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Journal Name:	International Journal of TROPICAL DISEASE & Health
Manuscript Number:	2013_IJTDH_6468
Title of the Manuscript:	STIGMA AND HIV/AIDS IN SOUTH AFRICA: A CAUTIONARY TALE OF RESPECT AND ADHERENCE
Type of the Article	Review

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments	This manuscript STIGMA AND HIV/AIDS IN SOUTH AFRICA: A CAUTIONARY TALE OF RESPECT AND ADHERENCE represents a large scale study using mixed methods to assess the collected data at four sites in South Africa. As the authors state, much of the reported data confirms prior research observations regards the role of certain psychosocial variables that contribute to medication and visit adherence. The Introduction of this paper is focused on stigma. But it not clear why since the study variables assessed in the paper are not well defined. Why were they chosen? How are they related to stigma? If this is not established, the Introduction content becomes irrelevant. Example – phrases like “missed visits” and “missed tablets and “missed <u>ever</u>” - are these different? “Missed ever” becomes relevant if one considers the duration of treatment (one year or ten years) – this must be addressed. Have the variables been used previously? The authors assume that the quantitative questions are measuring stigma. But some do not even have face validity. How does one know they are measuring stigma? What is the source of the questions asked? Why did the authors not use a standardized test	We have outlined more clearly how the variables were chosen in the methods section and how this paper relates to the literature more fully in the introduction and conclusion. Missed visits/tablets was during the present course of treatment. Ever missed was during all treatments and we agree that could vary from individual to individual. The qualitative questions were drawn from early analyses of the exit surveys and from the relevant literature. No acceptable standardized scale was available when we set up the question set.



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	which would allow for comparative data? How is direct health costs relevant to this study? It needs to be explained. Why is the type of housing important as a measure of wealth? And is the word wealth precise? The authors assume that where there is support from partners, family, friends, support groups etc. – there is the absence of stigma. But these are not the only sources of stigma. The authors need to explain how the questions (quantitative) were chose and why. Questions like this underline why the variables chosen must be defined. How is it that the samples were random? Qualitative interviews were only done at two sites. Is the sample adequate and does it represent the populations of the four sites? Demographics of the 15 people interviews should be provided. Qualitative research provides a rich set of data that often complements quantitative data derived from the same study sample. Again, it is not clear how the questions posed in the interviews were derived. Also, the paper states that the transcripts were thematically coded. But who did the coding and how? There are standardized methodologies for this and the relevance of using MS-Excel v.12.0 is lost on this referee. Did the analyses achieve exhaustion? The authors largely use SPSS output to both inform and format their data Tables. This is not helpful as it is not communicative and represents a certain lack of	This is not clear and has been removed. Given the difficulty of assessing wealth in countries like S Africa, other measures – not income – are required. In self-report, all terms are relative so wealth will lack precise. We agree but not all could be measured in this study which is part of a larger multi-objective project. The source of the questions is answered in response to another review. Sampling procedures, including randomization, are outlined now in the new methods section. The reasons for two sites only are explained in the text and came down to resource constraints. The demographics of the qualitative sample were in the original draft but have been moved to a better location – the methods section. The basis of the coding is outlined. Word macros are well used by those who do not want a numerical basis to interpretation as provided by NVivo and Atlas TI. The tables have been reformatted and we apologize for their state in the early draft. Haste is not very helpful.
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	effort by the authors who must provide a more cogent synthesis of the study data being reported. Data placed in Tables should be chosen with purpose and combined where relevant. Tables need to have proper descriptive titles. Further, stating the variable names used in SPSS in the text and tables is counterproductive. Typically such variables mean a great deal to the study staff – but little to the reader. Another example of this is the use of the word “cross tabs” in the tables. This needs to be removed/replaced. Similarly the number of Tables in this document are unwarranted. The authors must be selective and must combine data. The opening sentence of the Discussion underline why this paper is problematic. “These regressions suggest that respect from healthcare workers, feeling judged, support from family, and especially being part of a support group significantly influence treatment adherence and clinic visits. Thus, it is clear that community support and stigma are factors that influence adherence to ART.” Regressions are not the purpose of the paper nor do they represent the design of the study. Statistics are a tool, but they are not the purpose of a study. The variables stated in the sentence are summated as “community support”. But then one is confronted with the variable stigma. How was it measured? What variables were used to assess stigma? The authors reach conclusions that are unwarranted given the issues described in this review. The one contention that the authors state in this following	Tables are provided to show the strength of the univariate and multivariate analyses in a topic where there remains a great deal of uncertainty. We have in this tabular presentation tried to outline subtle relationships. But the tables have been significantly reduced in number as well as being more clearly articulated. We agree and have made changes to downplay method and emphasize findings. Agreed and we expressed our conclusion poorly. We do not see the conclusion as _____
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	sentence, and is emphasized in the abstract and is used to shape the paper title: "Is there a comfort which derives from support that permits sufferers to not follow treatment protocols as they do not fear scolding?". To be frank this conclusion is unwarranted and here is no compelling evidence in the paper to support such a conclusion.	unwarranted but have tried to make it more tentative.
<u>Minor</u> REVISION comments		
<u>Optional/General</u> comments	This paper describes a large data set. The data consists of variables that are predictors of medication adherence and clinic visits as narrowly defined by the methodology. The authors should recast this paper and focus on what they have observed and nothing more. The paper needs to focus on the valuable data and not speculate beyond it. There is a need for scientific rigor and precision in this paper. If that were achieved it would make an important contribution.	We have attempted to add rigour with a redrafted method section and a suggestiveness in conclusions.