Results of assessing the level of stigma and discrimination of women living with HIV in the EECA Region

Survey report

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Author of the analytical report: I. Zarubina, MPH, MSSs

Co-authors: D. Alexeeva, MSc, MBA; Y. Koval-Molodtsova, MA.

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The campaign materials are freely available in English/ Russian, as well as Kazakh, Kyrgyz, Uzbek, and Ukrainian languages, and include videos and other materials that can be used for online and offline promotion. You can find them at stopstigma.hiv.
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LIST OF ABBREVIATIONS

AIDS - acquired immunodeficiency syndrome
AIDS center (AC) – state budget healthcare establishment “Center for prevention and combating AIDS”
ART – antiretroviral therapy
EECA – Eastern Europe and Central Asia
HIV – human immunodeficiency virus
IVF – in vitro fertilisation
KP – key population group
LGBT – lesbian, gay, bisexual, transgender
NGO – non-governmental organization
PLHIV – people living with HIV
PWUD – people who use drugs
R - respondent
SW – sex-worker
WLHIV – woman living with HIV
INTRODUCTION

Stigma and discrimination in relation to people living with HIV continue to exist and impact different areas of human life, thereby creating obstacles and barriers to prevention and treatment of HIV infection and seriously reducing overall quality of life of people affected by this disease.

Since HIV infection is still associated with “inappropriate sexual behaviour” and belonging to the most marginalized groups of population, women are most susceptible to HIV-related stigma, as the still existing gender discrimination adds up to HIV-related stigma. Discrimination against women can discourage them from seeking necessary medical and psychological care they need [1]. HIV-related stigma in women is associated with rejection from family and friends, society, feelings of insecurity and loss, low self-esteem, fear, anxiety, depression, suicidal thoughts and even suicide attempts [2-5].

HIV-related stigma can be perceived as external (social) or internal (internalized) stigma. Social stigma stands for external discrimination against people living with HIV associated with negative public attitudes about HIV [6]. On the other hand, self-stigmatisation represents negative judgments of a person living with HIV in relation to themselves, which leads to feelings of uselessness, shame, guilt and emotional stress [7].

The level of HIV-related stigma and discrimination in the region of Eastern Europe and Central Asia remains high. About 70% of residents in Kazakhstan and Kyrgyzstan demonstrate discriminative attitudes towards people living with HIV [8]. Even though recent studies show that the frequency of manifestations of stigma and discrimination against PLHIV among healthcare professionals and PLHIV social environment is decreasing [9-11], people living with HIV continue to face various manifestations of stigma and discrimination from healthcare providers and their immediate environment. In Ukraine, 17% of PLHIV experienced various instances of stigma and discrimination from medical workers [9], a quarter of respondents from Russia and Kyrgyzstan reported that they were tested for HIV without their consent [10, 11]. Manifestations of internal stigma in PLHIV remain most acute for the EECA countries. The results of studies conducted in the EECA region indicate the high level of internal stigma among people living with HIV: 81.3%-91.2% of the responding PLHIV hide their HIV-positive status from others, half of the respondents suffer from guilt and shame because of their HIV status [9-12]. Studies also reveal gender differences: the level of self-stigmatisation among women living with HIV is usually higher than among men living with HIV [9-12].

Higher vulnerability and susceptibility of women to stigma and discrimination related with HIV, as well as the increased manifestations of discrimination and abuse against women during COVID-19 restrictions in the region [13] speak of the existing relevance and need for further research on HIV-related stigma among women living with HIV in EECA countries.

This study was conducted under the framework of the project “Combatting stigma to end HIV/AIDS in EECA” with the support of Gilead. The project aims at empowering women living with HIV and women from key populations, as well as at changing societal attitudes towards them. Four countries are participating in the project - Kazakhstan, Kyrgyzstan, Russia and Ukraine, as well as representatives from Uzbekistan. One of the purposes of the project is to reduce stigmatisation and self-stigmatisation of women living with HIV, thus reducing barriers to improving the quality of life of HIV-positive women. Media campaigning is one of the methods of dealing with stigma. Within the framework of the project, it is planned to develop and conduct a united campaign for the entire EECA region, as well as to develop various activities individually for each of the participating countries by their teams. The goals and objectives of the campaign, as well as the target group and distribution channels for its materials will be determined by the project participants, as well as representatives of the community of women living with HIV or affected by HIV. In order to fill in the gaps of knowledge and understanding in which areas of life women living with
HIV experience stigmatisation most acutely and feel more vulnerable and unprotected, the teams of the participating countries conducted this research with the help of and among women living with HIV.

