



People Living with HIV

STIGMA INDEX 2.0

in the Republic of Moldova

2023



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ABBREVIATIONS & ACRONYMS

ART	– Antiretroviral Treatment
GNP+	– Global Network of People Living with HIV
HIV	– Human Immunodeficiency Virus
ICW	– International Community of Women Living with HIV/AIDS
IPPF	– International Planned Parenthood Federation
LCR	– Limited Chain Sampling by Reference
VBS	– Venue-based sampling
MSM	– Men who have sex with men
NGO	– Non-Governmental Organization
PHCF	– Public Healthcare Facility
PLHIV	– People Living with HIV
PWID	– People Who Inject Drugs
SW	– Sex Workers
UNAIDS	– Joint United Nations Programme on HIV/AIDS
WHO	– World Health Organization

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EXECUTIVE SUMMARY

Stigma and discrimination have profound implications for HIV prevention, treatment, care and support services. They affect an individual's ability to recognize and manage their HIV infection, affecting their physical and psychological well-being as well as quality of life. In the Republic of Moldova, with about 15177 people living with HIV (PLHIV), of whom 6372 are women (about 42%), stigma and discrimination have remained a considerable challenge. Recent studies exploring and reporting on these issues faced by PLHIV in the Republic of Moldova have found the presence of abuse of PLHIV and key populations. Since the last Republic of Moldova Stigma Index Study in 2017, a combination of factors, including changes in the HIV epidemic, the increased availability of evidence on HIV-related stigma and discrimination, and changes in the overall response to HIV, particularly with the update of the testing and treatment strategy in line with the latest WHO recommendations, support the need to update the Republic of Moldova Stigma Index Study in line with new realities. It has evolved over time and achieved a status as an evidence-based advocacy study. The main objective of the Stigma Index 2.0 Study in the Republic of Moldova is to understand the phenomenon of stigma affecting PLHIV in the Republic of Moldova through a research approach, conducted by PLHIV and with the participation of different PLHIV communities, including people with different sexual and gender identities, involved in sex work and those who use drugs

The advantages of developing a Stigma Index Study come from the set of arguments to justify the protection of the rights of people living with HIV. The most important aspect to note is that the PLHIV Stigma Index Study 2.0 is not limited to the collection of information, although this collection is the main purpose of the research but is also a process in which the competence of the interviewer participants and the interviewed participants is manifested and implemented. The measurement of the Stigma Index is not seen as a survey or an abstract academic exercise. Calculating the Stigma Index has its own philosophy of a process that is different from other studies and from traditional and classical understandings of research. People living with HIV are at the centre of the whole process of data preparation and collection, as they act as both interviewers and respondents in the research process. They also act as leaders in the analysis of results and their subsequent use. The research aims to foster and promote a spirit of ownership of the process and collaboration among all people living with HIV involved.

The process of preparing for data collection and data gathering directly involves demonstrating the skills of people living with HIV, increasing activity in relevant networks and associations, strengthening communication and establishing closer and more intensive cooperation, and providing meaningful leadership to networks of people living with HIV, networks of women living with HIV and networks of key populations living with HIV. Thus, the study is based on the GIPA (Greater Involvement of People Living with HIV) principle.

The present study collected data from the right and left bank regions of the Dniester River using the structured and standardized "Stigma Index Survey 2.0" methodology to interview 868 PLHIV (including 463 from the right bank of the river, 190 from the left bank and 215 recruited by chain referral from both banks of the Dniester River). The quantitative distribution of survey respondents was as follows:

- General population living with HIV – 508;
- Female sex workers (FSW) – 58;
- Homosexual men and men who have sex with men (MSM) – 84; and
- Drug users (DU) – 218.

In terms of current gender identity, the study included 393 women; 473 men; 1 non-binary; and 1 of those who preferred not to specify their gender.

Nine out of ten respondents (87.3%) reported that other people were aware of their status. Two out of thirteen (15.4%) of such respondents reported that their status had been disclosed without their consent. Experiencing stigma and discrimination because of one's HIV status in the last 12 months was reported by 9% of all respondents.

Nearly 1/3 of respondents (29.3%) reported they had been tested for HIV without their knowledge and only found out after the test, and 2.4% of respondents reported they had been forced to take an HIV test. Four out of ten respondents (41.5%) delayed starting treatment for more than one month after being diagnosed with HIV, including half of them (22.7%) started treatment two years or more after diagnosis. Few respondents reported having been stigmatized by staff of a healthcare facility because of their HIV status. Most instances of stigma and discrimination were manifested by avoidance of physical contact or use of extra precautions (7.2%) and gossip (6.8%) by health workers. More than half of the respondents (55.2%) were sure hospital records were kept confidential and more than 1/3 (37%) were not sure.

As regards the abuse of their rights, 14.5% of respondents reported they had encountered such situations, with an insignificantly higher share among women (15.0%, compared to men (14.1%)). However, of those whose rights were abused, only four people claimed compensation for damages, all being women. Of those who did not act, 17.1% (three women and three men) reported the reason they did not act was fear that their actions would lead to people finding out about their HIV status; 14.6% (two women and three men) mentioned uncertainty about success as a result of their actions, and 14.6% reported they did not consider it necessary to do something / did not consider it a violation.

In terms of stigma experienced for reasons other than HIV, bisexuals and respondents with a gender identity different from their birth gender reported discriminatory gossip and harassment from family members as the greatest form of abuse experienced. For sex workers and gay/straight/MSM workers, the most reported abuse was physical assault/harassment. Lesbians and women who have sex with women did not report forms of abuse or discriminatory acts. People who use drugs reported discriminatory remarks and gossip from family members as the most frequent measure of stigma.

Trends in stigma and discrimination over the three rounds (2010, 2017 and 2022) showed improvements in key indicators. There has been a steady decrease in disclosure of status without consent (from 50.4% in 2011 to 5.3% in 2022), denial of access to healthcare services (from 13.3% in 2011 to 0.7% in 2022). At the same time, there are higher values of reported mandatory/forced HIV testing and medical procedures (from 26.6% in 2011 to 29.3% in 2022) and reported internalized stigma (feeling ashamed of having HIV: almost half of the respondents in each of the three rounds, 46.4% in 2011, 45.8% in 2017 and 47.8% in 2022).

Despite some of these achievements, widespread challenges remain, such as verbal abuse and disclosure of PLHIV status to others without their consent. In addition, stigma and discrimination on grounds other than HIV status, such as gender identity, sexual identity, sex workers and drug use, have emerged as a growing challenge. Hence, the Republic of Moldova has an obligation to address the issues of stigma and discrimination that affect human rights and health outcomes in the PLHIV. Removing barriers in access to HIV and non-HIV health information and services, as well as implementing laws and regulations to support and promote better health outcomes, are actions that need to be taken seriously by stakeholders.

Following the survey results, several key recommendations can be suggested for consideration and implementation:

- Above all, there is a need for greater awareness and sensitisation of the general population to the critical issues of stigma and discrimination as they affect people living with HIV. Awareness-raising campaigns need to convey in the media the image of women living

with HIV, including representatives of key populations, who are part of society and their communities and who are more often subject to stigma and discrimination by family members and others.

- Coordinated efforts are needed to implement laws and policies that aim to protect the rights of PLHIV and key populations.
- Key populations need to be informed and trained about their rights and how to claim compensation when their human rights have been violated. Mechanisms and guidelines need to be developed to facilitate better reporting, documentation and redress of stigma and abuse cases against people living with HIV and key populations.
- People living with HIV need to be informed about their rights, especially their sexual and reproductive rights: pregnancy planning, contraception, maternal and childcare services, etc. This must also target health workers who provide sexual and reproductive health services.
- Lifelong training and retraining of health care workers on interpersonal communication and provision of HIV and non-HIV services for people living with HIV without stigma and discrimination. Ongoing monitoring of the extent to which health workers providing HIV and non-HIV services to people living with HIV are applying what they have learned.
- The National HIV Prevention and Control Programme in its concept and implementing partners should further develop existing strategies to address stigma issues.
- Develop training and empowerment programmes for women living with HIV, focused on increasing self-esteem, self-empowerment and social integration.
- Developing mental health services with a focus on key groups and specifically for men, as they access fewer health services and are more prone to mental illness, substance abuse, alcohol, etc.

BACKGROUND

The first case of HIV infection in the Republic of Moldova was registered in 1987. By the end of 2021, 15249 cases of infection were registered on both banks of the Dniester River. The country remains among those characterized by a concentrated HIV infection¹. Moldova further experiences a concentrated HIV epidemic among injecting drug users (IDUs), men who have sex with men (MSM), sex workers (SWs) and their clients and sexual partners in the general population. During this period, sexual transmission is also the main likely route of infection in new cases recorded².

In 2021, 797 new HIV+ cases were registered in the Republic of Moldova, of which 161 in the eastern territories of the country. Among the cases registered in 2021 – 58.2% are male and 41.8% female; 47.4% are from urban areas; and the share of young people aged 15-24 years is about 7.0%.³.

The Republic of Moldova is part of the global commitments under the Sustainable Development Goals, including Goal 3.3.1, which states “By 2030, reduce the transmission of HIV and sexually transmitted infections, especially in key populations, and HIV-related mortality”. The country is also a signatory to the Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS in 2021, the 95-95-95 initiative and universal access.

The national HIV response is reflected in the National HIV/STI Control Programmes. First National Programme for the Prevention and Control of HIV/AIDS and Sexually Transmitted Infections (NP) was approved in 1995 (GD 692/09.10.1995), followed by the NP for 2001-2005 (GD 482/18.06.2001), 2006-2010 (GD 948/05.09.2005), 2011-2015 (GD 1143/16.12.2010; the NP for 2011-2015 was revised by approval of a new programme for 2014-2015 (GD 806/06.10.2014)), 2016-2020 (GD1164/22.10.2016). The new National Plan for 2022 – 2025 was approved in March 2022 (GD No.134 of 02.03.2022).

These programmes identify the priorities in the field, the results to be achieved, the interventions, the budget required, the monitoring and evaluation framework of the NP, as well as its management. The specific objectives of the current Programme are to maintain HIV infection prevalence among key groups (no more than 12% among IDUs, no more than 10% among MSM and no more than 2.5% among SW), to increase access to cascade services: diagnosis, treatment, viral suppression of people living with HIV and to improve programme management through health system strengthening, including provision of timely and high quality strategic information, which includes as core components supporting advocacy, communication and social mobilization of civil society by community system strengthening and reducing HIV-related stigma and discrimination.

People living with HIV often face stigma, discrimination, and abuse of their rights. Many of them do not know their rights and what they can do to change the situation for the better. An important area for organizations providing HIV services is combating stigma and discrimination based on HIV status and protecting the rights of people living with HIV.

The idea to conduct research on the Stigma Index came from people living with HIV, and the Research Guidelines were also developed by people living with HIV for people living with HIV.

The first study on the HIV Stigma Index in the Republic of Moldova was conducted in 2010 only on the right bank of the Dniester River. The second study was conducted in 2016-2017 and two separate reports were produced for both banks. This study is the third phase of the PLHIV Stigma Index in the Republic of Moldova. Each of these rounds was conducted under

¹ [REPUBLIC OF MOLDOVA, PROGRESS REPORT ON HIV/AIDS, UNAIDS, 2017](#)

² Idem

³ Idem

the coordination of the Civic Association “League of People Living with HIV in the Republic of Moldova” in partnership with UNAIDS, the National HIV Programme Coordination Unit, GNP+ and other key stakeholders.

The PLHIV Stigma Index 2.0 is the result of a joint initiative of several organisations, who have been working together to develop this methodology since 2005 and first launched the Stigma Index in 2008. The list of these organisations includes:

- Global Network of People Living with HIV/AIDS (GNP+)
- International Community of Women Living with HIV/AIDS (ICW)
- International Planned Parenthood Federation (IPPF)
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- John Hopkins University (JHU).

According to the results of the Stigma Index study, carried out in 2016 – 2017 on both banks of the Dniester river:

- Four out of ten PLHIV report having experienced discriminatory treatment in the last 12 months, with a higher share among women (40.6%) compared to men (38%). Most often these take the form of gossip and insults.
- Exposure to discriminatory treatments of PLHIV is also aggravated by multiple membership of at-risk groups, particularly in IDUs (17.4%), gender and identity manifestation (11,6%), gossip and insults being reported more often (47.3%).
- PLHIV also face rejection within the couple or even the PLHIV community, as well as the phenomenon of discrimination against family members due to their HIV+ status.
- One in ten respondents reported having to change their place of residence or having experienced difficulties in renting accommodation, and 10.7% of these were defined by the respondent as being caused by the HIV status. Similarly, every tenth has been dismissed or lost their sources of income, of which 5.1% due to HIV status.
- In summary, 6.1% of respondents reported having experienced at least one situation where they were denied their basic rights because of their HIV+ status in the past 12 months. Women (6.9%), young people 15-29 years (7.9%) and the unemployed (7.8%) are the groups with a higher incidence of facing such treatment.
- Internalized stigma as a phenomenon is much more prevalent than social, external stigma. Virtually every PLHIV self-stigmatizes in one form or another. Most often this is through self-blame, feelings of shame, lowered self-worth and suicidal tendencies, manifested by 6.6% of respondents. Among women living with HIV, feelings of shame (50%) compared to men (32%), low self-worth (33%) compared to men (24%) and suicidal desire (6%) persist more often than men (5%) due to HIV+ status.
- Internalized stigma forms are different for different socio-demographic groups. Suicidal tendencies are experienced by newly diagnosed (11%) and single people (10%).
- HIV infection also shapes self-imposed restrictions, primarily the refusal to marry and give birth to children, to have sexual relations, refusal of health services. Women more often decided to stop having sexual relations (13%), compared to men (10%), decided not to have children (34%), compared to 29% of men, gave up on health services (13%), compared to 7% among men.
- One in four PLHIV says they know about the UN Declaration on HIV/AIDS and more than half have heard about the HIV/AIDS Law in the Republic of Moldova. Only 12.5% and 30.5% respectively have read/discussed the provisions of these documents.
- The level of knowledge of organizations/civil society groups providing services for PLHIV

is high, with eight out of ten respondents saying they know where they can address in case of need.

- Every fourth respondent claims to be part of some PLHIV group/network, particularly women (28.04%) and older people 50+ (29.8%).

The IBBS 2020 survey found that people who inject drugs (18.8%), men who have sex with men (17.3%) and sex workers (5.1%) avoided seeking health care or HIV testing services out of concern or fear of being stigmatized by medical staff or neighbours, or someone finding out they were injecting drugs, or out of fear of possible violence, harassment, or arrest by police.

According to the *Study on the causes of ARV treatment dropout among PLHIV*, conducted in 2021, a significant proportion of respondents motivated their abandonment of ART by fear of being stigmatized: fear of relatives and close friends (18.3%) or others (11.7%) finding out about the diagnosis.

According to the *Study on Causes of Late ART Initiation among PLHIV*, more than a quarter (27.5%) of respondents were not informed that they would be tested for HIV. Respondents cited HIV-related stigma/self-stigma as a reason for late initiation of ART: they are ashamed of having HIV (26.0%), about a quarter of respondents are afraid of someone finding out about their status, and every 10th respondent fears negative attitudes towards PLHIV from medical workers.

At the same time, Law No.23 on HIV/AIDS Prevention of 2007, as last amended in 2018, declared it illegal to discriminate against people based on their HIV status. The law prohibits any employer, individual or organization from requiring anyone to take an HIV test as a precondition for employment or access to services. This provision was intended to create a more supportive environment, enabling people living with HIV to live their lives as normally as possible.

In the Republic of Moldova, according to Art. 48, para. (2) of the Constitution, “the family is based on marriage between a man and a woman”. According to the provisions of Art. 15, para. (1), letter h) of the Family Code of the Republic of Moldova, the registration of same-sex marriage is not allowed thus contributing to the restriction of the right to family of lesbian, gay, bisexual and transgender (LGBT) people based on their sexual orientation and gender identity. Law No. 121 on Ensuring Equality of 2012, in Article 7 (point 1) prohibits discrimination against LGBT people in the field of employment and occupation, as follows: “Any distinction, exclusion, restriction or preference based on the criteria established by this Law, which has the effect of limiting or undermining equality of opportunity or treatment in employment or dismissal, in non-employment and in vocational training, shall be prohibited. The prohibition of discrimination on grounds of sexual orientation shall apply to employment and occupation”. This is the only law that actually legitimizes a right for this group.⁴

The sexual and reproductive rights are reflected in different policies of the Republic of Moldova. The most important document is the National Programme on Sexual and Reproductive Health for the period 2018-2022 approved by Government Decision. The document is evidence-based, human-rights and gender based, with clear and robust priorities, interventions, budget and M&E framework.

Since the last Stigma Index survey in 2017, a combination of factors, including changes in the HIV epidemic, increasing available evidence on HIV-related stigma, and changes in the overall response to HIV, especially with the alignment of the testing and treatment initiation strategy with the latest WHO recommendations, support the need to update the current Stigma Index study in the Republic of Moldova. Moreover, the data from this Stigma Index Study provided metrics and a powerful advocacy tool for relevant government agencies and bodies to address

⁴ <http://lex.justice.md/md/343361/>

stigma issues. The League of People Living with HIV and the community of people affected by and living with HIV used findings from the Stigma Index studies to develop a roadmap for destigmatizing people living with HIV, to guide programmes, advocacy and dialogue frameworks, in systematically addressing issues of stigma and discrimination. Global changes in the HIV/AIDS trajectory and the platform created by GNP+, including the adoption of the new global HIV strategy, the political declaration focusing on eliminating inequalities and the country's determination to end HIV/AIDS by 2030, determined the need to conduct the HIV Stigma Index 2.0 study.

The People Living with HIV Stigma Index 2.0 study proposes a standardized methodology for collecting information on manifestations of stigma, discrimination and violations of the rights of people living with HIV in order to use the information obtained to develop policies and tools to protect the rights of people living with HIV. The collection of information and presentation of the data obtained in the form of an index allows a clearer understanding of the extent and forms of stigma and discrimination faced by people living with HIV in different countries.

The PLHIV Stigma Index 2.0 is coordinated by an International Partnership of two global networks of people living with HIV – the International Community of Women Living with HIV (ICW) and the Global Network of People Living with HIV/AIDS (GNP+) – with the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and John Hopkins University (JHU).

The results of the previous study cannot be compared with the results of the current study, because the methodologies are different. A feature of the PLHIV Stigma Index 2.0 study was an attempt to implement a cross-sectional approach. Unlike previous rounds of the study, which focused exclusively on HIV-related stigma and discrimination issues, for the first time in the Stigma Index 2021 study, an attempt was made to study the experience of stigma and discrimination of PLHIV based on their belonging to key populations: drug users, sex workers and men who have sex with men. There was also an attempt to recruit transgender people into the study, but in the Republic of Moldova the number of transgender people with an open HIV status is only 2 people, of which 1 person did not offer consent to participate in the study, and the other person was not in the country at the time of the study.

To do this effectively, it is important to have extensive partnerships between networks of people living with HIV and networks of key populations. For example, the focus on cross-sectional stigma in the PLHIV Stigma Index 2.0 allows for a broader assessment of who a person is or is not, opening up to assess the profile of who a person living with HIV is rather than relying on assumptions about whether or not the interviewee is a member of a key population.

The research results will thus allow to:

- Assess the phenomenon of stigma and discrimination among people living with HIV who experience it because of their HIV status or/and because of belonging to a certain key group.
- Compare the situation of people living with HIV in different regions of the same country or in different countries, in terms of stigma and discrimination based on their HIV status.
- Identify trends in changing levels of stigma and discrimination related to HIV status.
- Complete the evidence base and arguments for influencing policy and programmatic interventions.
- Implement programmes to protect rights and combat stigma and discrimination based on HIV status.
- Investigate the phenomenon of stigma and discrimination of PLHIV based on their membership of key groups.

