Reviewer’s report

Title: Stigma in health facilities: why it matters and how we can change it

Version: 1 Date: 08 Oct 2018

Reviewer: Sarah Gordon

Reviewer's report:

I think this paper has addressed many of the reviewers' feedback and is much improved. However, I believe it has a major shortcoming in terms of the foundation for proposing there is the potential for interventions to simultaneously reduce multiple stigmas in health facilities; and that this warrants investigation; and then, that the results of the investigation supports the potential for interventions to simultaneously reduce multiple stigmas in health facilities.

So, for example, in the introduction you identify the drivers of discrimination and then go on report that the seven conditions were selected as the focus of this correspondence article due to their high degree of commonality in drivers: HIV, tuberculosis, mental illness, addiction, diabetes, leprosy, and cancer; yet you don't say how or what the commonalities are. I also wonder about whether this is more in relation to 'high-level' drivers - e.g. fear - which I would imagine is common across these conditions but the specifics of that fear would be quite different. The co-prevalence of stigmatised conditions as another rationale would presumably relate to some of these conditions more than others, thereby raising questions re the overall generic approach.

In terms of your methodology I wonder about the inclusion of the studies of interventions that targeted clients in the intervention population - this would seem to be a very different proposition when compared to addressing health provider stigma, as the reported differing strategies used highlights.

One of the problems that you have with the preponderance of identified articles being related to mental illness and/or addiction is that there are a number of reviews of interventions that have already been conducted and published with a greater degree of analysis and by people that specialise in this particular area.

Does the location etc of the studies explain why some health conditions are not addressed (because they don't exist or are very rare in those countries)?

The inference from the descriptions that interventions targeted 'knowledge of the condition' and that the most commonly targeted driver (derived from such inference) was knowledge about the
condition is potentially problematic given that, in relation to stigma associated with mental illness (at least), it is known that there is no evidence that solely increasing knowledge of mental illness results in decreased stigma or discrimination. I wonder if the strategy of 'contact' is being interpreted as an intervention that targets knowledge of the condition?

In terms of new knowledge you could perhaps highlight the conditions that are not addressed and compare and contrast those that are but I think you would need to be more specific rather than high level.

I think the gaps identified seem to be valid but don't really relate to the intro in terms of the aim of the paper and the inability to address that as a result of the limitations of what was found through the review.

The gaps and opportunities for future work seems to identify approaches to stigma reduction that are important yet haven't been identified in the introduction, nor specifically assessed through the methodology. These do not relate to what is identified as the purpose of the paper in the introduction.

I feel that approaches and methods identified as being similar across interventions to address different health condition stigmas are too high level and not necessarily valid in supporting a conclusion that multiple health condition stigmas could/should be addressed simultaneously. For example, the approach of 'contact', which I understand as being the most effective approach to counter stigma and discrimination, is going to be different for the different conditions. The method of educational materials is going to be different depending on the different conditions.

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