PURPOSE AND OBJECTIVES OF THE RESEARCH

The purpose of the research is to identify experiences of stigmatisation and discrimination of women living with or affected by HIV in five EECA countries on the part of representatives of various establishments and immediate environment of women in order to obtain information necessary for the development of the regional media campaign and individual country activities for the project to reduce stigma and self-stigma in women living with or affected by HIV.

Research objectives:

• to identify areas of life of HIV-positive women where they are most vulnerable to stigma, and how stigma in these situations affects the quality of life of women with HIV;

• to determine which manifestations of stigma can be effectively influenced by means of a media campaign, to identify the subjects of stigmatisation and the specifics of the relationships between them and women living with HIV;

• to determine the mutual influence of external stigma and self-stigma and to develop recommendations for further studies of this phenomenon;

• to determine the key target groups to be addressed by the media campaign;

• to identify factors that are important for the development of effective interventions and individual work with HIV-positive women to reduce self-stigma;

• to prepare recommendations regarding the choice of the target group, the means, and channels for the transmission of the message and campaign materials.

RESEARCH METHODS

This study was implemented as mix-method research, engaging several methods: quantitative research and qualitative research.

Collection of data

To collect data, a questionnaire was developed that included both closed and open-ended questions. The questionnaire consists of 44 questions and covers several thematic blocks aimed at obtaining data on socio-demographic characteristics of respondents, manifestations of external stigma and discrimination from both the representatives of various establishments (medical, legal, educational) and from the immediate environment (family members, spouse/partner, neighbours); instances of internalized stigma and discrimination; applying for help and support; and opportunities to reduce stigma and discrimination.
The main questionnaire in the Russian language was prepared by the staff members of the NGO involved in the implementation of the project “Combatting stigma to end HIV/AIDS in EECA” in the five countries of Kazakhstan, Kyrgyzstan, Russian Federation, Uzbekistan and Ukraine. Representatives of the community of women living with HIV were also engaged in the development and editing of the questionnaire. After the development of the questionnaire, a pilot run of the instrument was conducted, it was then corrected and translated into national languages.

The survey was conducted by the representatives of the community of women living with HIV (WLHIV) in five participating countries. All interviewers received prior training on data collection.

The survey was conducted verbally, while the answers to the questions were entered into an online database. A separate block of clarifying open-ended questions suggesting detailed answers were asked in the course of interviews. Answers to these questions were recorded by the interviewers in a form convenient for them (in writing or audio recording).

The survey was conducted in September 2022.

**Sample**

The survey was conducted among female respondents who met all of the following criteria: age 18 or older, signing an informed consent, living in one of the five project countries, being HIV-positive, or raising an HIV-positive child.

The first 120 respondents (15-30 women per country) were recruited by NGOs which implement the project in target countries. They were the first respondents to complete the questionnaire. They, in turn, recruited and interviewed 2-3 respondents who fit the criteria of the study.

The total of 412 women living with or affected by HIV were interviewed. The sample for further analysis included 404 completed questionnaires.

**Data analysis**

The analysis of the collected data was carried out by means of descriptive statistics methods using Statistical Package for the Social Sciences software (SPSS). Thematic analysis of responses to open-ended questions was carried out using the methods of coding and categorization.

**Study limitation**

The sample of the study is not representative of the EECA region, as well as of individual countries participating in the study. It is not possible to accurately extrapolate assessments of external and internal stigma and discrimination and other characteristics to all women living with HIV or affected by HIV in the region and countries. However, the links between stigma and discrimination and other characteristics can provide important generalizations and give basis for future research into stigma and discrimination faced by WLHIV.
CHARACTERISTICS OF THE RESPONDENTS

Socio-demographic characteristics of the respondents

412 women living with HIV or affected by HIV from five countries took part in the survey. 404 respondents were included into the data analysis (Table 1).

Table 1. Distribution of the respondents by the country of residence

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kazakhstan</td>
<td>91</td>
<td>22.5%</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>88</td>
<td>21.8%</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>84</td>
<td>20.8%</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>38</td>
<td>9.4%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>103</td>
<td>25.5%</td>
</tr>
<tr>
<td>Total</td>
<td>404</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Survey participants belong to various age groups. The majority of women are aged 36-45 y.o. (50.2%). It is characteristic of all the participating countries: from 39.8% in Kyrgyzstan to 60.7% in the Russian Federation (Figure 1, Appendix 1).

Figure 1. Age of respondents (n=404), %

85.9% of the respondents are city dwellers, 13.1% live in rural areas (Figure 2). Respondents from Kyrgyzstan who live in rural areas make 42.0%. While rural dwellers from Kazakhstan, the Russian
Federation and Ukraine comprise minimal portion (from 1.2% in Russia to 12.6% in Ukraine). Respondents from Uzbekistan are represented by city dwellers only (Appendix 1).