The Stigma Index is a tool that can be used in advocacy to support the shared goal of government, community organisations, activists and people living with HIV to reduce the stigma and discrimination associated with HIV status.

It is important for the perspectives of people living with HIV reflected in the study results to be triangulated with other sources of information available in the country, such as studies measuring HIV-related stigma and discrimination against PLHIV by health workers, discrimination against populations at higher risk of HIV infection, including the general population, etc. The regular calculation of the Stigma Index, together with the development of other studies that address the issue of marginalisation in relation to HIV status, could help broaden and deepen the collective understanding of the manifestations of stigma and discrimination on the basis of HIV status both in our country and worldwide.

The results of the study will be used to strategically develop an action plan to reduce stigma and discrimination, to evaluate social support programmes for people living with HIV and as part of a mid-term evaluation under the National Programme for the Prevention and Control of HIV/AIDS and STIs.

OBJECTIVES

The PLHIV Stigma Index 2.0 aims to support comparisons across areas where stigma occurs and over time to assess the retrospective, present and/or future impact of stigma reduction measures for people living with HIV, in line with the overall UNAIDS goal of eliminating stigma in response to the HIV pandemic.

General objective

- The PLHIV Stigma Index 2.0 seeks to understand the phenomenon of stigma affecting PLHIV and, through a PLHIV-led research approach, aims to empower the PLHIV community across different domains.

The main principle: PLHIV Stigma Index 2.0 study involves engaging diverse PLHIV communities, including people with a range of sexual and gender orientations and identities, those involved in sex work and those who use drugs.

Specific objectives:

- Measure levels of social stigma and discrimination, prevalence of stigma and discrimination against people living with HIV in different spheres of life: health care, social relationships, employment and occupation, confidentiality and disclosure of HIV status, human rights violations and willingness to protect them;
- Measure levels of internalized stigma and discrimination;
- Measure the level of stigma and discrimination against PLHIV based on their belonging to key populations: drug users (DU), sex workers (SW), men who have sex with men (MSM), transgender people (TGP).
- Determine key health status indicators, indicators of social conditions for people living with HIV (access to health care and social services).

METHODOLOGICAL ISSUES

Study design

The study is replicated, multicentric, population-based, section-based, and questionnaire-based. As in previous rounds of the study, a holistic approach to empirical data collection was used to determine the extent, forms and experiences of stigma among people living with HIV in the Republic of Moldova and strategies to address them. The study was quantitative and involved the use of a structured and standardized Stigma Index Survey 2.0 questionnaire to interview PLHIV from the general population and key groups on both sides of the Dniester River. In addition, formative interviews were conducted with key informants to determine specific sites for recruiting study participants.

Sampling

The target group is people living with HIV, registered in the territory of the Republic of Moldova, living in the territory of the Republic of Moldova (on both sides of the Dniester River), including women, men, and members of key groups (DU, MSM, SW). At the planning stage, 25% of the total sample was allocated to PLHIV in key groups.

The eligibility criteria for participation in the study are:

1. Person, living with HIV (at least 12 months), registered in the territory of the Republic of Moldova (both banks of the Dniester River);
2. Has lived in the territory of the Republic of Moldova for the last 12 months (both banks of the Dniester River);
3. Age 18 and above;
4. Physical and mental ability to understand the questionnaire and other instructions in the study;
5. Gave informed consent for study participation;
6. Knowledge of spoken Romanian or Russian.

The sampling frame consisted of 7619 people living with HIV on both sides of the Dniester River, including key populations living with HIV (PLHIV KP: SW PLHIV, MSM PLHIV, DU PLHIV, TGP). The following cases were removed from the initial list:

- Deceased people;
- Lack of information about the administrative territory;
- Citizens of other countries;
- People under the age of 18.

The GNP+, ICW and UNAIDS International Partnership, with support from John Hopkins University, has recommended guidelines to countries on determining sample sizes based on fear or avoidance of seeking care due to anticipated stigma. Therefore, the study used data from the latest “Stigma Index Moldova” study, which showed that 12.6% and 9.6% of people with HIV who participated in the study avoided visiting the clinic and hospital, respectively, even though they needed to, because of anticipated stigma related to their HIV status. The average of these two figures (11.1%) was used to calculate the sample size. Since in the previous Stigma Index study most respondents were recruited from lists of antiretroviral treatment centres, the 11.1% was considered an underestimate and an adjustment factor had to be applied. By consensus of

the national implementation team of the study it was decided to multiply 11.1% by a coefficient of 1.5 ($11.15 \times 1.5 \approx 17\%$). The sample size was calculated, according to the recommendations of the electronic sample size calculator guide https://hall.shinyapps.io/PLHIV_Stigma_Sample_Size_Calculator, applying the Estimated Prevalence of 17% and the Target Precision of 5%, and represented about 11% of the sample frame (868 respondents).

Limited chain referral recruitment was planned among the key populations PLHIV DU, PLHIV MSM and PLHIV SW for a quarter (215 individuals) of the sample. Within the sample stratified by location, 653 codes of potential respondents were randomly selected (463 from the right bank and 190 codes from the left bank of the Dniester River) (Table 1).

Table 1. Socio-demographic structure of sample

	Sampling universe			Sample designed		
	Female	Male	Total	Female	Male	Total
Right bank	2581	2811	5392	221	242	463
18-29 yrs old	377	231	608	33	20	53
30-39 yrs old	1040	984	2024	89	84	173
40-49 yrs old	718	1014	1732	62	87	149
50+ yrs old	446	582	1028	38	50	88
KPs ⁵						
SW	≈13500	n/a	≈ 13500	32	5	37
MSM		≈ 13000	≈ 13000		54	54
IDU			27500	15	58	73
Left bank	1095	1132	2227	93	97	190
18-29 yrs old	121	64	185	10	5	15
30-39 yrs old	433	380	813	37	33	70
40-49 yrs old	344	475	819	30	41	71
50+ yrs old	197	213	410	16	18	34
KPs ⁶						
SW	≈ 2400	n/a	≈ 2400	13		13
MSM		≈ 1600	≈1600		11	11
IDU			≈4700	5	22	27
Total	3676	3943	7619	314	339	653

Within each site, the sample size was proportionally supplemented with participants from key groups so⁷ as to ensure that the study adequately collected experiences of cross-sectional stigma by recruiting sufficient participants from each key population.

⁵ Estimated key population sizes are included here. In calculating the planned sample size for the key populations, the size of the key population and the estimated HIV prevalence in the key population were taken into account.

⁶ Idem

⁷ The estimated sizes of the key populations for each site and the HIV prevalence among such populations in each site were taken into account.

Recruitment of participants

Broadly speaking, there are two key elements of the sampling design, with a focus on proportionate sampling at geographic sites that people living with HIV may visit, including ARV treatment centres and NGO locations that provide psychosocial support services to PLHIV (venue-based sampling), and by leveraging social networks for chain-referral sampling (limited chain-referral sampling (LCR)).

This two-tiered strategy was designed to capture the diverse and cross-sectional experiences of stigma more adequately across population groups. Three quarters (75.2%) of respondents were recruited using venue-based sampling, while 24.8% were recruited using limited chain referral.

Venue-based sampling

As a sampling frame for the sample, we used the list of treatment centre codes⁸, the list of people who have ever sought HIV-related medical services in one of the antiretroviral treatment centres (on the right or left bank of the Dniester River) and the list of beneficiaries (not only active) of support projects for PLHIV who are alive and have not settled abroad.

For location-based sampling, a two-stage sampling scheme was used. At the first stage, the number of administrative units in which data will be collected and which specific administrative units will be involved in data collection were prioritised to ensure access to PLHIV from urban/suburban and rural areas.

Using this approach, 653 (75.2%) study participants (KP PLHIV and non-KP PLHIV) were recruited. To ensure inclusion of people with HIV who may not access traditional outpatient treatment facilities due to experiences of stigma, sites from which participants were recruited were expanded to include PLHIV/KP support groups and NGOs that provide specialized PLHIV/KP community support services. Community-based locations that provide services to key hard-to-reach populations were intentionally targeted.

Location criteria for recruiting participants:

- The venue should be an accessible, safe and reliable public health care facility for the target group that provides services to people living with HIV, ranging from HIV antiretroviral treatment, STI testing and treatment or other sexual/reproductive health services, syringe exchange, condom provision or other HIV-related services, or community sites for those less connected to treatment.
- Location where management was willing to assist in recruiting their patients to participate in the Stigma Index 2.0 survey
- Location with a patient population of at least 10 people with HIV in a four-hour period.

Limited chain- referral sampling

To ensure the representativeness of key groups in the final sample, limited chain reference sampling was used – an approach that takes advantage of some of the benefits of respondent-guided sampling, including creating additional sample diversity by limiting the sample at each stage. To this end, a number of measures were undertaken in this round of research:

⁸ The anonymous treatment center code is the order number in the therapy center's patient list. It does not contain any data which could be used to directly or indirectly identify the patient.

- At the stage of identification of service recipients from the list of treatment centres selected for participation in the study, a number of codes were highlighted, assigned to clients of NGOs on the Right bank of Dniester river: CA "Gender_DOC M", CA "Positive Initiative", CA "For Present and Future", Union for HIV Prevention and Harm Reduction (UORN), and on the left bank of the river – Alians Zdorovia and Trinity.
- Through existing members of under-represented communities in the sample, there was a transition to inclusion in the sample by agreement, with participants invited to participate in the study directly or through the social networks of the MSM, SW or DU, living with HIV, connected or unconnected to care and support services provided by community networks or treatment centres.
- Following the limited chain-referral- recruitment approach, selected community members received three recruitment coupons for distribution to networks of acquaintances in the community living with HIV who confirmed that they would be able to participate in the study interview. The recruitment coupons contained information about the data collection site, a contact phone number, but did not include inclusion criteria or the research topic. Recruitment coupons were distributed to people who already knew potential respondents to minimize privacy concerns. Prospective participants who contacted study staff were screened against eligibility criteria. Potential eligible participants were then entered into the study and asked if they would like to participate. Face-to-face meetings were scheduled with eligible participants who agreed to participate. Informed consent was obtained from potential participants, after which interviews were conducted.

Preliminary process

Document review

The research team conducted a targeted review of study documents, including the study protocol, previous Stigma Index study documentation: study protocol, technical reports, technical meeting presentations, existing working papers and research instruments, as well as quantitative questionnaires. These revised documents provided the basis for structuring the research process and identifying gaps and questions requiring revision.

Review meetings

A series of online consultations and email correspondence with GNP+, ICW and UNAIDS experts, supported by John Hopkins University, took place during the period of documentation review and study protocol development. The recommendations of the GNP+ experts were discussed and analysed and for the most part accepted. Thus, appropriate adjustments were made to both the Study Protocol and the development of the study documentation. The study implementation team came up with the idea of applying methodological aspects and monitoring recruitment through limited chain referral similar to those previously applied in the most recent bio-behavioural study among key populations in the Republic of Moldova, conducted through guided sampling of respondents.

Several review meetings were held with members of the Technical Group/Country Implementation Team of the study. Part of the technical group were CA League of People Living with HIV in the Republic of Moldova, as leader and coordinator, with technical support from UNAIDS Moldova and the National HIV/AIDS and STI Programme Coordination Unit and members of the research team. At the planning stage, with the initiation of the technical working group, the methodological aspects of the study, sample size calculation, inclusion criteria, key populations and their proportion in the final sample were presented.

In the Technical Working Group, after review of the study protocol and data collection instrument by each Working Group member and feedback from the Steering Committee, the necessary adjustments were made, and the study was started.

The study questionnaires were translated into Romanian language and pretested. The instruments were administered to 30 people living with HIV. Among them were 20 non-KP and 10 KP persons. A total of 20 men and 10 women were interviewed.

Interviewer Training

Prior to the start of the data collection process, all staff who were planned to be involved were trained theoretically and practically in the use of the study participation algorithm, conducting the interview, using the electronic questionnaire, using techniques to facilitate conversation with potential respondents, data management, ethics, confidentiality. The training lasted three days: two days online and one day offline.

The trainings contributed to the capacity building of participants and ensured that participants had a good understanding of the methodological and logistical aspects of implementing the HIV Stigma Index Study, understood the study approach and were familiar with all the survey tools on the REDCap platform.

Similarly, all staff have been trained on the implementation of the Protocol, available in Romanian and Russian languages.

Special attention was paid to ensuring security measures at data collection points (Annex 3).

At the same time, during the offline training, tablets, registers and all necessary materials for the data collection process were distributed and interviews were simulated in RedCap. Data collection started the day after the training.

At the end of the training, the research team confirmed that all participants had improved their knowledge and met the minimum requirements to be part of the study. The training was attended by 10 men and 13 women who subsequently collected data.

Minimum requirements for interviewer selection:

- PLHIV or PLHIV from key populations with open status.
- The staff involved in data collection for the right bank of Dniester river, Romanian-speaking as well as Russian-speaking, and mandatorily Russian-speaking for the data collection points on the left bank of Dniester river.
- Ability to use an Android tablet.
- Resident of the locality where the study is implemented.
- Completed all training sessions.

Data collection

Data collection started on 5 November 2021 and lasted until March 2022. The 10 data collection sites were located in Chisinau, Balti, Cahul, Tiraspol and Rabnita:

Data were collected using REDCap electronic data capture software. At the end of each day of data collection, the data were reviewed by supervisors before being uploaded to the server. All data collection point managers provided interim reports on the progress of the survey, including

the scores achieved by typology. The research team provided constant support to data collection point managers and interviewers during the data collection phase. The research team monitored the quality of the work. This was done by reviewing the data from the server back-end. Support was provided to the field teams through personal supervision as well as by telephone and email. Data collection point managers provided direct monitoring of the process.

Data analysis

Data collected during the quantitative component of the study were analysed using SPSS software. The main data analysis methods were:

- Calculation of descriptive statistics, i.e. one- and two-dimensional distributions of respondents' answers to the questionnaire. The main characteristics, according to which the analysis of the two-dimensional distributions was carried out:
 - Demographic characteristics (sex, age, occupational status, length of life with HIV, place of residence, etc.).
 - Experience of belonging to vulnerable groups: DU, SW, MSM and people who do not belong to any of them.
 - Status disclosure experiences, HIV treatment engagement (PLHIV receiving or avoiding HIV treatment services).
- Calculation and analysis of integral indicators related to stigmatization and discrimination, including due to HIV status in different spheres of life, comparing them in dynamics over the years (if possible).

Ethical considerations

The study dossier has been discussed within the Monitoring and Evaluation Technical Group and the HIV Technical Group of the National Coordinating Council, as well as with institutions and organizations providing services to people living with HIV and using the study data and the community of representatives of people living with HIV in joint meetings of the KAP Committee (Committee of Key Populations Representatives). Agreement was obtained from service providers and communities of people living with HIV to contribute and ensure collaboration in the study process. Key input at all stages of the study was provided by the international partnership (GNP+, ICW, UNAIDS), which guided the implementation of the study at all stages.

The study dossier was submitted to the National Committee of Ethical Expertise which issued a positive opinion with no. 1173 dated 25.08.2021. The recommendations have been integrated into the study implementation method. Any non-ethical events occurring during the mandatory study had to be reported to the institution organizing and carrying out the study and subsequently to the National Committee of Ethical Expertise. No such events were detected during the study.

OUTCOMES

Socio-demographic characteristics

In the People Living with HIV Stigma Index Study, 868 people living with HIV participated, of whom 393 (45.3%) were women and 475 (54.7%) were men. About 61% of respondents said they did not belong to any of the KPs, while 39% (338 respondents) belonged to one or more such groups at the same time (Figure 2). Of the sample, 58 (14.8% of women) were sex workers, 29 (6.1% of men) were sex workers, while 218 (25.1%) were drug users. The majority of participants – 357 (41.1%) – were aged between 35 and 44, while about two-thirds of both female and male participants (66.5% and 64.9% respectively) indicated that they were currently involved in an intimate/sexual relationship. Participants' current gender identity is illustrated in Figure 1, shown below:

Table 2. Sample structure by typology, age, gender and key population membership

Features	Male (475)	Female (393)	N=868
Recruited, %			
PLHIV (non-key populations)	246 (51,8%)	284 (72,3%)	530 (61,1%)
MSM/gay	84 (17,7%)		84 (9,7%)
DU	151 (31,8%)	67 (17,0%)	218 (25,1%)
SW	29 (6,1%)	58 (14,8%)	87 (10,0%)
Age groups, %			
18-24 yrs old	20 (4,2%)	16 (4,1%)	36 (4,3%)
25-34 yrs old	70 (14,8%)	114 (29,0%)	184 (21,2%)
35-44 yrs old	203 (42,8%)	154 (39,2%)	357 (41,1%)
45-54 yrs old	140 (29,5%)	76 (19,3%)	216 (24,9%)
55+	41 (8,6%)	33 (8,4%)	74 (8,5%)
Gender, %			
Total	475 (54,7%)	393 (45,3%)	868 (100%)
Currently involved in an intimate/sexual relationship, %			
Yes	316 (66,5%)	255 (64,9%)	571 (65,8%)
No	159(33,5%)	138 (35,1%)	297 (34,2%)

