOR=0.62, CI 95%: 0.50 – 0.78)”; reviewer comments: But it's not significant -- -1 not included in the confidence interval.

Author’s Response: By definition, 95% confident interval which does not include ONE is statistically significant, whether the OR is above one (risk or positive association) or below one (protective or negative or inverse association). In this case, the OR is below one and the 95% CI does not include one. Thus, it is statistically associated with the event of interest.

However, this association analysis was deleted from the manuscript as we did not have enough data to further explore this inverse association.

We included a revised Table 3
Discussion: includes quite a lot of information that should be in the background section or is repetitive of what's in the background section. The discussion section should focus on the significance of the results. There should be only briefer references to background information already given.

Author’s Response: The discussion has been revised accordingly.

Lines 262-263: “Likewise, although sexual exploitation of minors is criminalized by the Brazilian legislation” was excluded.

Line 275: “Free access to health care is a right guaranteed to the Brazilian population since 1988” was excluded.

Lines 300-301, we included: Environments with high stigma against FSW, the fear of discrimination and their consequences can led them the lack access to prevention healthcare services.

(7) Lines 279-283: The results of this study confirm the use of PHC units as the main source of care among FSW, with only a small portion seeking specialized care services. Our results indicate that non-disclosure of FSW status to health care providers was associated with poor uptake of preventive exams, such as Pap smear exam in the last 2 years and HIV testing in the last 12 months, despite availability of testing and screening services free of charge in PCH units.

Does this not seem to be a counter-intuitive result? If someone is not disclosing, their uptake is not impeded by discrimination. Perhaps worth a better explanation?

Author’s Response: As we explained above we have revised the analysis and the manuscript and no longer included in the univariate analysis (Table 3) the association between “discrimination perception in health services for being a FSW” with “non-disclosure of FSW status to health care staff”.

This study design is a cross sectional one and from the interview questionnaire and dataset we cannot assume that the association could be explained by anticipated stigma or past discrimination.

Line 201, Data analysis- we excluded “and discrimination variables”

We included a revised Table 3
(8) Lines 287-296: However, perception of discrimination in health services was negatively associated with non-disclosure of FSW status to health care providers, indicating that those anticipating stigma would be more likely to reveal their status. While the experience of discrimination results from stigma due to sexual work, non-disclosure may be reflecting an anticipated stigma that would be perceived by "revealing" their occupation [36].

Again, this is counter-intuitive. Why would someone anticipating stigma be quicker to reveal the status that is the source of the stigma?

Again, this seems to make sense only if it is demonstrated that those not revealing their status had previously experienced discrimination. Was that result found?

Author’s Response: As we explained above we have revised the analysis and the manuscript and no longer included in the univariate analysis (Table 3) the association between “discrimination perception in health services for being a FSW” with “non-disclosure of FSW status to health care staff”.

This study design is a cross sectional one and from the interview questionnaire and dataset we cannot assume that the association could be explained by anticipated stigma or past discrimination.

Line 201, Data analysis- we excluded “and discrimination variables”

We included a revised Table 3

Line 301: What is "health evaluation"? Author’s Response: We changed to healthcare

Line 305: What is "space-time monitoring"? Author’s Response: We changed to monitoring

Line 309: Their ability to organize is not a socio-political strategy. Their actual organization represents a strategy. Author’s Response: We excluded socio-political

Line 313: It was already said that sex work is not criminalized in Brazil. Author’s Response: We excluded.

Line 317: "although half had been exposed to an HIV risk that should have triggered the use of PEP" or "although half had been exposed to an HIV risk that should have triggered a recommendation for PEP”. You can't assume that there was a "clear recommendation" given to or heard by the sex worker.
Author’s Response: We changed to: although half had been exposed to an HIV risk that should have triggered the use of PEP.

Line 349: A more direct priority for what? Recommendation should be clearer. Meaning clear strategies are needed to reach this group?

Author’s Response: We changed to: Line 341: clear strategies are needed to reach this priority group despite the illicitness and social invisibility of adolescent girls

(9) Did we get a description of the role of this group in the study? If not, there should be a description, or this paragraph should be omitted.


Author’s Response: We included the follow explanation in Methods:

Lines 121-123:

Co-Investigators were responsible for conducting the study in each of the 12 cities and their names are listed under the Brazilian FSW Group.