Figure 1. Gender identity of PLHIV respondents

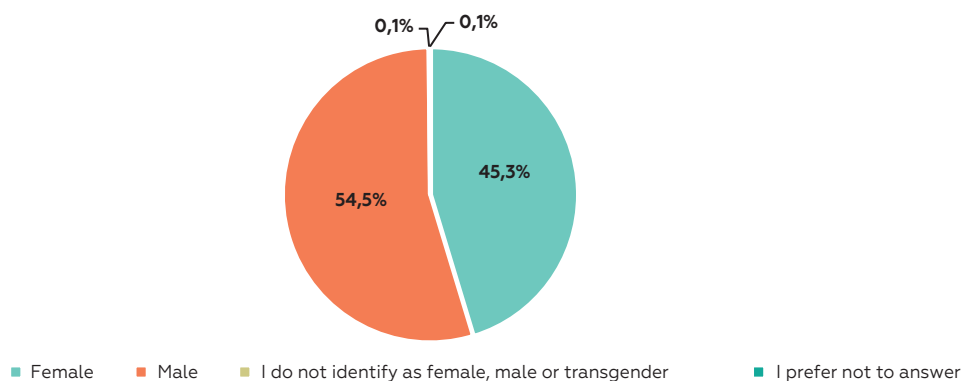
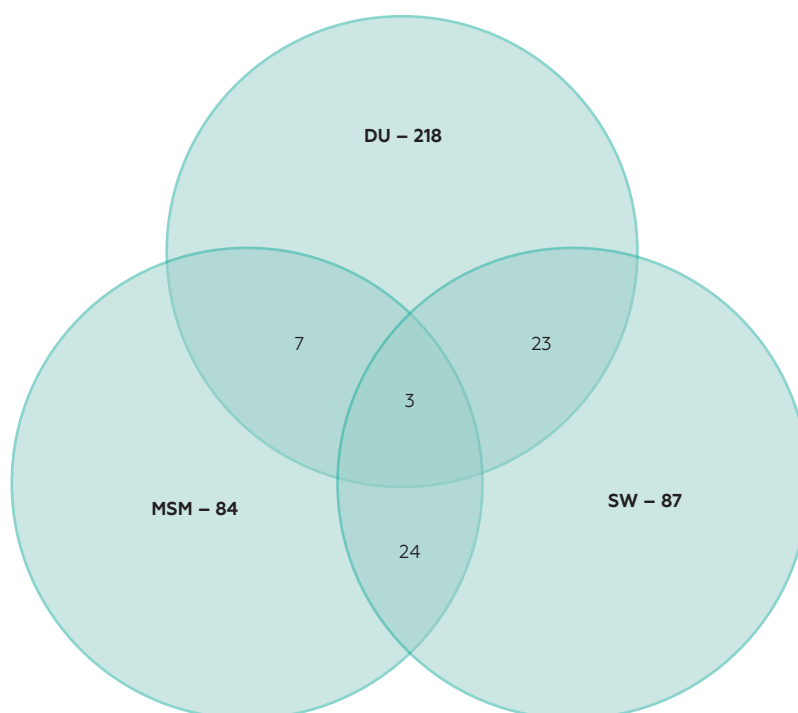
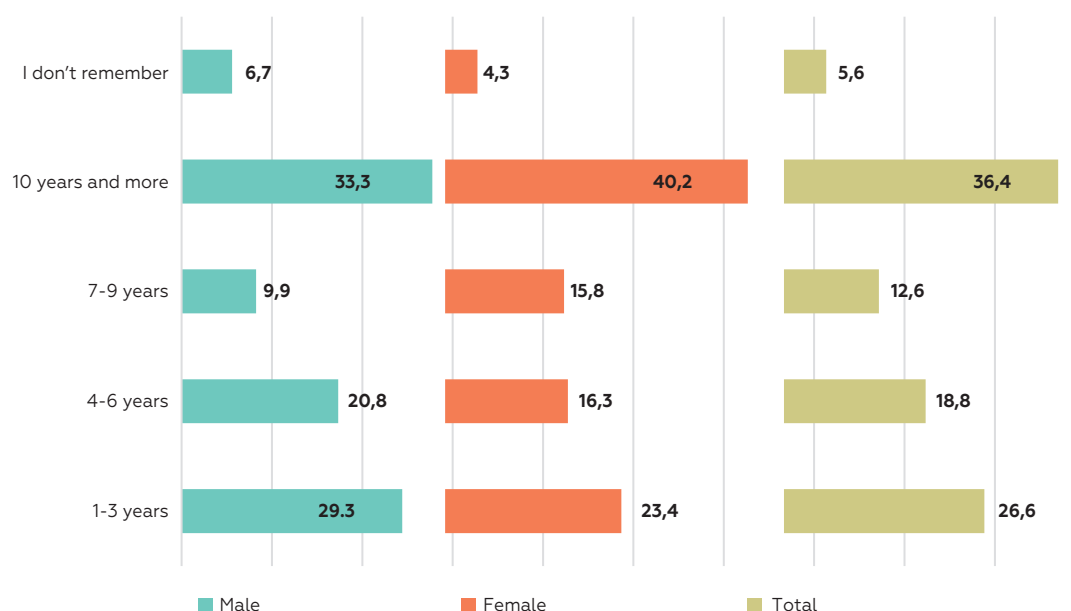


Figure 2. Respondents' belonging to key populations, #

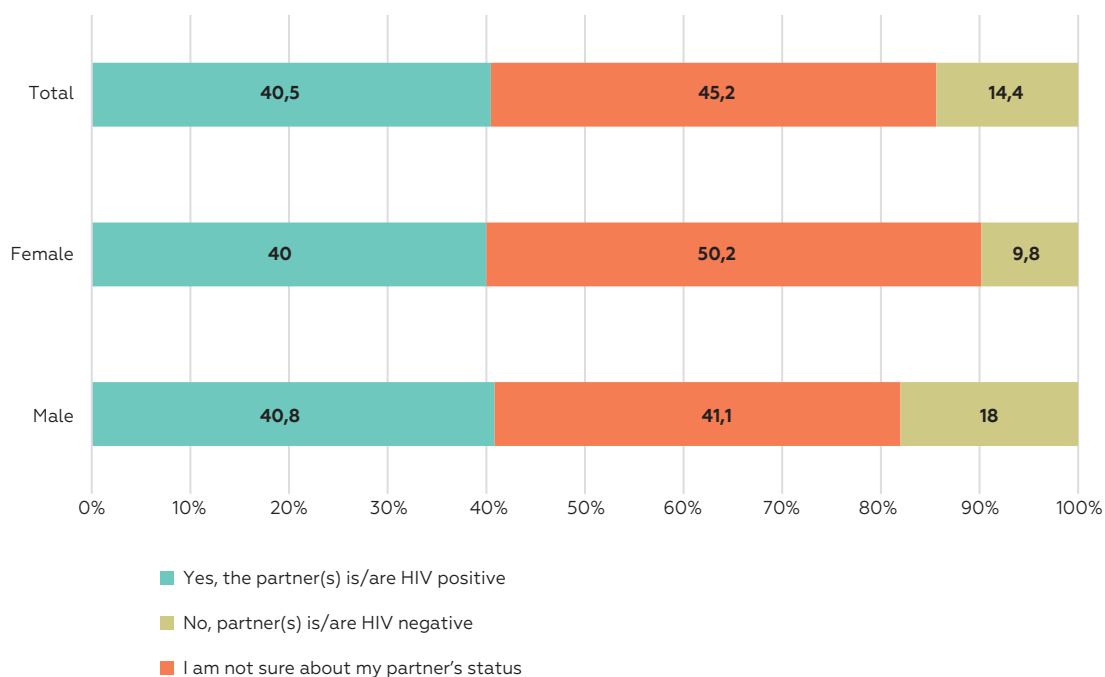


As regards knowledge of one's HIV status, 158 (40.2%) female participants and 158 (33.3%) male participants reported having known their status for 10 years or more. Figure (3) below represents a distribution of participants by duration of knowledge of one's HIV status.

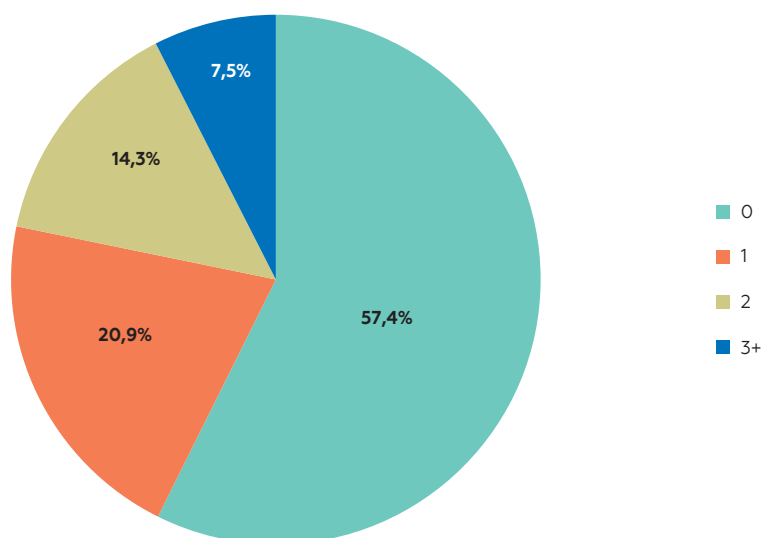
Figure 3. Lifetime with HIV, %



Of those who reported being involved in intimate/sexual relationships, 231 (40.5%) reported that their partner was also HIV positive, while 82 (14.4%) participants were unsure of their partner's status.

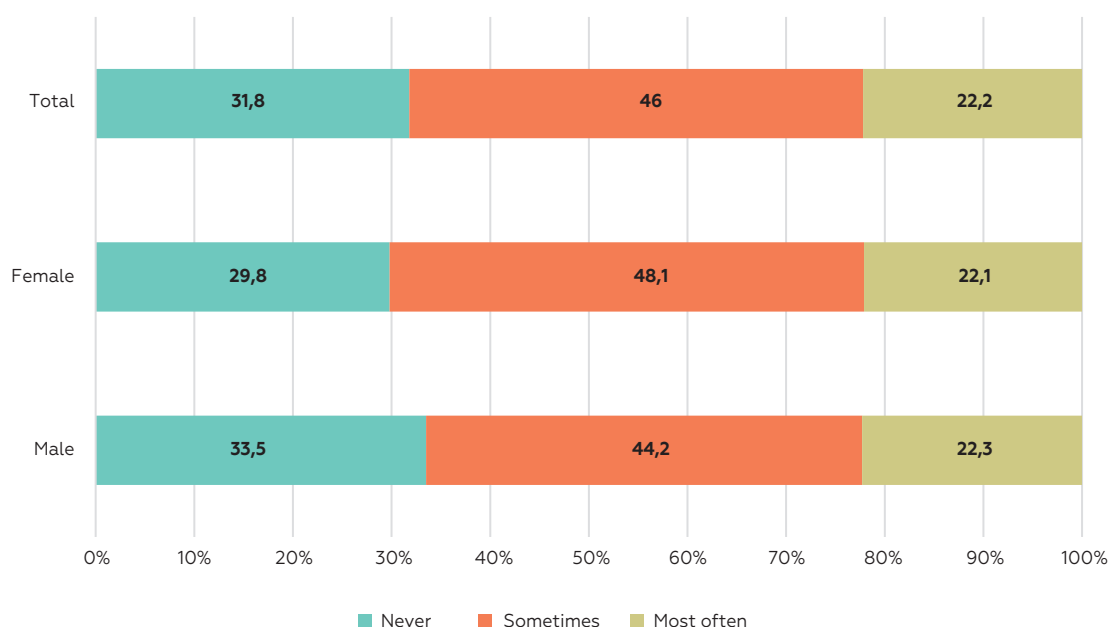
Figure 4. HIV status of partners, %

In terms of the number of children living in participants' households, 65 (7.5%) participants reported having at least 3 children living in the same household, while 498 (57.4%) participants reported having no children/no children living in the household with them.

Figure 5. Number of children in the care of participants living in the same household, %

The study also investigated participants' ability to meet their basic needs. Almost one third of respondents (276 participants (31.8%)) reported they were able to meet their basic needs always in the last 12 months, 399 (46%) of participants sometimes were not able to meet their basic needs, and every fifth respondent 193 (22.2%) was not able to meet his/her basic needs most of the time when needed. Women more often were unable to meet their basic needs, most likely because a higher proportion of women (41.2%) were not employed, compared to men (25.1%). Female sex workers also more often reported being unable to meet their basic needs in most cases (34.5%) compared to the rest of the women (20.0%).

Figure 6. Challenges in participants' ability to meet basic needs, %



In terms of educational status, at the time of the interview there were 15 respondents (1.7%) who were studying in an educational institution, 15 (1.7%) of the participants had not graduated from any educational institution, the largest proportion were those who had specialized secondary education or had graduated from technical vocational school 371 (42.8%) and those who had graduated from basic/general secondary education or had secondary education 349 (40.3%). In terms of occupational status, more than two thirds of participants 955 (70%) were employed, 19 (1.5%) were retired and 266 (21.5%) were unemployed.

Table 3 presents data disaggregated by subcategories of participants' highest level of education and employment status.

Table 3. Level of education and occupational status

Features	Male (475)	Female (393)	N=868
Level of education, %			
Have not graduated from any education institution	6 (1.3%)	9 (2.3%)	15 (1.7%)
Primary school or its equivalent	30 (6.3%)	24 (6.1%)	54 (6.2%)
Basic/general secondary education or secondary education	181 (38.1%)	168 (42.7%)	349 (40.3%)
Specialized secondary education or technical vocational school	216 (45.5%)	155 (39.4%)	371 (42.8%)
Higher education	41 (8.6%)	37 (9.4%)	78 (9.0%)
Occupational status, %			
Full-time work	162 (34.1%)	116 (29.5%)	278 (32.0%)
Part-time work (as an employee)	74 (15.6%)	49 (12.5%)	123 (14.2%)
Full-time work but not as an employee (self-employed or contractor)	18 (3.8%)	8 (2.0%)	26 (3.0%)
Casual or part-time work (as a self-employed person or services paid for by others)	71 (14.9%)	35 (8.9%)	106 (12.2%)
Retired/pensioner	31 (6.5%)	23 (5.9%)	54 (6.2%)
Not working/unemployed	119 (25.1%)	162 (41.2%)	281 (32.4%)

Respondents were asked whether they belonged to different specific groups. 124 (14.3%) respondents reported they were former prisoners, 118 (13.6%) respondents were people with disabilities, 61 (7.0%) participants were members of socially vulnerable groups, 30 (3.5%) participants were migrant workers, 19 (2.2%) reported belonging to a racial, ethnic or religious minority group, 7 (0.8%) people had migrated from one locality to another and 4 people (0.5%) were refugees or asylum seekers. More than ¼ of respondents (26.7%) were members of a PLHIV support network/group, with no significant differences between women (27.5%) and men (26.1%), with a higher prevalence on the right bank of Dniester river (29.5%), compared to the left bank (19.5%) and in the younger age group (33.3% in the 18-24 age group).

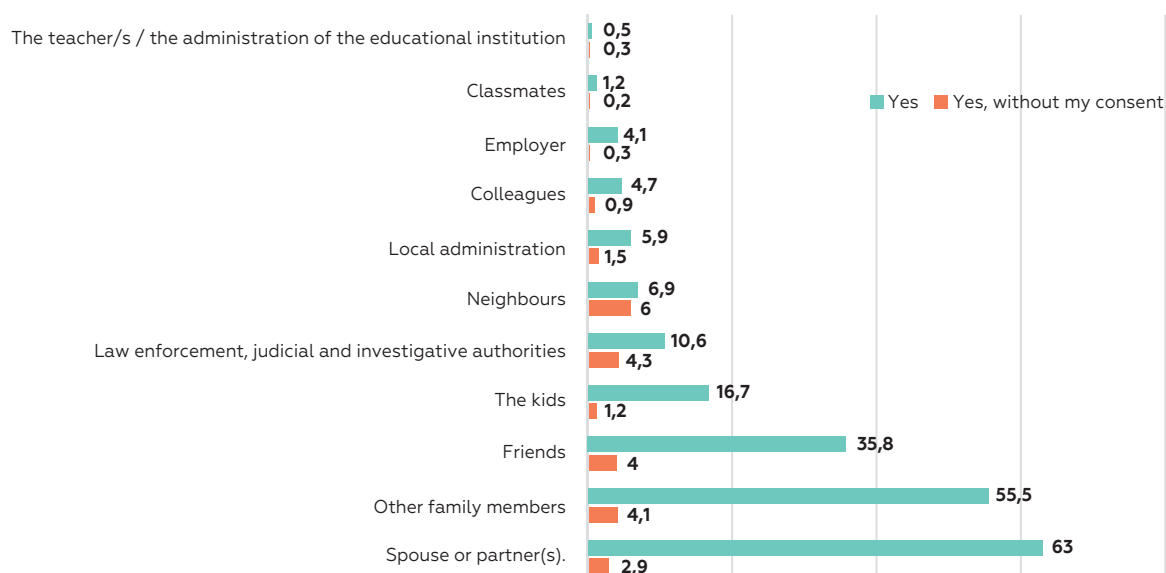
Table 4. Belonging to a socially vulnerable group, % of participants

	Yes	No	I'd rather not answer
Racial, ethnic or religious minority	2,2	97,2	0,6
Person with disabilities (visual, hearing, motor, intellectual/developmental) (excluding HIV)	13,6	86,3	0,1
Refugee or asylum seeker	0,5	99,3	0,2
Migrant worker, refugee	3,5	96,4	0,1
Person who has migrated from one part of Moldova to another	0,8	99,1	0,1
Former prisoner	14,3	85,4	0,3

Disclosure and confidentiality

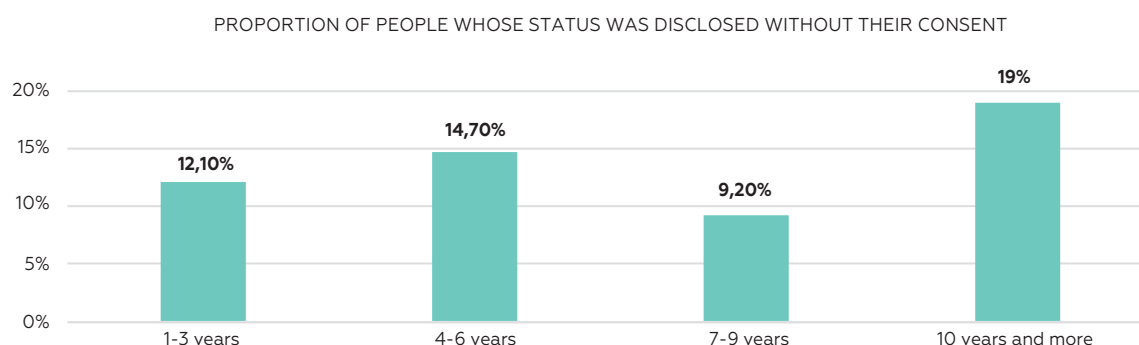
Figure 7 highlights the groups of people who know about participants' HIV status, with or without the participant's consent. Of the 758 (87.3%) participants who reported having disclosed their HIV status, 134 (15.4%) reported their status had been disclosed without their consent, of these 28 people had been living with HIV for 1-3 years, 24 people – for 4-6 years, 10 people – for 7- years and 60 people – for 10 years and more. 52 (6.0%) participants reported their status had been disclosed to neighbours without their consent, 37 (4.3%) participants reported their status had been disclosed to law enforcement, judicial and investigative authorities without their consent. Involuntary disclosure of status also occurred among other family members (4.1%) and friends (4.0%), spouse (2.9%), children (1.2%).

Figure 7. Proportion of voluntary and involuntary disclosure of HIV+ status, by category of group, %



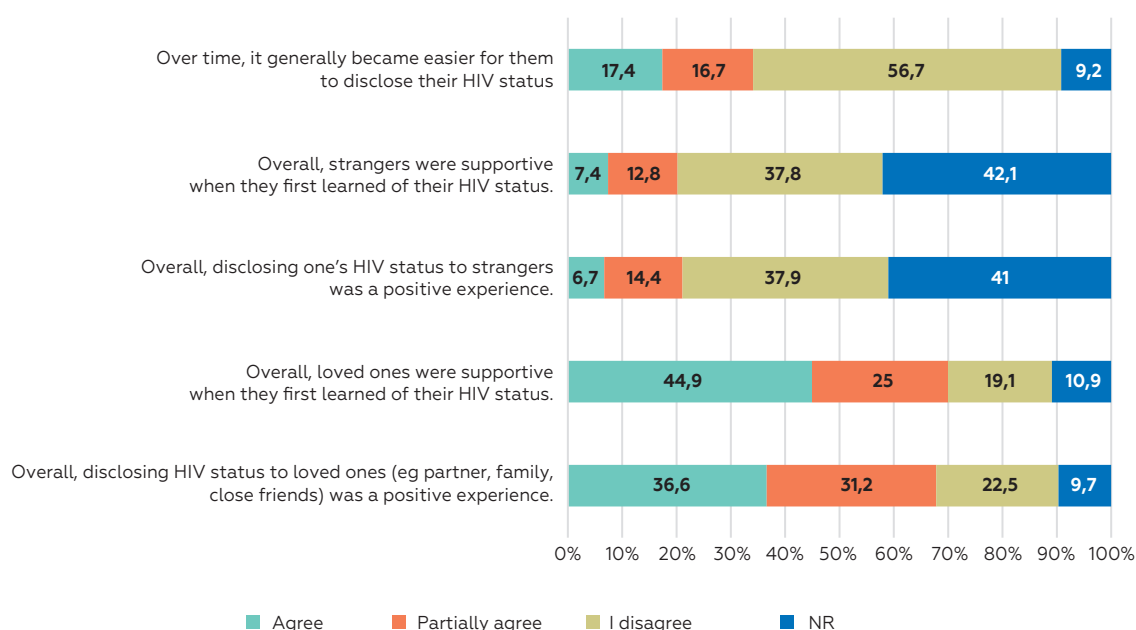
Analysis of disclosure of one's HIV status to others without the respondent's consent shows the phenomenon has not essentially decreased over time, considering that for people who have known their HIV status for the last 3 years it is even more prevalent than among people who have known their HIV status for 7-9 years (Figure 8).

Figure 8. Disclosure of HIV status to others without their consent, based on the participant's awareness of their HIV status.



Regarding respondents' disclosure of HIV status and people's reactions, most had a positive experience (36.6%) and received support (44.9%) from people close to them. Only one fifth of respondents described their experience as negative. More than one third of respondents rated the experience of disclosing their HIV status to a stranger as negative and other 2 in 5 refused to answer, which still qualifies as a more negative experience. Every third respondent indicated that, over time, it had become easier or partly easier to disclose their HIV status, while this still remains difficult to do for two thirds of respondents. (Figure 9)

Figure 9. HIV+ disclosure experiences, %



Stigma and discrimination experience

An analysis of the burden of stigma and discrimination faced by people living with HIV because of their HIV status reveals that 10.7% of participating women had experienced some form of stigma and discrimination in the past 12 months, while 26.5% indicated they had some time experienced some form of stigma and discrimination. Among key populations, every fifth MSM/Gay (20.2%) and SW (19.5%) experienced some form of stigma and discrimination due to their HIV status in the past 12 months, as shown in Table 5 below. Stigma and discrimination issues considered included exclusion from social gatherings, religious or family activities; discriminatory remarks or gossip; verbal or physical harassment; blackmail; denial of a job or income because of their HIV status.

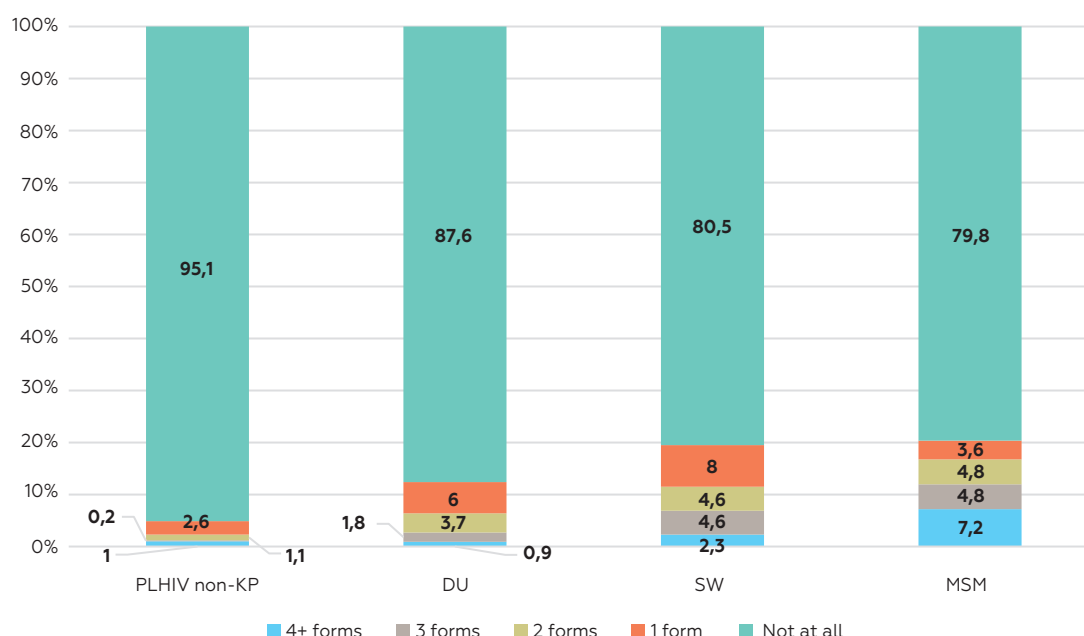
All PLHIV age groups reported having experienced some form of stigma and discrimination. More than ¼ of participants aged 18-24 (27.8%) experienced some form of stigma and discrimination in the past 12 months, while every 10th (9.8%) participant aged 25-34 and every 11th (9.0%) participant aged 35-44 reported having experienced some form of stigma and discrimination in the past 12 months.

Table 5. Proportion of respondents who experienced stigma and discrimination due to HIV status by typology, age group and gender

Features	Yes, in the past 12 months	Yes, but more than 12 months ago
Categories		
PLHIV (non-key populations)	4,9	19,4
MSM/gay	20,2	26,2
DU	12,4	38,1
SW	19,5	39,1
Age groups, %		
18-24 yrs old	27,8	16,2
25-34 yrs old	9,8	21,2
35-44 yrs old	9,0	28,6
45-54 yrs old	6,0	28,7
55+	6,8	13,5
Gender, %		
Male	7,6	24,2
Female	10,7	26,5
Total	9,0	25,2

Analysis of how PLHIV face stigma and discrimination because of their HIV status shows us that it differs according to other intersectional identities. As shown in Figure 10, MSM/gay people and people who have ever sold sex reported experiencing proportionately more forms of discrimination in the past 12 months because of their HIV status compared to people who are not part of any key population. This indicates a greater vulnerability of people who belong to more than one population group compared to the general population.

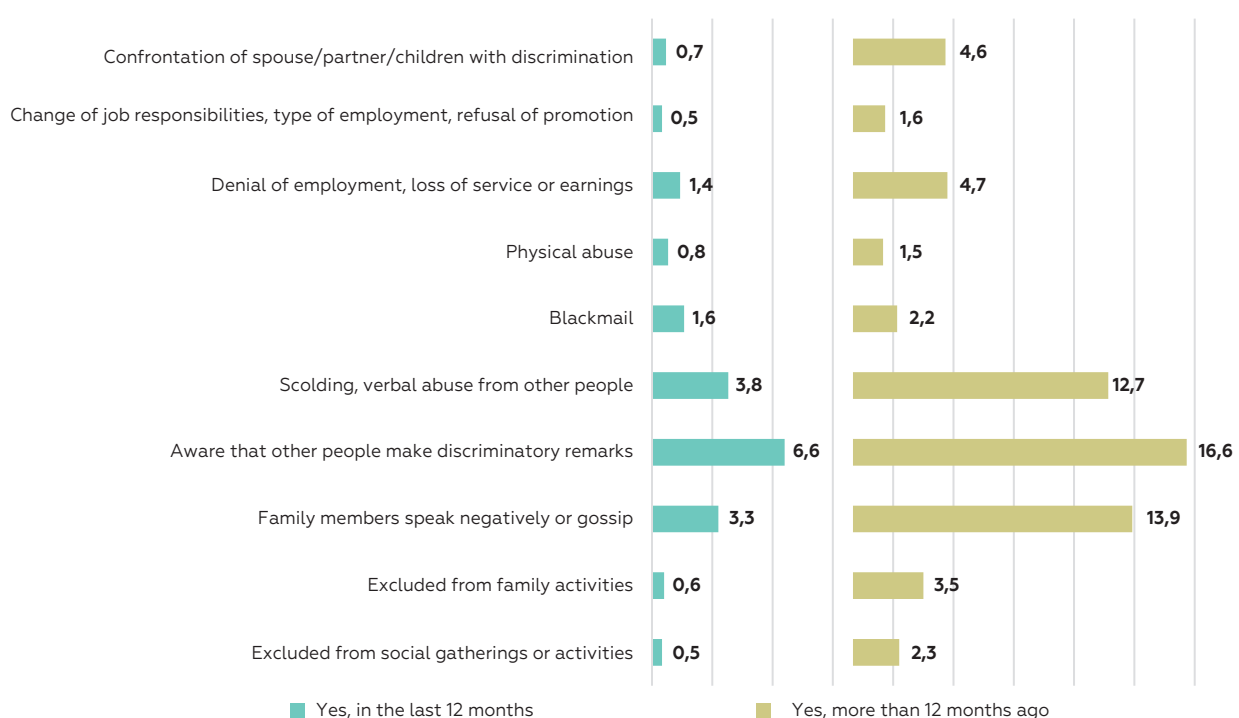
Figure 10. Number of forms of stigma and discrimination experienced in the last 12 months by type, %



Many participants reported that the most common type of stigma and discrimination they experienced was verbal, through gossip, discriminatory remarks, verbal abuse, blackmail, etc. These were the top categories for the types of stigma and discrimination faced by respondents.

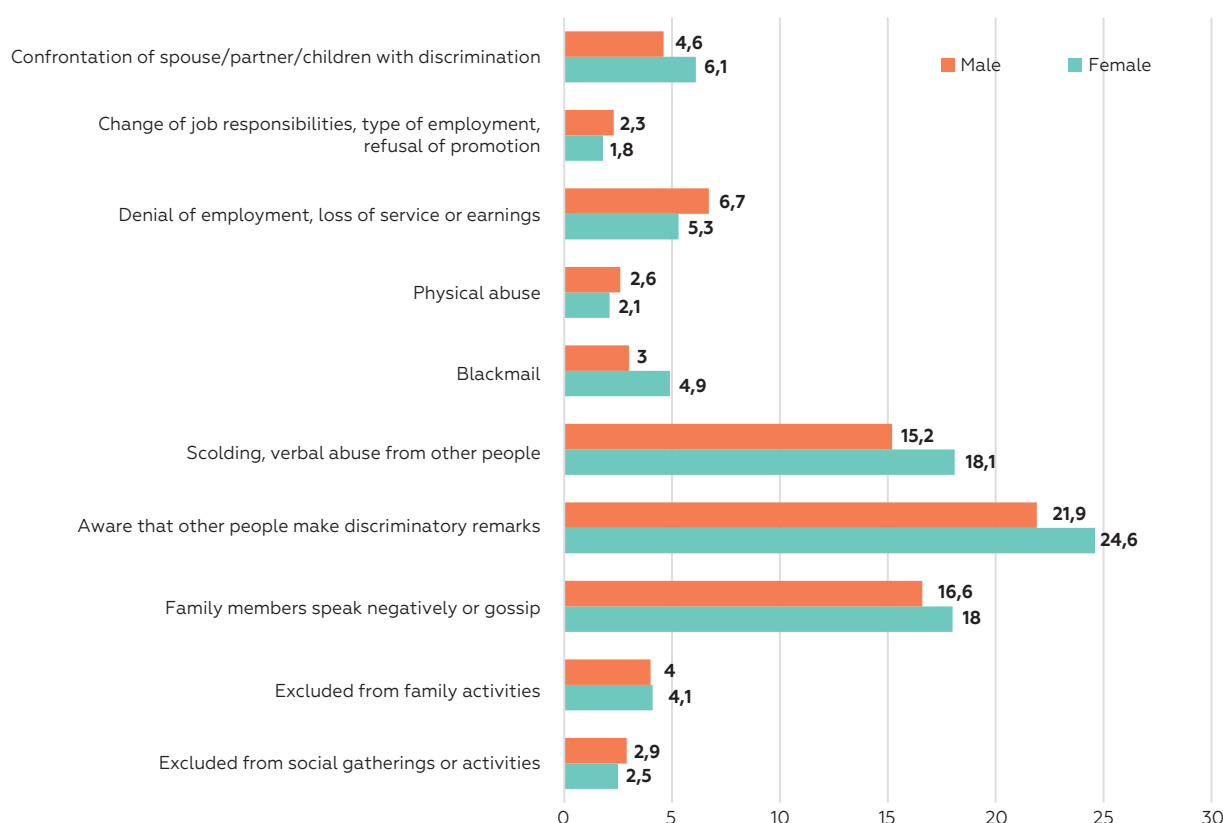
Common forms of stigma and discrimination were verbal, through gossip, discriminatory remarks and verbal harassment. Participants also identified some form of stigma and discrimination related to their employment: 12 (1.4%) in the past 12 months and 41 (4.7%) prior to the past 12 months. Physical harassment was reported by 7 (0.8%) respondents within 12 months and 13 (1.5%) prior to 12 months. Six (0.7%) participants reported that their partners or children had experienced discrimination in the past 12 months and 40 (4.6%) prior to the past 12 months.

Figure 11. Experiences of stigma and discrimination because of HIV status.



Women compared to male participants reported more often discrimination including discriminatory remarks from family members (18.0% compared to 16.6% for men) and others (18.1% compared to 15.2% for men), verbal abuse and blackmail (4.9%, compared to 3.0% for men), as shown in Figure 12. These data confirm and reflect women's vulnerability to stigma and discrimination.

Figure 12. Experiences of stigma and discrimination because of HIV status., disaggregated by gender, %



Internalized stigma

Respondents were asked about their ability to meet their needs prior to the last 12 months compared to the last 12 months. Participants indicated whether their ability to meet these needs was worse, better or about the same. Every fifth participant, 167 (19.2%) reported an improved ability to meet their needs in the past 12 months, while for 61 (7.0%) participants this ability has decreased in the last 12 months, as shown in the Figure below.

More than two-thirds (79.0%) of study participants agreed they found it difficult to tell people about their HIV status and just as many said they hide their status; almost half of participants felt ashamed (47.8%) or guilty (46.7%) about being HIV positive, while every 5th respondent (20.0%) reported feeling dirty about their HIV status.

Women more often than men find it difficult to disclose their status to people (83.7% vs. 75.2%) and hide their HIV status (82.7% vs. 75.8%). Respondents on the Right bank of Dniester river more often mentioned that they hide their status (83.9%) and find it difficult to reveal their status (82.9%); are ashamed (49.1%) or felt worthless (42.9%), compared to respondents on the Left bank of the river.

Figure 13. Ability of participants to meet their needs in the past 12 months compared to before the past 12 months, %, sample of 868 respondents,

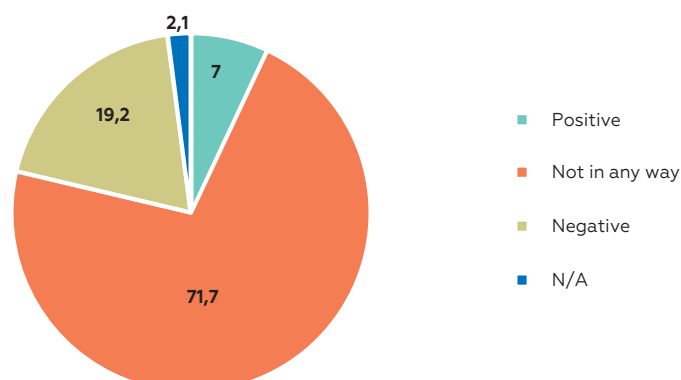


Table 6. Feelings experienced due to HIV status, in the last 12 months, disaggregated by gender, %

Features	Male (475)		Female (393)		Total	
	Agree	Disagree	Agree	Disagree	Agree	Disagree
It's hard for me to tell someone I'm HIV positive	75,2	24,8	83,7	16,3	79,0	21,0
Being HIV positive makes me feel dirty	17,3	82,7	23,4	76,6	20,0	80,0
I feel guilty about having HIV	48,8	51,2	44,0	56,0	46,7	53,3
I'm ashamed to be HIV positive	44,2	55,8	52,2	47,8	47,8	52,2
Sometimes I feel worthless because I am HIV positive	36,4	63,6	48,9	51,1	42,1	57,9
I hide my HIV status from other people	75,8	24,2	82,7	17,3	78,9	21,1

Table 7. Feelings experienced due to HIV status, in the last 12 months, disaggregated by banks of the Dniester River, %

Features	Right bank		Left bank	
	Agree	Disagree	Agree	Disagree
It's hard for me to tell someone I'm HIV positive	82,9	17,1	82,9	17,1
Being HIV positive makes me feel dirty	17,7	82,3	17,7	82,3
I feel guilty about having HIV	45,8	54,2	45,8	54,2
I'm ashamed to be HIV positive	49,1	50,9	49,1	50,9
Sometimes I feel worthless because I am HIV positive	42,9	57,1	42,9	57,1
I hide my HIV status from other people	83,9	16,1	83,9	16,1

In attempting to decipher the ability of people with HIV to respond to emotional needs, the study found that the majority of participants reported that their HIV status did not affect these abilities in any way. More than a quarter of participants reported that their self-confidence (30.6%), ability to cope with stress, ability to find love (28.8% each) and ability to secure a relationship (26.0%) were negatively affected because of their HIV status in the past 12 months, while 43 (5.0%) of participants reported that their respect for other people was positively affected because of their HIV status in the past 12 months. Forty-three (5.0%) participants reported that their ability to practice their religion/faith was negatively affected because of their HIV status, while only 14 (1.6%) were positively affected by their desire to have children. Other categories considered in this measure of resilience include the ability to achieve professional and personal goals and the ability to contribute to the community, as shown in Table 8 below.

Table 8. To what extent participants' HIV status has affected their ability to meet their emotional needs in the past 12 months, %

Features	Has positively affected	It has not affected it in any way	Has negatively affected	N/A
Self-confidence	3,9	64,6	30,6	0,8
Self-respect	3,6	76,7	19,1	0,6
Respect for other people	5,0	88,0	6,3	0,7
Ability to cope with stress	5,0	65,7	28,8	0,6
Ability to build close and secure relationships with others	4,6	67,7	26,0	1,6
Ability to find love	1,7	60,3	28,8	9,2
Desire to have children	1,6	60,8	19,7	17,9
Achieving personal and professional goals	2,1	68,9	22,9	6,1
Ability to participate in my community's life	3,2	68,0	8,6	20,2
Ability to practice faith/religion as I wish	1,7	76,7	5,0	16,6

Out of 868 respondents who were asked about the actions they took due to internalized stigma, 95 (10.9%) reported they chose not to have sex, of whom the majority (52, 13.2%) were female and 52 (21.6%) were from the left bank of Dniester river. 74 (8.5%) participants chose not to apply for jobs, of whom 43 (58%) were female and 74 (8.5%) participants avoided going to the hospital when they needed to, of whom 37 (9.4%) were female and 36 (14, 9%) were from the left bank. 66 (7.6%) participants chose not to seek social support and 54 (6.2%) participants isolated themselves from family and friends, with 27 (11.2%) respondents from the left bank of Dniester river compared to 27 (4.3%) from the right bank.

Table 9. Self-restrictions due to HIV status, last 12 months, disaggregated by gender, %

Features	Male (475)	Female (393)	N = 868
I preferred not to attend social events	5,3	3,8	4,6
I chose not to seek medical help	7,8	9,4	8,5
I chose not to commit to work	6,5	10,9	8,5
I chose not to seek social support	9,5	5,3	7,6
I have isolated myself from family and/or friends	6,3	6,1	6,2
I chose not to have sex	9,1	13,2	10,9

Table 10. Self-restrictions due to HIV status, last 12 months, disaggregated by banks of the Dniester River, %

Features	Right bank	Left bank	N = 868
I preferred not to attend social events	5,3	2,9	4,6
I chose not to seek medical help	6,1	14,9	8,5
I chose not to commit to work	7,5	11,2	8,5
I chose not to seek social support	8,0	6,6	7,6
I have isolated myself from family and/or friends	4,3	11,2	6,2
I chose not to have sex	6,9	21,6	10,9

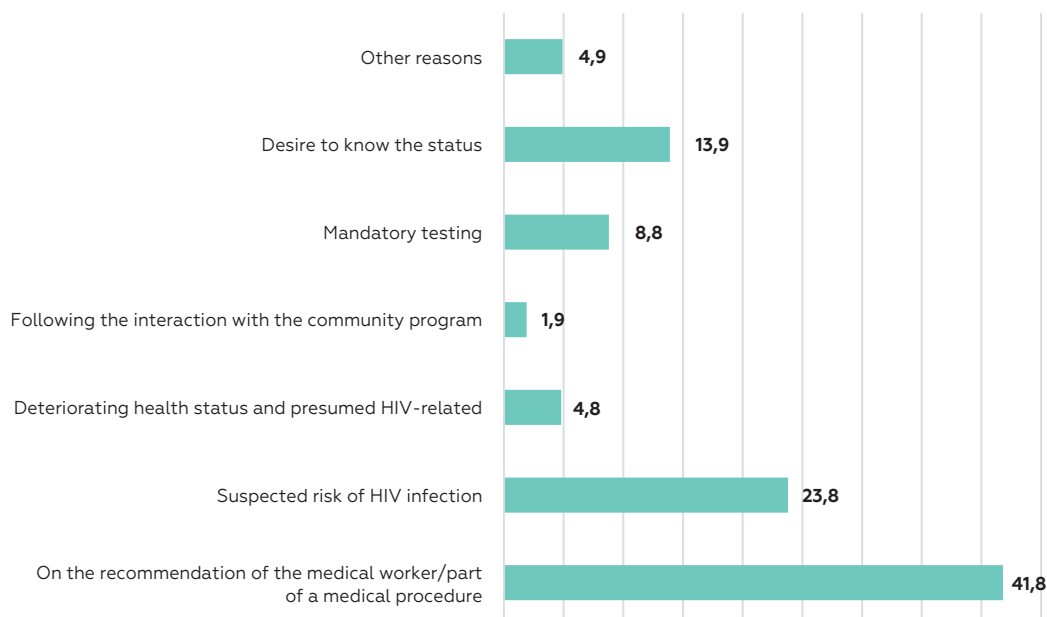
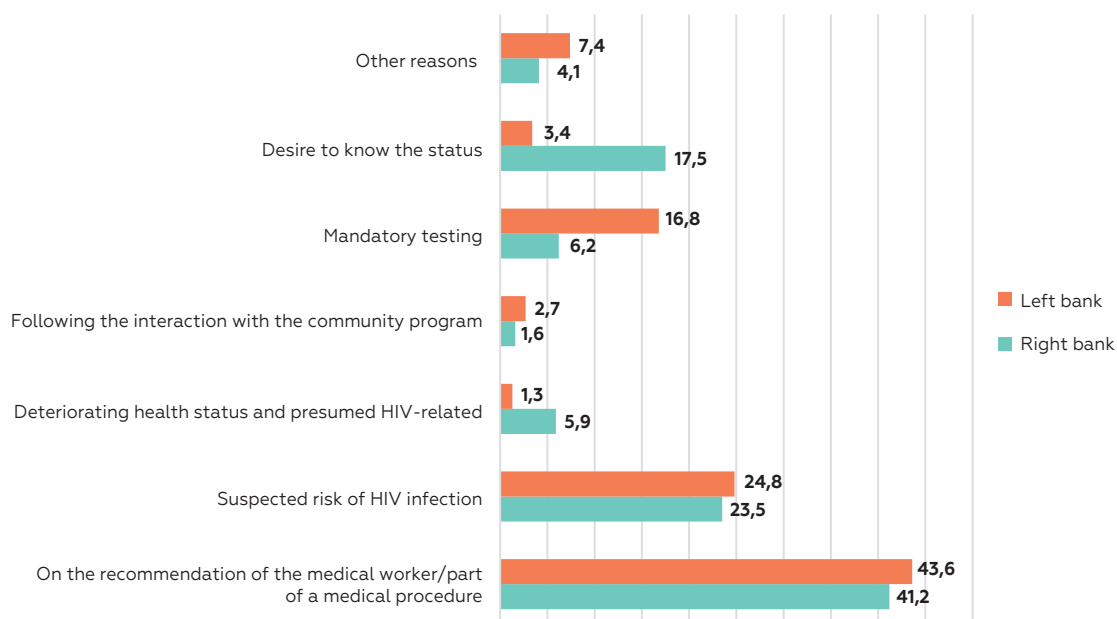
Interaction with healthcare services

HIV testing, care and treatment

Almost 2/3 of the sample – 545 (62.8%) participants – tested on their own initiative, 43 (5.0%) participants reported they had been pressured to test for HIV; 254 (29.3%) participants reported they had been tested without their knowledge and only found out after testing. Only 2.4% of respondents reported having been forced to take an HIV test and 5 (0.6%) participants reported being born HIV-positive. Respondents on the left bank of Dniester river more frequently reported being pressured 27 (11.2%), or forced to test for HIV 13 (5.4%) compared to respondents on the right bank 16 (2.6%) and 8 (1.3%) respectively.

Participants who tested for HIV on their own initiative were then asked how long it took them to decide to get tested for HIV. More than 2/3 – 413 (70.2%) of participants reported that it took them 6 months or less, while about every tenth respondent (11.2%) reported that more than 6 months passed before they decided. One hundred seventy-three (29.4%) participants said the reason for their hesitancy to get tested was due to fear of how other people would respond to their result.

Moreover, 246 (41.8%) participants said testing had been recommended by the healthcare worker or was part of a complex medical service, while 52 (8.8%) said testing had been mandatory, as shown in Figure 14. Mandatory HIV testing is more frequently reported 25 (16.8%) by left bank respondents compared to right bank respondents 27 (6.2%), and conversely, simple curiosity to find out their status is more frequently reported by right bank respondents 77 (17.5%) compared to left bank respondents 5 (3.4%).

Figure 14. Reason for HIV testing**Figure 15. Reason for HIV testing, right bank/left bank**

In terms of starting treatment, participants were asked about why they hesitated, delayed or were prevented from starting HIV care or treatment. 279 (32.1%) said they were not ready to cope with HIV infection; 260 (30.0%) participants said they were worried about other people who were not family/friends finding out; 255 (29.4%) participants feared bad treatment from health workers or disclosure of their status without their consent; 201 (23.2%) of participants were worried their partner/family/friends would find out; 119 (13.7%) participants reported they were late because they had previously had bad experiences with health workers.

The 850 (97.9%) participants who responded they had already been on treatment were asked about their reasons for starting ARV treatment. 685 (80.5%) participants reported they had been told of the benefit and chose to start it when offered. 143 (16.8%) persons said they decided to wait and start later when offered treatment; 11 (1.3%) persons said they felt pressured or forced

by medical staff to start treatment, and 12 (1.4%) said they started treatment for other reasons. There were also questions about the interval between HIV diagnosis and starting treatment. As shown in the table below, about ¼ of respondents who had ever been on treatment (23.5%) started ART immediately after their HIV-positive diagnosis; for more than ¼ (27.8%) of participants the time from diagnosis to initiation of ART was between one day and one month. At the same time, 193 (22.7%) participants started ART 2 years or more after diagnosis.

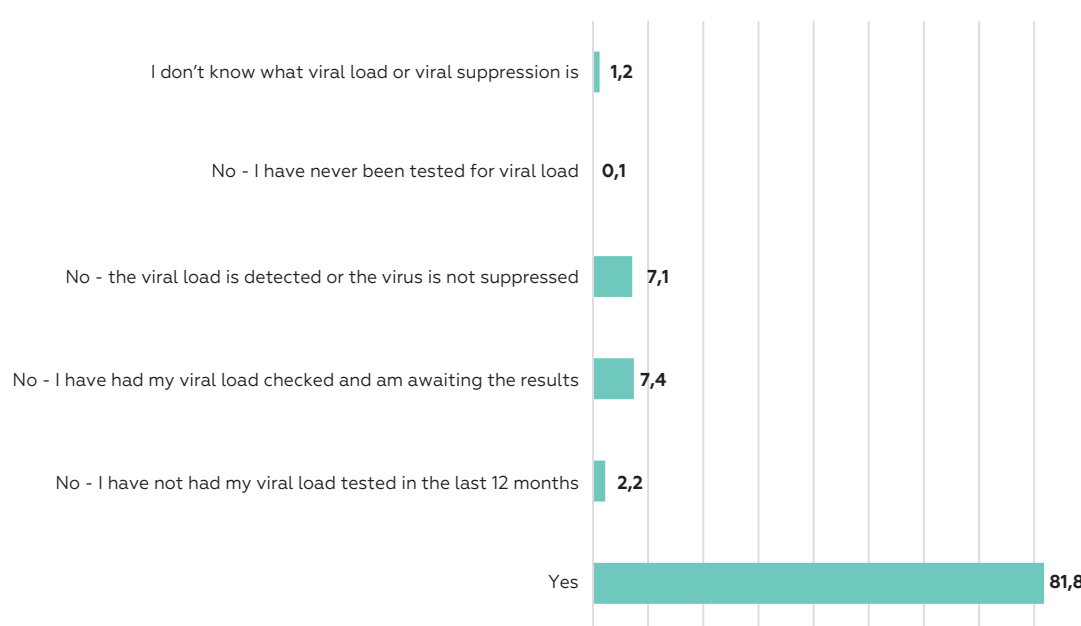
Table 11. Time between HIV diagnosis and starting treatment, %

Features	#	%
Immediately or the same day the diagnosis was made	200	23,5
>1 day and up to 1 month (30 days) after diagnosis	236	27,8
>1 month and up to 6 months after diagnosis	82	9,6
>6 months and up to 2 years after diagnosis	78	9,2
>2 years after diagnosis	193	22,7
I don't remember	61	7,2

Interaction with health services

More than 4/5 (81.8%) of the participants responded that at their most recent test in the last 12 months their viral load was undetectable; 63 (7.4%) were awaiting the result of their viral load test; 62 (7.3%) participants had detectable viral load; and 10 (1.2%) participants reported they did not know what viral load or viral suppression was, as shown in the Figure below. Members of a key population more often mentioned undetectable viral load (85.6%) compared to non-members of a key population (79.3%). Women, in an insignificantly lower proportion, have an undetectable viral load (80.9%), compared to men (82.5%).

Figure 16. Viral load undetectable in latest viral load test



In terms of stopping or discontinuing treatment, 195 (22.9%) participants reported some time stopping or discontinuing their treatment. Stopping or discontinuing treatment was mostly due

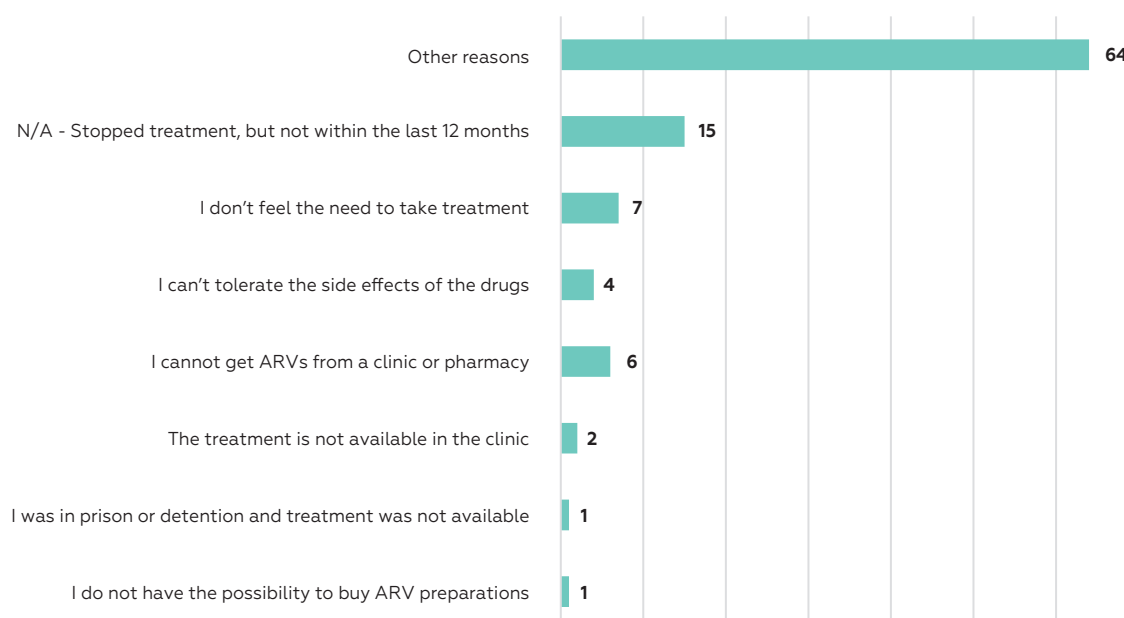
to reasons other than stigma 100 (51.3%), 31 (15.9%) participants – unprepared to do anything about their HIV status, 20 (10.3%) participants – worried that someone else would find out their HIV status, and these data are presented in the table below.

Table 12. Causes of stopping or discontinuing antiretroviral treatment, 195 respondents

Features	#	%
I was worried that someone would find out about my HIV status	20	10.3
I wasn't ready to do anything about my HIV status	31	15.9
I was scared that health professionals (doctors, nurses, staff) would treat me badly or reveal my status without my consent	2	1.0
I was refused HIV treatment (ARV) because I was using drugs at the time	0	0.0
N/A – I have never taken or stopped antiretroviral therapy in the last 12 months	42	21.5
Reasons other than stigmatization	100	51,3

One hundred (100%) participants had other reasons for stopping or discontinuing ARV treatment that were not related to stigma. Seven respondents (7%) reported they did not feel the need to take treatment; 6 participants (6%) reported they could not take medication from the treatment centre; four participants (4%) could not tolerate the side effects of medication, while other reasons mentioned by participants included being abroad – 19 participants (19%), alcohol consumption – 14%, memory problems (11%) and financial problems (10%), personal reasons (7%) etc.

Figure 17. The main non-stigma-related reasons for stopping or discontinuing treatment



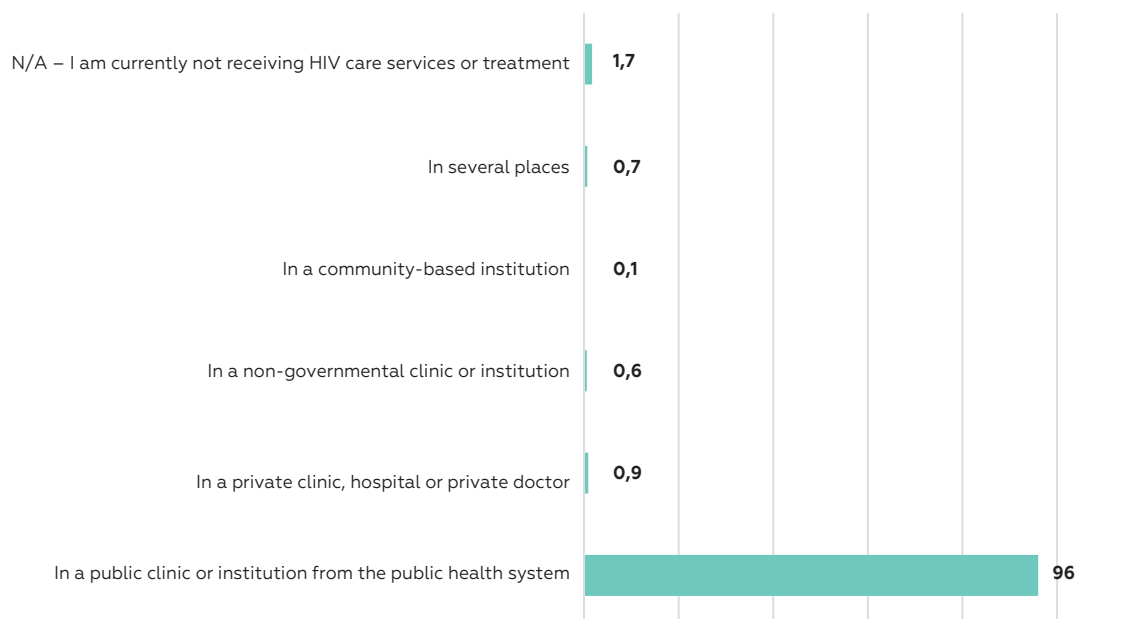
Respondents were asked about their overall health: 396 (45.6%) reported being in good health; 402 (46.3%) participants described their health as average; and 70 (8.1%) participants said their health was poor. The study investigated the diagnosis of other HIV/AIDS-related diseases/conditions. Most commonly reported were diagnosed mental health disorders – 109 respondents (12.6%), followed by non-communicable diseases (10.5%), alcohol/drug dependence (9.3%), viral hepatitis (6.0%), tuberculosis (3.8%) and sexually transmitted diseases (3.8%). Men, compared to women, more often reported mental health disorders (13.5% compared to 11.5%), alcohol/drug addiction (11.2% compared to 7.1%), viral hepatitis (7.2% versus 4.6%), sexually transmitted diseases (5.9% versus 1.3%) and tuberculosis (4.6% versus 2.8%). Participants who are members of a key population more often alleged poor health (10.9%) than other participants (6.2%) and more often reported mental health disorders (21.6% versus 6.8%), alcohol/drug addiction (19.8% versus 2.6%), viral hepatitis (12.1% versus 2.1%), sexually transmitted diseases (8.9% versus 0.6%) and tuberculosis (5.6% versus 2.6%). Of those diagnosed in the past 12 months, 62.9% reported being offered treatment for these conditions, while 34.0% had not taken any medication or treatment. Most respondents (70.2%) reported they had not been diagnosed with any of the conditions.

Table 13. Health status assessment and diagnosis of HIV-related diseases

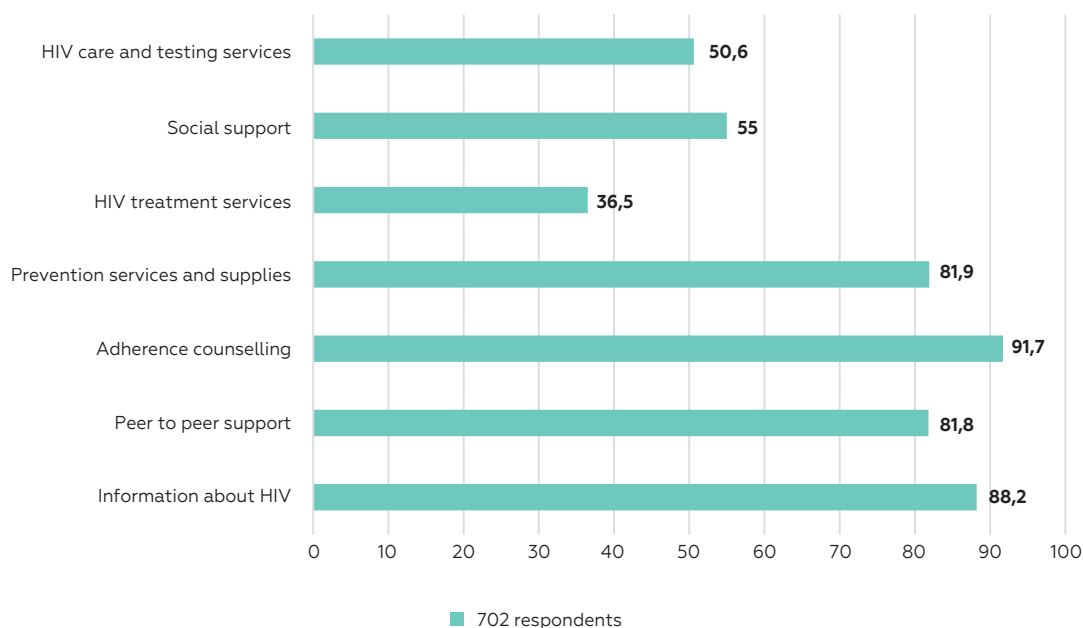
Features	#	%
Self-assessment of health status		
Good	396	45.6
Average	402	46.3
Bad	70	8.1
Diagnosis with other diseases		
Tuberculosis (TB)	33	3.8
Viral hepatitis	52	6.0
Sexually transmitted diseases (e.g. herpes, gonorrhoea, chlamydia, syphilis)	33	3.8
Mental health disorders (e.g. anxiety, depression, insomnia, post-traumatic stress disorder)	109	12.6
Non-communicable disease(s)	91	10.5
Opportunistic infection(s)	19	2.2
Alcohol/drug dependence syndrome	81	9.3

Experience in obtaining services

The majority of the participants – 833 (96.0%) – confirmed they had received HIV care and treatment in public health facilities; 8 people (0.9%) – in a private clinic; 5 (0.6%) – in a non-governmental clinic or institution; 6 people (0.7%) reported having received treatment in more than one place, while 15 (1.7%) stated that they were neither under medical supervision nor receiving treatment.

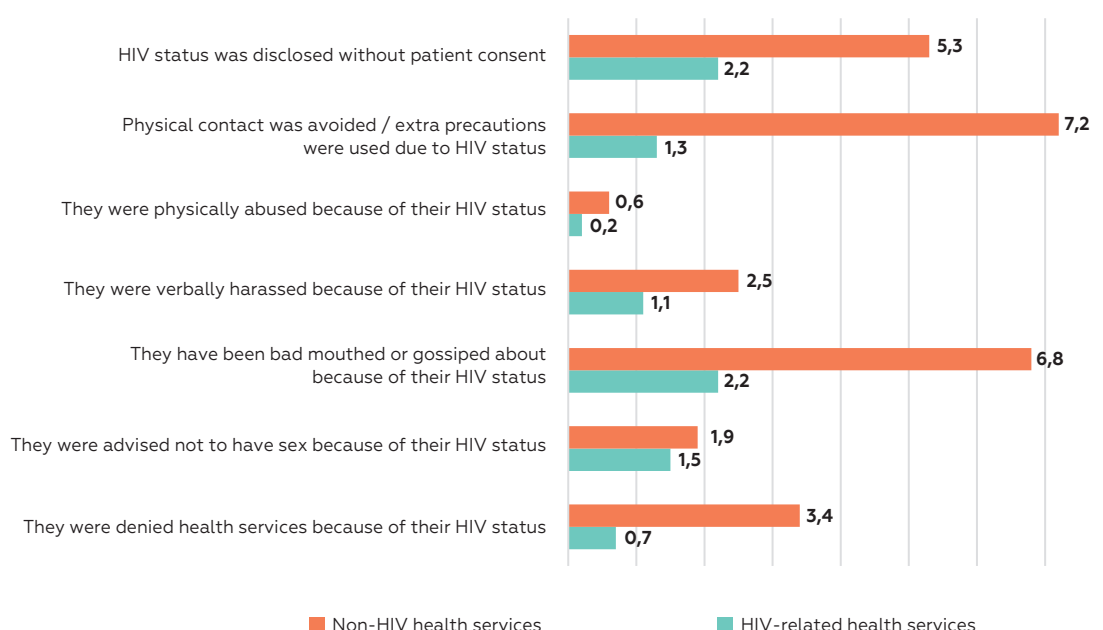
Figure 18. Locations of access to health services

About 2/3 of the sample (65.8%) know about the existence of community centres that offer HIV services and have access to HIV-related care, 15.1% know about the existence of these centres but do not have access to HIV-related care, every 6th (16.9%) did not know about the existence of these community centres. The most frequently mentioned services available in community centres were adherence counselling (91.7%), HIV information (88.2%), prevention services and supplies (81.9%), and peer support (81.8%). Key group participants are more familiar with the availability of most of the services mentioned in community centres that provide HIV services.

Figure 19. HIV-related services available in community-based/community-led organizations, 702 respondents, %

When asked about stigma experienced in the past 12 months on behalf of the health facility staff because of their status when seeking HIV-specific health care, 6 participants (0.7%) disclosed refusal of HIV-related health services because of their HIV status, compared to 3.4% who reported refusal of non-HIV-related health services because of their HIV status. It should be noted that over 1/3 (37%) of the sample reported needing medical assistance for reasons other than HIV infection in the past 12 months. Avoiding physical contact/use of additional protective measures (7.2%) and gossiping because of HIV status (6.8%) were the most common forms of discrimination by health care workers, as shown in Figure 20.

Figure 20. Experiences of stigma and discrimination due to HIV status on behalf of medical staff, in the last 12 months %



1 in 4 participants (25.3%) of the total population confirmed their status was known to other people/health facilities outside the unit/clinic where they received HIV care and treatment. More than half of the respondents (479), representing 55.2% of the total population surveyed, with a higher proportion of respondents from the Left bank of Dniester river (57.7%) compared to the Right bank (54.2%) were confident that their medical records were kept confidential. 321 PLHIV (37.0%) were not confident of this, and the remaining 7.8% claimed their medical records were not kept confidential. The respondents from the left bank of Dniester river said more often (10.8%), compared to those on the right bank (6.7%), that their medical records were not kept confidential.

Sexual and reproductive health

The tables below show the negative actions of health workers towards people living with HIV and women living with HIV by region. Most often people with HIV have been advised by health workers not to have children because of their status. In terms of actions against PLHIV women, the most frequent action was by health workers advising them to terminate pregnancy (11.4%). Health workers' actions towards PLHIV occurred most frequently in the central and northern localities.

Table 14. Health workers' actions towards people with HIV because of their HIV status in the last 12 months

Features	Chisinau	North	Centre	South	Left bank	Total
They were advised not to have children	4	4	4	2	3	21 (2,4%)
Were pressured or encouraged to get sterilized	4 ⁹		1		2	8 (0,8%)
They were told that in order to receive HIV treatment they had to use (a certain method of contraception)		1	1			2 (0,2%)

Table 15. Health workers' actions in relation to women with HIV because of their HIV status

Features	Yes, in the past 12 months	Yes, but not in the past 12 months	No	N/A	I'd rather not answer	Total
They were advised to terminate their pregnancy	4	41	249	99	0	45 (11,4%)
There was pressure to use a particular type of contraception	1	21	325	47	0	22 (5,6%)
Pressure was exerted in choosing a specific method of delivery	1	12	266	114	0	13 (3,4%)
Pressure was exerted in choosing a specific method of feeding the child	0	17	256	119		17 (4.3%)
Have you been pressured to take antiretroviral therapy during pregnancy	0	8	267	117	1	8 (2.0%)

Rights, legislation and policies

Asked about incidents in which some of their rights were violated by discriminatory practices of state institutions, 55 (6.3%) participants reported they had been required to test for HIV in order to receive health services, with a significantly higher share of respondents on the left bank of Dniester river (19.5%) than on the right bank (1.3%). 40 (4.6%) participants were forced to disclose publicly their HIV status, or it was revealed without their consent, with 9.1% among respondents on the left bank, compared to 2.9% among respondents on the right bank, while 29 (3.4%) participants reported being forced to take an HIV test or disclose their status to apply for a job or get a pension plan, with 7.5% of respondents on the left bank, compared to 1.8% of respondents on the right bank. Other categories are highlighted in Table 16 below:

⁹ 1 respondent did not remember the place

Table 16. Incidence of rights violations due to HIV+ status

Features	Male	Female	Right bank	Left bank	Total
Forced to take an HIV test in order to...					
...obtain a visa or apply for a residence/ citizenship permit in Moldova or another country	11 (2,3%)	5 (1,3%)	11 (1,8%)	5 (2,1%)	16 (1,8%)
...apply for a job or resort to the pension fund	15 (3,2%)	14 (3,6%)	11 (1,8%)	18 (7,5%)	29 (3,4%)
...attend an educational institution or receive a scholarship	1 (0,2%)	1 (0,3%)	1 (0,2%)	1 (0,4%)	2 (0,2%)
...enjoy healthcare services	33 (6,9%)	22 (5,6%)	8 (1,3%)	47 (19,5%)	55 (6,3%)
...obtain health insurance	8 (1,7%)	3 (0,8%)	7 (1,1%)	4 (1,7%)	11 (1,3%)
Arrested or convicted for reasons related to HIV status	2 (0,4%)	1 (0,3%)	2 (0,3%)	1 (0,4%)	3 (0,3%)
Detained or placed in isolation due to HIV status	0 (0,0%)	1 (0,3%)	1 (0,2%)	0 (0,0%)	1 (0,1%)
Because of his HIV status, he was refused a visa or entry to the Republic of Moldova	9 (1,9%)	5 (1,3%)	10 (1,6%)	4 (1,7%)	14 (1,6%)
Has been denied a place to live or a residence permit because of HIV status	13 (2,7%)	8 (2,0%)	15 (2,4%)	6 (2,5%)	21 (2,4%)
Was forced to disclose his/her HIV status publicly or it was disclosed without their consent.	24 (5,1%)	16 (4,1%)	18 (2,9%)	22 (9,1%)	40 (4,6%)
Was forced to have sex against their will.	4 (0,8%)	14 (3,6%)	14 (2,2%)	4 (1,7%)	18 (2,1%)
Was denied a shelter for victims of domestic violence	0 (0,0%)	3 (0,8%)	3 (0,5%)	0 (0,0%)	3 (0,3%)
Their spouse/partner prevented them from receiving health services (public health, private sector, community provided services)	0 (0,0%)	10 (2,5%)	7 (1,1%)	3 (1,2%)	10 (1,2%)

Many respondents (85.5%) participating in the survey claimed that their rights had never been violated. Of the participants who had experienced abuse of their rights, only 4 (0.5%) participants had sought compensation for damages, while 41 (4.7%) respondents opted not to do so. Of the people living with HIV who sought corrective measures to the abuse they received, two (0.1%) reported contacting a community organisation/network of people living with HIV for support, one participant approached the police and one participant decided to look for another job to avoid spreading the information.

Of the 4 respondents who tried to compensate for the damage, 2 reported that nothing happened/ problem was not solved; for one respondent the problem was solved; and one respondent said the solution of the problem was under consideration. The study also investigated the reasons why people with HIV did not take action against violations of their rights. The most common reason for not taking action was that they did not know where to go (7, 17.1%); were afraid their actions would lead to people finding out about their HIV status (6, 14.6%); uncertainty about the success of the action's outcome; and 6 respondents reported they did not consider it necessary to undertake something/ did not consider it a violation, as shown in Figure 21 below. Two respondents indicated they had been refused when applying for a visa to reside in Russia.

Figure 21. Reasons why people with HIV have not taken action against rights violations



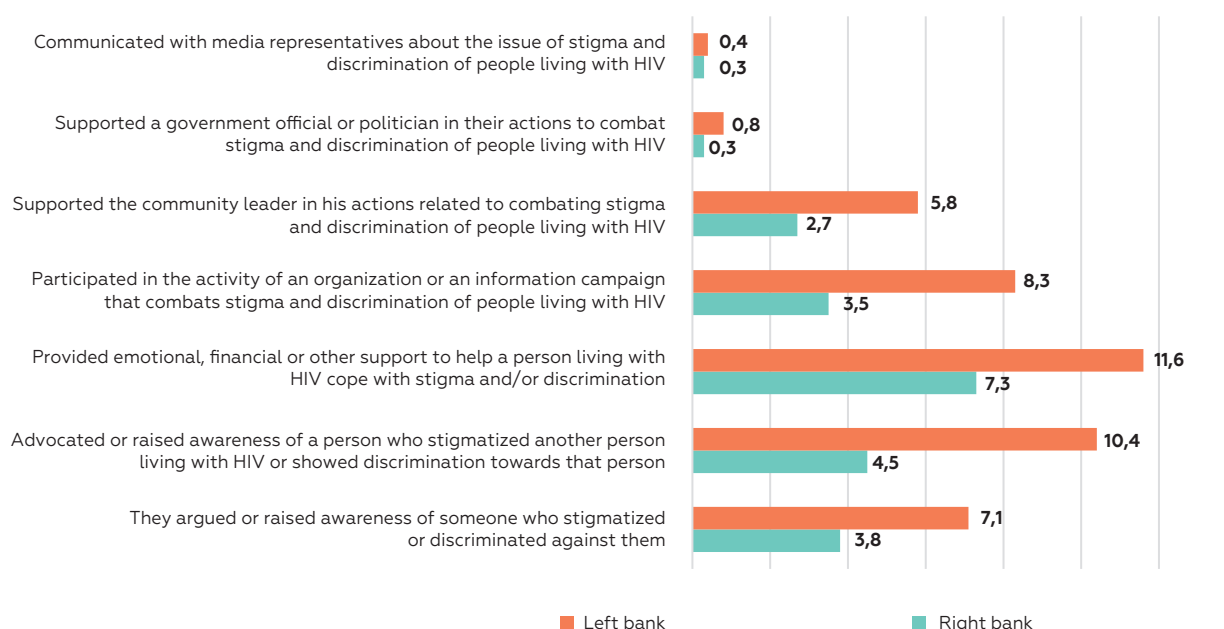
Nearly half of the respondents – 406 (46.8%) – with a share over twice as higher for the respondents from the right bank of Dniester river (55.7%) than on the left bank (23.7%) indicated they were aware of the laws protecting their rights in the Republic of Moldova. At the same time, 100 (11.5%) participants, 17 (2.7%) on the right bank and 1/3 (83, 34.4%) on the left bank considered these laws to be non-existent and a total of 362 PLHIV were unaware of such laws.

To prevent the frequent occurrence of stigma and discrimination, few of the people with HIV interviewed engaged in education campaigns to increase public awareness of HIV. In the past 12 months, 8.5% of respondents reported having provided emotional, financial or other support to help a person living with HIV cope with stigma and/or discrimination; 6.1% argued or raised awareness of a person stigmatizing or discriminating against another person living with HIV; and only 4.7% of PLHIV argued or raised awareness of a person committing abuse. All actions taken by respondents to prevent the frequent occurrence of stigma and discrimination were more frequently (twice as often) mentioned by left bank respondents as compared to right bank respondents, as shown in Table 17 below.

Table 17. Actions taken by respondents

Features	Yes, in the past 12 months	Yes, but NOT in the past 12 months
Argued or raised awareness of a person who stigmatized or discriminated against them	4,7	13,8
Argued or raised awareness of a person stigmatizing or discriminating against another person living with HIV or showed discrimination against them	6,1	11,5
Provided emotional, financial or other support to help a person living with HIV cope with stigma and/or discrimination	8,5	8,6
Participated in the work of an organization or information campaign that combats stigma and discrimination against people living with HIV	4,8	5,3
Supported the community leader in their work to combat stigma and discrimination against people living with HIV	3,6	4,3
Supported a government official or politician in their actions related to combating stigma and discrimination against people living with HIV	0,5	1,6
Communicated with the media representatives about stigma and discrimination against people living with HIV	0,3	1,6

Figure 22. Actions taken by respondents in the last 12 months %, disaggregated right bank/ left bank



Stigma and discrimination on grounds other than HIV status

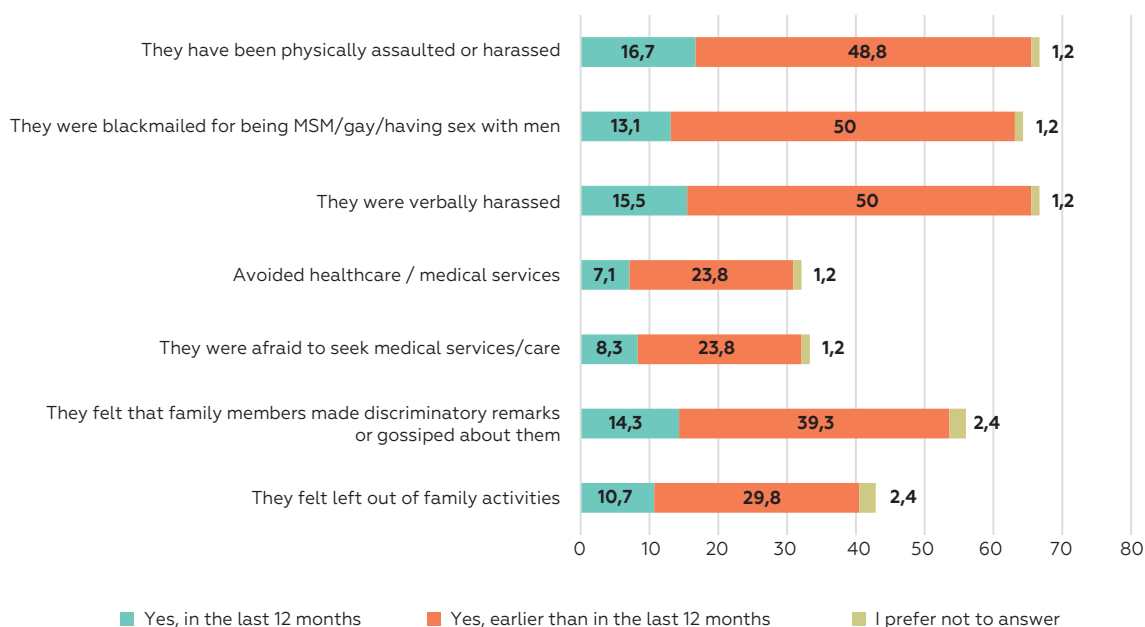
Gender identity

There were 3 participants in the sample who do not identify themselves with the gender they were assigned at birth. They answered questions about whether they had been victims of more than one discriminatory act and verbal abuse, even from family members in the past 12 months. Of this subgroup, 1 (0.1%) participant confirmed that he had been excluded from family activities prior to the last 12 months, had been the victim of a number of discriminatory acts and verbal abuse by family members prior to the last 12 months, and had been subjected to blackmail because of the gender identity. This respondent did not confirm that his gender identity was known to the family, friends and others in their community, but only to other transgender people or people whose gender was different from their sex specified at birth.

Gay/ homosexuals/ MSM

PLHIV who identified themselves as Gay/Homosexual/MSM (9.7%) were asked if they had experienced any form of discrimination and verbal abuse in the past 12 months because they were Gay/Homosexual/MSM. Every 6th respondent, out of those who identified themselves as Gay/Homosexuals/MSM – 14 (16.7%) – reported they were physically assaulted/harassed, 13 (15.5%) participants were verbally harassed; 12 (14.3%) participants experienced discriminatory bullying/gossip from their family members as shown in Figure 21 below. Subsequent participant responses indicated other gay men were aware of their status (78 MSM, 92.9%), 64 respondents (76.2%) stated their sexual orientation was known to family/friends and 68 respondents (81%) including community members.

Figure 23. Stigma for being gay/ homosexual/ MSM



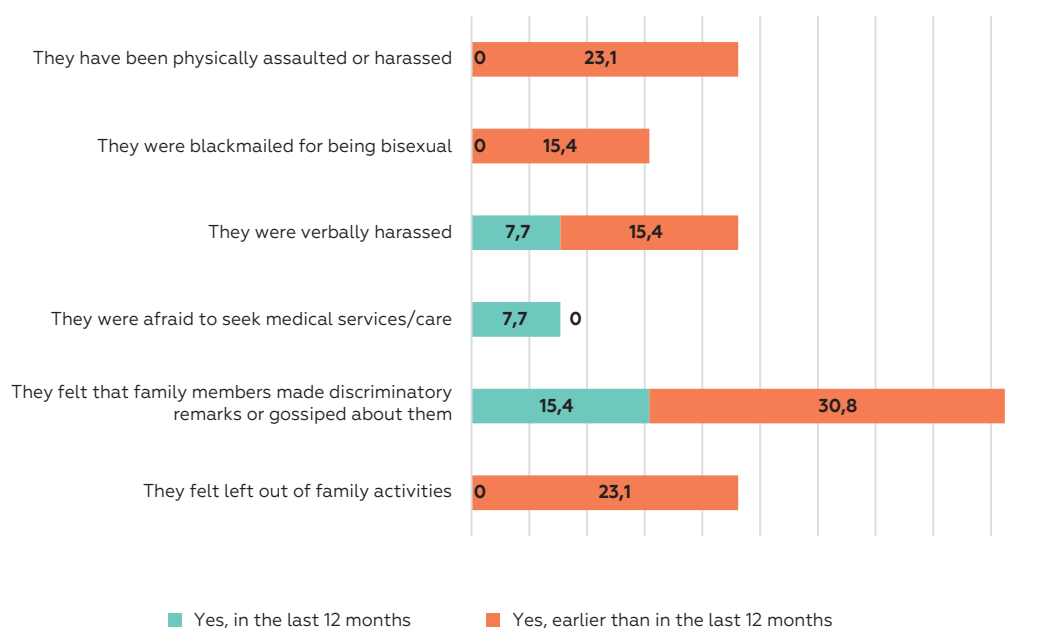
Lesbians/WSW

In the sample, there were 5 people (0.6%) who identified themselves as lesbian/women who have sex with women, who were asked about their experiences of stigma caused by being a lesbian/WSW. No respondents reported they had been a victim of discrimination or abuse in the past 12 months or prior to that period because they were lesbian/WSW. Only one respondent confirmed that other lesbians/WSW, family, friends and others in her community knew that she was a lesbian/WSW.

Bisexual participants

Thirteen people (1.5%) declared themselves to be bisexual, and all of them claimed to have been abused and stigmatized by their family members and the rest of society. Two PLHIV (15.4%) confirmed their family members had made discriminatory remarks and gossiped about them in the past 12 months, as shown in Figure 24. All 13 people reported that other bisexual people were aware of their sexual orientation. They claimed that their family and friends (10 respondents – 76.9%) and community members (11 respondents – 84.6%) were also aware of their sexual orientation. Subsequent responses indicated that 6 (46.2%) of these individuals belong to support groups for bisexual persons/who have sex with men and women.

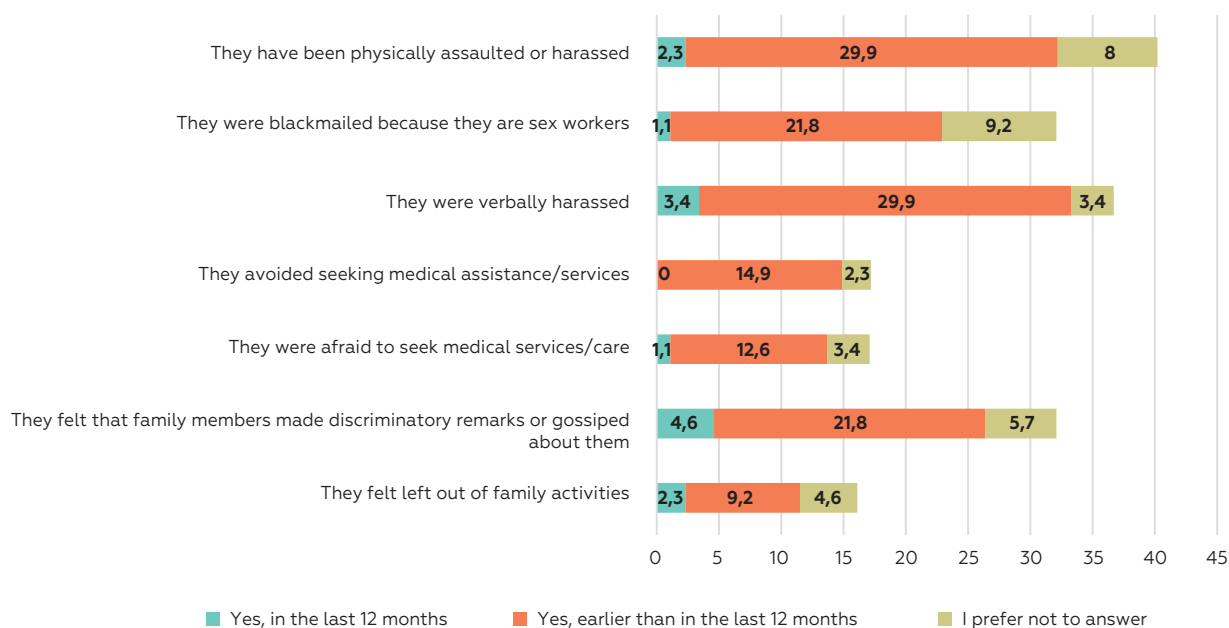
Figure 24. Stigma for being bisexual



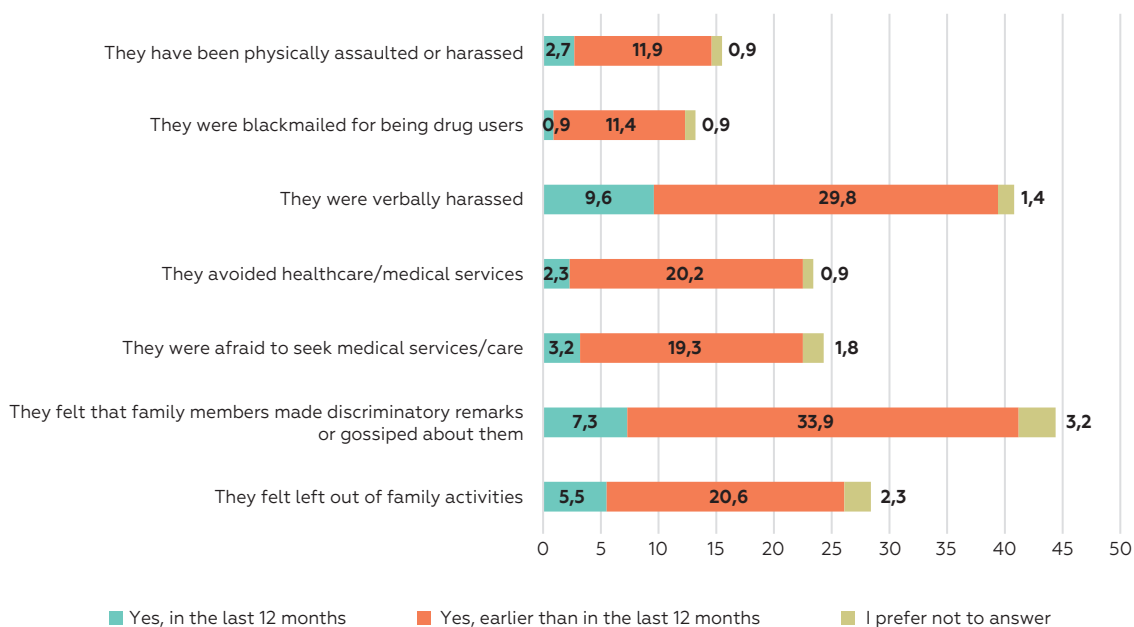
Sex workers

Study participants who identified themselves as sex workers (3.3%) and people who had ever sold sex (10.0%) also experienced discrimination by family members and others.

In the past 12 months, four respondents (4.6%) reported their family members made discriminatory remarks and gossiped about them, three respondents (3.4%) were verbally assaulted, and two respondents (2.3%) were excluded from family activities in the past 12 months, as shown in Figure 25. In addition, 25 PLHIV (28.7%) indicated that family or friends knew about their occupation, while 15 (17.2%) of this population reported belonging to a network or support group for people who are (or were) sex workers or sell (or sold) sex.

Figure 25. Stigma for being sex workers**Drug users**

In the study sample, 218 (25.1%) people reported having used drugs some time, 158 (18.2%) of the enrolled participants identified themselves as people who have been using (or used) drugs. Participants who had ever used drugs were asked about their experiences of stigma caused by the fact that they have been using drugs.

Figure 26. Stigma for being drug users

Of the study sample, 6.5% of enrolled participants, identified as drug users, also experienced some form of discrimination from their family members. Of these, 21 respondents (9.6%) indicated they had been verbally harassed; 16 (7.3%) participants reported their family members had made discriminatory remarks and had gossiped about them; 12 (5.5%) had felt excluded from family activities in the past 12 months because they were (had been) using drugs. At the same time, seven (3.2%) participants were afraid to seek medical care/services because they were afraid that someone might find out they were using drugs, as shown in Figure 26 below.

The majority of the participants – 196 (89.5%) – who use drugs indicated that their peers were aware they are/were drug users. Over $\frac{3}{4}$ of respondents (170, 77.6%) indicated that their family and friends knew they were using drugs, and 146 (66.7%) reported that other people in the community knew they were using drugs. Out of them 85 (38.8%) DUs belonged to the Support Group for drug users.

DISCUSSIONS

The aim of the study was to describe the different forms of stigma and discrimination experienced by PLHIV in the Republic of Moldova. The results of the Stigma Index Study 2.0 showed that the diversity of PLHIV profiles and locations was achieved in proportion to that set for recruitment. A balanced distribution was also achieved for the characteristics of the recruited respondents, such as: age groups, length of time living with HIV, education level, occupational status. Self-identification of respondents as members of marginalised groups was also performed.

All of the above regarding the diversity of the recruited group suggests that the information generated by the study reflects the experiences of different population groups and cultures. This means that the results can be extrapolated to a wider population. Furthermore, taking into account the gender distribution, with 45% of all recruited respondents being female participants, we can see that these data were proportional to the general population of HIV-positive women in the Republic of Moldova (\approx 46% of people living with HIV).

Large proportions of men who have sex with men (MSM) (38.1%), sex workers (SW) (20.7%) and people who have ever used drugs (DU) (22.0%) have experienced HIV status disclosure without their consent. This had repercussions on the respondent's psychological state and mental health, led to decreased respondent self-esteem and self-stigma. The highest proportion of disclosure without consent for MSM and SW occurred among respondents' neighbours, and for DU – within law enforcement, judicial and investigative authorities. Involuntary disclosure of HIV status indicates that HIV infection is still widely perceived as socially dangerous. Involuntary or inappropriate disclosure of HIV status results in denial of employment, violence and many other collateral consequences. Respondents were quite divided in their experiences of disclosing their status. Only 1/3 of respondents reported that over time it had become easier for them to disclose their HIV status. More than 2/3 of respondents agreed that voluntary disclosure was a positive experience and mentioned the support of loved ones when they first learned their HIV status. This demonstrates the need for strategies that encourage HIV status disclosure and the necessary scale-up of index testing, especially among highly marginalized populations with a high burden of HIV infection. This issue illustrates the importance of family members supporting individuals to accept their diagnosis and learn to live with it as with any chronic disease.

The study also found that every fifth MSM (20.2%) and SW (19.5%) and every eighth DU (12.4%) respectively experienced HIV-related stigma and discrimination in the past 12 months, compared to 4.9% of respondents who are not members of a key population. This is a direct indication of the increased risk of discrimination faced by members of key population groups because of their HIV status. Despite the fact that the proportion of MSM, SW and DU who reported experiencing stigma and discrimination actions and attitudes in the last 12 months is lower compared to the proportion of those who experienced stigma and discrimination prior to the last 12 months, this still remains a major problem. It is most likely to be associated with double discrimination in the case of key groups, both as a PLHIV and as a member of the key group they represent. Younger adults (18-24 years) experienced considerably more stigma and discrimination in the last 12 months (27.8%) compared to middle-aged adults (25-34 years) (9.8%) and 35-44 years (9.0%) and older adults (45-54 years) (6.0%) and 55+ years (6.8%). Every 10th woman (10.7%) had experienced some form of stigma in the past 12 months, while every fourth (26.5%) indicated that they had ever experienced some form of stigma and discrimination. Verbal abuse, discriminatory remarks and gossip were reported as the most recurrent type of stigma and discrimination experienced by PLHIV, with these being mentioned more frequently by female respondents. Around 5% of women experienced verbal abuse (3% for men), 18% suffered from discriminatory remarks from family members and others (16.6% and 15% for men respectively). This suggests the need to target awareness-raising and behaviour change interventions towards PLHIV through the lens of gender, age and cultural group sensitivity.

Overall, the data showed that 7% of respondents also reported that their ability to meet their emotional needs since being diagnosed was better prior to the last 12 months than in the last 12 months. These findings suggest that there is a segment of the PLHIV group that is emotionally distressed, which was confirmed in both the current study, about 49% and 44%, as well as in the previous 2017 study, about 48% and 46% felt either guilty or ashamed respectively because of their HIV status. In addition, results showed that abstaining from sex (10.9%), avoiding seeking medical help and avoiding employment (8.5% each) were the most recurrent internalized stigma actions taken by PLHIV because of their status. 7.6% chose not to seek social help and 6.2% isolated themselves from family and friends, and these actions probably stem from the respondents' desire to keep their status hidden from others for fear of stigma and discriminatory treatment. The finding is confirmed by the fact that about 79% of respondents hide their HIV status from others, but also by their distrust towards state institutions to keep it confidential. This social isolation could have negative consequences for the health, including mental health, of PLHIV.

The results contribute to the understanding that issues of stigma and discrimination affect HIV testing and treatment efforts. About 2/3 (70.2%) of respondents reported that they were tested within six months of when they first considered getting tested for HIV. Even more worrying is the fact that only 23.5% of respondents opted to start treatment after being diagnosed with HIV and just 22.7% waited for more than two years after being diagnosed with HIV. The most cited reasons for delaying testing were fear of the reaction of others if they tested positive (29.4%) and delays in starting treatment were because respondents were not prepared to deal with HIV infection (32.1%). 30% of respondents were worried that others would find out their HIV status and 29.4% feared a negative attitude from health workers or disclosure of status without consent. Typically, fears of this kind are generated by lack of knowledge about HIV infection, reliance on myths about HIV infection and strong dependence on the opinion of others (the need to correspond to the social desirability).

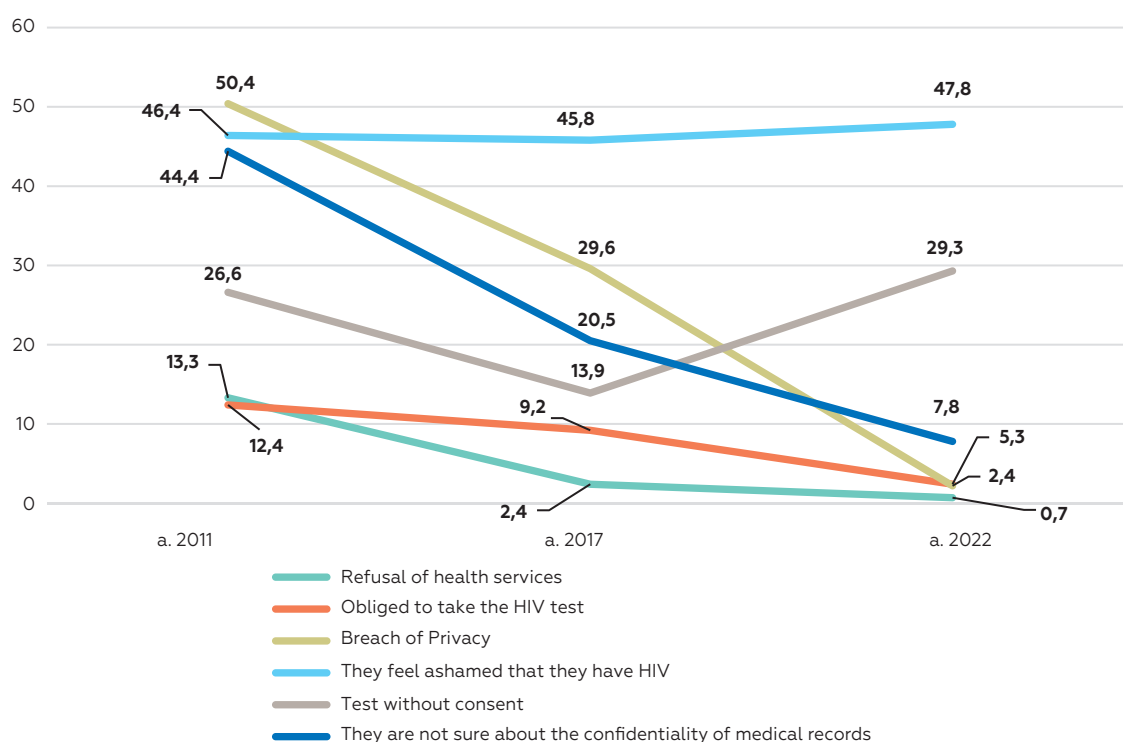
These data further confirm the information that stigma and discrimination as a result of disclosure continues to affect many aspects of HIV programming. The study also identified several issues related to interactions with health workers. The results showed that the most commonly reported stigma came from health care workers avoiding physical contact/using extra precautions (7.2%), allowing themselves to gossip/talk badly about respondents because of their HIV status (6.8%), and disclosing respondents' HIV status to others without respondents' consent (5.3%). In addition, 7.8% of respondents felt that their hospital records were not kept confidential. Others reported negative actions by health workers, such as insisting on not having children and forcing them to sterilize/take contraceptives. In terms of actions against PLHIV women, the most common action was from health workers advising them to terminate pregnancy (11.4%). Such stigmatizing and discriminatory interactions of PLHIV with health workers will make it even more difficult to encourage PLHIV to access health services. In this regard, studies exploring the reasons why health workers stigmatise and discriminate against people living with HIV in healthcare settings would be welcome, with subsequent inclusion of outcome indicators in the planning process for the development of appropriate interventions focused on the specific issue of stigma and discrimination.

In terms of violation of rights, every seventh (14.5%) respondent said they had experienced abuse of their rights, and of those whose rights had been abused, only four people claimed compensation for damages, while 41 people (4.7%) preferred not to. Most often respondents reported that they did not know where and how to act or for fear that action would lead to disclosure of the status or felt that their actions would not yield any results. These reasons invoked suggest that PLHIV are not educated on the extent of their rights and how to defend their rights. Similarly, there is a lack of confidence in the success of such action. As a result, it is inevitable that many cases of abuse of the rights of people living with HIV will go unreported until interventions in this area are planned and implemented.

In terms of stigma generated for reasons other than HIV, different categories of respondents, including sex workers, homosexuals/MSM, lesbians/WSW, DU, experienced stigma and discrimination for various reasons. For bisexuals and respondents with a gender identity different from their gender at birth, verbal abuse, gossip and discriminatory remarks, even from family members, were the most reported types of abuse. Homosexuals/MSM were most often physically assaulted/harassed. Both homosexuals/MSM as well as sex workers suffered from discriminatory remarks/gossip from family members and verbal harassment, while DU most often reported verbal harassment and discriminatory remarks or gossip from family members.

Although the methodology of the "Stigma Index 2.0" study is different, the research team tried to triangulate the main indicators with similar/identical ones from previous studies and tried to monitor the phenomenon of stigma and discrimination over time through these indicators and to illustrate the values of the main indicators graphically and dynamically. The figure below shows the recorded values of the six indicators over three rounds of the Stigma Index Study. Indicators on access to health services and treatment services, perceived stigma, rights abuse and interaction with health workers were presented.

Figure 27. The main indicators, which reflect the stigma of PLHIV, measured on three rounds of studies, which studied and measured the phenomena of stigma and discrimination.



Over the years, however, there is a decrease in the share of respondents who indicate various forms of discrimination: refusal of medical services, the obligation to be tested for HIV, breach of confidentiality and distrust in the safe keeping of medical documentation. In the current study, testing without consent is reported more often, which is difficult to explain in the context where in the medical system the procedure of providing informed consent before the procedure is implemented for all invasive procedures. The indicator of internalized stigma remains high when people with HIV feel ashamed of having HIV infection, a phenomenon explained by the lack of correct knowledge and belief in widespread myths.

There was a decrease between 2011 and 2021 in the proportions of stigma and discrimination experienced by PHIV for four of the six indicators. However, one indicator ('Tested without consent') had double the value in 2021 compared to 2017, with 13.9% reported in 2017 and 29.3%

reported in 2021. In terms of internalised stigma, the value of the indicator “Feeling of shame due to HIV status” is insignificantly higher than in previous rounds. Overall, it can be noted that there are some improvements in addressing stigma and discrimination. It must still be recognised that current levels of stigma and discrimination are still above tolerance levels. There are still widespread challenges such as verbal abuse and disclosure of HIV status to others without consent. These phenomena are maintained at high levels and are difficult to combat also because the influence of the church and clergy is still very strong in the Republic of Moldova, but the church is very punitive and restrictive at the social level, especially when it comes to key groups.

Health promotion and stigma prevention in conjunction with social, economic and legal determinants of health must be reflected in health policies. The UNAIDS recommendations call for a targeted focus on removing social and legal barriers in service delivery and developing and applying people-centred approaches. It is very important to review and redefine policies and laws which encourage (condone) discrimination and stigma, particularly with regard to age for marriage, non-disclosure of HIV status, exposure and transmission, travel restrictions and mandatory testing. Stakeholders, including government, partners, programme, implementers, influencers and civil society must continue to work together to implement the recommendations presented in this report in order to achieve the goal of “Stigma-free Moldova”.

STUDY LIMITATIONS

There are some shortcomings of the “Stigma Index Survey 2.0 in the Republic of Moldova” Study. These limitations are presented based on information obtained during the study. The main limitations include:

- Although the selection of the study subjects was random, due to the reduced accessibility for service providers to reach some segments of PLHIV, the sample may have shifted towards PLHIV receiving psychosocial support services, which cannot be quantified.
- Although interviewers were trained and provided with a definition guide to ensure that respondents could understand the questionnaire questions, there were difficulties in understanding some of the terms/concepts in the questionnaires.
- There were challenges in ensuring the participation of respondents from the randomly selected list in order to have geographical, age or gender diversity, and it was necessary to replace a considerable proportion of potential participants with other participants with the same criteria from additional code lists.
- There were challenges in recruiting transgender people into the study. There were 2 TG individuals with open status, one of whom refused to participate in the study, and the other was unavailable, not in the country.
- There were technical challenges related to the functionality of electronic devices/ uploading the questionnaires, gaps in the content of the questionnaires due to the quality of Internet, requiring at times repeated uploading of questionnaires and manual deletion of duplicates, online checking of each questionnaire to ensure the quality of the data collected, and repeated consultation with interviewers on certain omitted questions.
- A challenge was the exceptional public health situation related to the Covid-19 pandemic, when visits to medical and non-medical facilities were avoided/reduced due to limited access and restrictions imposed by the authorities, and also due to the fear of the population and the target population to become infected with Covid-19.

CONCLUSIONS

The Stigma Index Study documented experiences of stigma and discrimination among people living with HIV in the Republic of Moldova. Stigma and discrimination trends in the three rounds of the HIV/AIDS Stigma Index Study show improvements in key indicators. Over the three rounds there was a decrease in disclosure of status without consent, denial of access to healthcare services because of their HIV status. At the same time, there are higher values of reported mandatory/forced HIV testing and medical procedures and reported internalized stigma.

Despite some of these achievements, challenges such as verbal abuse and disclosure of PLHIV status to others without consent remain. In addition, stigma and discrimination on grounds other than HIV status, such as gender identity, sexual identity, sex workers and drug use, have emerged as a growing challenge. These actions were most often reported by family, relatives and neighbours, which needs to be taken into account when adjusting anti-discrimination and anti-stigma programmes.

It is therefore mandatory in the Republic of Moldova to address the issues of stigma and discrimination that affect human rights and have repercussions on the health status of PLHIV. National stakeholders need to work jointly and collaboratively to reduce the levels of stigma and discrimination experienced by PLHIV. Removing barriers in access to HIV and non-HIV health information and services, creating awareness and informing the population, and implementing laws and regulations that aim to support and promote better health outcomes – these are actions that need to be taken seriously by national stakeholders.

RECOMMENDATIONS

The following recommendations were made based on the results of the study:

1. There is a need to raise awareness and sensitize the general population about HIV stigma and discrimination. Expand anti-stigma and anti-discrimination campaigns involving Government, Ministries, relevant NGOs and media partners to discourage people from abusing people with HIV and KP-PLHIV. Awareness campaign activities should pay special attention to HIV-related stigma and discrimination faced by PLHIV, but also to people who do not get tested for HIV because of social fears. The main issues to be addressed in the campaign should include combating verbal abuse, discriminatory remarks and inadvertent disclosure. This is where intensive work needs to be done with health professionals at all levels and with the families of people diagnosed with HIV. It would also be useful during the Campaign to have the media broadcast the image of PLHIV women – including from key populations – who are an integrated part of their society or community. This could also help dispel myths about HIV transmission and promote U=U campaigns.
2. Train and empower PLHIV about their rights, especially their sexual and reproductive rights. This is particularly important for women living with HIV. Guide people living with HIV on actions they can take to address issues of abuse of their rights. It is recommended to further promote mechanisms to identify cases of discrimination and abuse and to take action, including strategic litigation, in cases of violation of the rights of people living with HIV. Community organizations and community social workers play a key role in training and guiding PLHIV on sexual and reproductive rights, including gender and age specific.
3. Train, empower and guide key populations living with HIV on the right and ways to seek protection and justice when their human rights are violated. This would be made possible by further developing mechanisms for reporting, documenting and remedying/responding to stigma and abuse associated with people living with HIV and key PLHIV groups.
4. Continuous training of health workers at all levels (primary care, hospital, specialised outpatient healthcare) providing various health services. In this context it is important to provide training and guidance on confidentiality and non-discrimination measures to all staff in healthcare facilities from management to technical staff.
5. Develop a tool to monitor the application of what has been learned by medical and non-medical staff in healthcare facilities who have been trained in interpersonal communication.
6. There is a need for continuous training and requalification especially on interpersonal communication (stigma and discrimination) for health workers. Training health workers will help promote the provision of 'stigma-free' and non-HIV services for people living with HIV. This will encourage people with HIV to use HIV testing and treatment services as well as non-HIV health services and improve their quality of life.
7. Form linkages with mental health and psychosocial support services to address perceived stigma. This can involve support groups for PLHIV with attracting as many people with HIV as possible, youth friendly services for engaging young people with HIV and/or key groups emerging at adolescent and young adult age; they can come in the form of distribution of information materials. These would help mitigate the impact of self-exclusion from social isolation and other forms of internalized stigmatizing actions taken by PLHIV because of their status.
8. Strengthen protection programmes for victims of domestic violence and extend them to women living with HIV and from key groups, as they are most often physically, sexually or psychologically abused, including being forbidden by their partners to seek medical care. Strengthening and expanding empowerment programmes for women with HIV on achieving financial independence, knowledge and empowerment to insist on respect for

their dignity and rights in the family and society could help combat violence against them in the family environment.

9. Develop campaigns and programmes to raise awareness and reduce issues of gender, sex identity and risk behaviours in society and in the community of people living with HIV and key populations.
10. Continuous training and adaptation of sexual and reproductive health services to provide services that are friendly to women with HIV and to families where one partner is HIV positive at all stages from adolescent development, family planning, safe pregnancy and childbirth, safe abortion assumed by women, couple-friendly contraception, prevention of reproductive organ cancer, the right to a harmonious sexual life.
11. Engage and train community leaders, women's groups, religious organizations, youth groups, NGOs providing services to key groups and PLHIV on HIV infection and stigma to disseminate information in their communities. These Interventions can reduce fear and misperceptions, increase understanding of HIV infection and interaction between people living with HIV and other community members.
12. Involve the National HIV Programme and implementing partners in recognizing the existing challenges of stigma and discrimination faced by people living with HIV and how this affects efforts to detect HIV cases, link to treatment, retain in care and achieve viral load suppression. Include appropriate strategies to address stigma in all draft HIV programmes and apply them in counselling, psychological support, differentiated services, etc. Engage line ministries and funding partners to prioritize and support HIV-related stigma and discrimination issues.
13. Coordinated efforts are needed to implement laws and policies aiming to protect the rights of PLHIV and KPLHIV. Ministry of Justice, Ministry of Labour and Social Protection, and Ministry of Internal Affairs must work together to ensure compliance with existing provisions of laws protecting the rights of people living with HIV. The government should push for the integration of the law on ensuring equality with other legislation aimed at preventing and combating discrimination as well as ensuring equality of all persons in all state institutions and increase information on this dimension. In addition, the government should increase initiatives to reduce HIV-related stigma and discrimination in the workplace, including employer associations, trade unions, etc.
14. It is necessary to track and report on indicators of HIV-related stigma and discrimination in different health facilities. It is also necessary to document systematically the presence of factors underlying stigma and discrimination.
15. The exercise of implementing the recommendations embodied in the National Action Plan or the adjustment of existing plans must include costing and financing of the Plan's actions.
16. Monitor the implementation of recommendations on combating stigma and discrimination by Civic Association "League of People Living with HIV in Moldova" in partnership with UNAIDS and in collaboration with identified stakeholders.
17. Substantial efforts to implement the above recommendations are recommended for the districts on the left bank of the Dniester River, as stigma and discrimination are reported in higher proportions in this study.

ANNEXES

Annex 1: Information sheet

INFORMATION SHEET

Note: This information sheet is designed for the participants to keep as a summary of the project if they are interested. If participants are unable to read, make sure that this information is read to them and any questions they may have, have been answered, before moving on to the informed consent procedure.

This information sheet serves as a resource guide for participants about the People Living with HIV Stigma Index (PLHIV Stigma Index). Please read this information carefully and feel free to ask any questions you may have before providing your consent to participate.

THE PURPOSE AND NATURE OF THE PEOPLE LIVING WITH HIV STIGMA INDEX

The PLHIV Stigma Index was designed to document the ways in which stigma and discrimination experiences by people living with HIV occur and manifest. This initiative aims to not only broaden the understanding of stigma and discrimination faced by people living with HIV in different contexts and over time, but more importantly, to use the information gathered for national and global level advocacy to fight for the human rights of people living with HIV.

This research is led by the national network of people living with HIV, and the information will be gathered using the PLHIV Stigma Index questionnaire. While the questions focus on your individual experiences of stigma and discrimination, the findings will be presented as a general idea of experiences by the larger community of PLHIV.

PROCEDURES AND PROCESSES INVOLVED IN PARTICIPATION

This information sheet describes the purpose of this study and what your participation involves and, at the same time, ensures that you receive all the information you need to decide whether or not you give your consent to participate. Please note that participation in this study is entirely voluntary. If you choose to participate, you will be asked to sign a consent form before starting the interview. You are free to not answer any of the questions, and you can decide to stop participating at any time without any consequences.

During the interview, you will be asked questions about your experiences of stigma and discrimination, access to health services, disclosure of HIV status, and your knowledge about your rights as a person living with HIV. Your responses will be recorded either on paper, or on a mobile device.

CONFIDENTIALITY AND POTENTIAL RISKS OF PARTICIPATING IN THE STUDY

Your confidentiality is very important to us, and the study staff has put in place several measures to prevent anyone outside of the research team from accessing your personal information. For example, your name will not be recorded on the questionnaire, and neither will any information that would allow someone to link the questionnaire back to you. Additionally, all questionnaires and other forms used in this project will be stored and/or locked in a secure place with restricted access.

DISCOMFORT THAT YOU MIGHT EXPERIENCE AS A PARTICIPANT

The questionnaire asks personal questions that may make you feel uncomfortable at times, and it may bring up topics that are difficult to talk about. If you feel uncomfortable at any point during the interview, you can decide to pause or stop the interview at this time – it is completely up to you to decide this and to indicate to the interviewer that you wish to pause or stop the interview process.

POTENTIAL BENEFITS FOR YOU AND THE COMMUNITY IN RELATION TO YOUR PARTICPATION

Your participation will contribute to the generation of rich and valuable information that will assist both national and global efforts to reduce HIV-related stigma and discrimination and ultimately improve the lives of all people living with HIV. In addition, in case you need psychological or physical support, such as counselling, legal assistance or advice concerning educational, health or social support, a list of professional support services within the community has been developed. The interviewer will be happy to share this information with you.

Annex 2: Informed consent

INFORMED CONSENT FORM

Notes to the country team:

The informed consent form is to be completed by the interviewee and the interviewer.

Please ensure the interviewer has sufficient copies of the consent form, as participants have the right to obtain a copy.

The specific requirements for informed consent may differ per context. Sometimes verbal consent may be sufficient, while written consent is necessary in other situations. Please be sure to check the requirements for the informed consent process in your country and adjust this template accordingly.

My name is _____ [insert name of interviewer].

I am administering a questionnaire about the experiences of people living with HIV, particularly in relation to stigma and discrimination.

You have been provided with an information sheet that describes the purpose of this questionnaire and how the information collected will form part of a larger study that is being conducted in this country to document the stigma and discrimination experiences of people living with HIV. The information gathered may be used to inform the advocacy activity in order to improve access to care and quality of life for people living with HIV in your country and globally. The information sheet also outlines what types of information you will be asked during this interview, how we will keep this information confidential, and the potential risks involved in your participation in this study.

Before we begin the questionnaire, I would like to make sure that you are voluntarily willing to participate in this study and that you have obtained all the information that you need to make an informed choice about your participation.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information, and I will take time to explain. You do not have to decide today whether you will respond to this questionnaire. Before you decide, you can talk to anyone you feel comfortable with about the questionnaire and/or the study.

Please feel free to contact the country coordinator or the _____ [local ethics committee] if you have any questions or concerns about this questionnaire or the study. These are the contact details for the country coordinator and the _____ [local ethics committee]:

Country coordinator:

_____ [insert name]

[Contact details – insert relevant contact details, such as telephone number, email address and physical address]

Local ethics committee:

_____ [insert name]

_____ [Contact details – insert relevant contact details, such as telephone number, email address and physical address]

If you choose to respond to this questionnaire and participate in the study, I will ask you some questions about some of your experiences as a person living with HIV, in particular those related to stigma and discrimination. I expect that the interview will take between one and two hours.

Before asking you whether you would like to participate, I would like you to know that:

Your participation in this project is entirely voluntary. It is your choice whether to participate or not.

Some of the questions are personal and may cause distress or a feeling of discomfort. You are free to not answer any of the questions in the questionnaire.

You may stop participating in the interview at any given time and this will not have any consequences.

The information collected in this interview will be kept strictly confidential. To help ensure confidentiality, I will not write your name on the questionnaire or this form, and I will not write down any details that would allow you to be identified. If you would like to know more about the measures that we are taking to protect confidentiality, please ask me to provide you with these details.

If you wish, I can provide you with a list of services that are available in our community, including health care, social support, and legal services. If you choose to participate, you will receive 150 MDL to compensate you for your time and travel associated with participation in this study.

Do you consent to participating in the interview?

Yes

No

– If 'No': Thank you for your time

– If 'Yes': Thank you for agreeing to take part in this study

Saying 'yes' means you have read the information on the information sheet, or it has been read to you. You have had the opportunity to ask questions related to the questionnaire and the People Living with HIV Stigma Index study and any questions you have asked, have been answered to your satisfaction. You consent voluntarily to be a participant in this study, and you understand that you have the right to end the interview at any time.

You consent to:

The information being recorded

The information being used by the country team and International Partnership (GNP+, ICW, and UNAIDS) in an anonymized form

The data being stored indefinitely, with the assurance that if you decide to enforce your right to be forgotten, your data will be deleted within 48 hours.

If you agree, I will now sign this form to confirm that your consent has been obtained.

Signature/initials of the interviewer: _____

Data: _____

Signature/initials of interviewee*: _____

Data: _____

- * Note: in some cases, verbal consent is all that is needed to go ahead with the interview. If so, the interviewee does not need to sign this consent form. Please be sure to check the requirements for the informed consent process in your country and adjust this template accordingly.

Annex 3: Confidentiality agreement

CONFIDENTIALITY AGREEMENT FOR STUDY STAFF

By signing this confidentiality agreement, I, _____ [insert name], [insert role] in the implementation of the People Living with HIV Stigma Index study in the Republic of Moldova (right bank/left bank), agree to the following:

- I. I will take all possible steps to protect the confidentiality of the information that I handle. This means that I will protect the identity of all people participating in the People Living with HIV Stigma Index study.
- II. I will do nothing that discloses the identity of someone who is or has been associated with the study. If personally identifying information is made known to me during the course of the study, I will not disclose it – either verbally or in writing – to anyone, unless:
 - a. explicitly instructed to do so by the participant in the study; or
 - b. compelled to disclose specific information under a court order of a competent court.

_____ [Insert role]

Signature: _____

Name: _____

Data: _____

Place (city, country): _____

Country coordinator [or another witness]

Signature: _____

Name: _____

Data: _____

Annex 4: Safety Guide

Introduction

The purpose of these guidelines is to provide a general overview of security issues. Each data collection point should develop local security procedures and train staff on these procedures. It is important for the staff to be able to avoid problems through common sense and a humane attitude. The staff should always be vigilant about their own security and that of their colleagues. By adopting the recommendations in these guidelines, staff will be able to recruit and interview participants in an effective way while maintaining their own security.

Plan ahead

- Have an emergency action plan at hand. Know in advance what you will do if the situation suddenly escalates. Know who to contact in an emergency. Always know where all the exits from any section of the interview point are.
- During interviews always choose the position closest to the door. It is not good to have a boisterous participant between you and the exit.
- Agree on a code word to ask for help from a colleague. You could use something like the phrase "Please bring me the red folder". If a staff member is unable on his/her own to interview a participant comfortably or needs help in dealing with an uncooperative participant, he/she can ask a colleague to bring him/her the "red folder" to signal that he/she needs assistance.

Be vigilant

- You need to know your surroundings. If a dangerous situation arises, leave the site immediately. Leave quickly, but in a focused and 'clear-headed' manner.
- Use all your senses to assess the situation. If something doesn't "smell right", don't suppress the feeling. If your intuition tells you that this is not a safe place, leave immediately.
- Treat each potential respondent so that he/she feels welcome but be cautious if you have concerns about the person.

Keep computers and other equipment safe

- Keep your computers in a locked, out of sight, secure place when not in use.
- Upload data from computers to the central database at the end of each day (or at the end of each morning and afternoon). This reduces the risk of data loss if a computer is lost or stolen.

Use your judgement

- Limit the amount of cash available in the field (including incentives for participants).
- Avoid wearing items that appear to be of value; jewellery, expensive watches and purses can cause theft.
- Do not leave valuable items or project materials in your car unlocked or in plain sight.

End the interview at any time if you feel threatened by the participant or the environment

- Aggressive or threatening persons. If confronted directly by such a person, apply verbal appeasement methods: place yourself at an angle and leave extra space between you and the other person; don't smile; let them cool off; listen and acknowledge their concerns; avoid becoming defensive; lower your voice, tone and tempo; and react to justified complaints.
- Sexual harassment. If a respondent makes sexual advances or sexually harasses you, you have the right to end the interview. If you feel that the respondent is behaving inappropriately, you must first remind him or her that you are only there to interview and that you are not interested in any sexual advances. If the respondent insists, tell him/her that you will end the interview if he/she does not focus on the questions. If this does not help, end the interview.
- Drunk or intoxicated respondents. It may happen that the respondent is unable to complete the interview or give accurate answers for a number of reasons. If he has had little sleep or has recently consumed alcohol or drugs, he may be unable to answer questions coherently, may be "off" or very groggy during the interview.
 - o If you have started the interview and the participant stops giving coherent answers, stop the interview, thank the respondent for their time and record a description of what happened in the interviewer's commentary.

Develop procedures for reporting incidents in the field

- Develop local security instructions and incident debriefing procedures before starting fieldwork.

If an incident occurs in the field, notify the study coordinator immediately and explain all details of the incident.