![Figure 2. Places of residence of respondents (n=404), %](image)

In general, the majority of the survey participants have secondary professional education (35.6%) (Figure 3). Among the respondents from Russia and Uzbekistan, the same situation is observed (58.3% and 47.4%, respectively). At the same time, in Kazakhstan and Kyrgyzstan, the majority of the responding women have secondary education (39.6% and 62.5%, respectively), and in Ukraine - higher education (37.9%) (Appendix 1).

![Figure 3. Education of the respondents (n=404), %](image)

32.9% of the respondents are legally married (Figure 4). This situation is characteristic of all countries except for Kazakhstan. In Kazakhstan the majority of women reported they had long-term partnerships (civil marriage) (Appendix 1).
Four out of five respondents have a child/children (82.7%, n=334). This is characteristic of all women from the participating countries who took part in the survey. 41.9% indicate having children over 18 y.o. 32.9% and 34.7% report having children aged 8-12 and 13-18 respectively. Every fourth respondent (25.1%) has children aged 4 to 7 years, every fifth has children under the age of three (22.5%) (Figure 5). For a larger proportion of women from all countries except Kyrgyzstan and Uzbekistan, the presence of older children (18 years and older) is typical. In Uzbekistan, a large proportion of respondents (38.9%) have children under three years of age; in Kyrgyzstan, half of the respondents have children aged 13 to 18 (Appendix 1).

The majority of women who participated in the research have official employment (41.8%). 19.6% are employed unofficially, while 16.3% are housewives. Every tenth (13.4%) respondent reported to be unemployed. Among the participants there are women who are students or who are already retired (4%)
(Figure 6). For each country it is typical that the bigger proportion of respondents are employed officially (Appendix 1).

![Figure 6. Sources of income of respondents (n=404), %](image)

Half of the participants report that they have medium level of income (51.2%) (Figure 7). It is characteristic of all countries except Ukraine, where 58.3% of the respondents identify their level of income as low (Appendix 1).

![Figure 7. Level of income of respondents (n=404), %](image)

Every fourth woman of the respondents identify themselves as a single mother (26.5%) and a woman in difficult life circumstances (24.3%). Every tenth is a woman who raises an HIV-positive child (12.6%), every twentieth is a woman who raises a child with disabilities (5.0%). 7.7% identify themselves as migrants and temporarily displaced people due to military hostilities. At the same time, 41.1% of the participants in
the survey chose to not identify themselves with any of the proposed social groups (Figure 8). Speaking about each individual country, the majority of the respondents who identify themselves as belonging to some social group describe themselves as single mothers. With the exception of participants from Ukraine, where a large proportion of women (41.7%) identify themselves as women in difficult life circumstances, and every fifth - as temporarily displaced person due to military hostilities (Appendix 1).

Figure 8. Social statuses survey participants identify with (n=404), %

The question suggested the possibility of multiple choice of answers.

Belonging to key population groups and duration of living with HIV

The question about key population groups (KP) provided possibility for multiple choice of answers, consequently some respondents checked several KPs. 75.5% of the respondents chose just one KP (n=305), 24.5% of women (n=99) marked more than one group.

93.6% of the survey participants are women living with HIV. Women who are the mothers of HIV-positive children make 11.6% of the total, among them 44.7% are HIV-positive, 55.3% are mothers without HIV status. 12.9% of the participants have been imprisoned at least once, 9.4% have experience of drug use. Just 2.2% and 1.2% of the respondents identified themselves as sex-workers and LGBT representatives respectively (Figure 9).
Woman living with HIV comprise 100% of the respondents in all participating countries except for Kyrgyzstan. In Kyrgyzstan WLHIV make 70.5% of the respondents. In Kazakhstan, Russia, Uzbekistan and Ukraine former prisoners, people who use drugs (PWUD) make the second and the third largest KPs (Appendices 2-6). Situation observed in Kyrgyzstan is different: the second largest KP of 37.5% consists of mothers of HIV-positive children. Notably, all women who themselves do not have an HIV-positive status, but who are raising HIV-positive children, are respondents from Kyrgyzstan. The third most common KP inKyrgyzstan is former prisoners (Appendix 3).

The majority of HIV-positive women have been living with HIV for more than 10 years (36.6%). 29.2% of respondents live with HIV from 6 to 10 years, 24.1% - from 1 to 5 years, 3.2% - up to a year. 6.9% of the respondents are HIV-negative women with HIV-positive children (Figure 10). Women living with HIV for six years or more make up a large proportion of respondents for each country, with the exception of Kyrgyzstan, where a significant proportion of the survey participants are women without HIV status but raising HIV-positive children (Appendices 2-6).
RESULTS OF QUANTATIVE RESEARCH

External stigma and discrimination

The experience of stigma and discrimination

The majority of the survey participants at least once spoke to medical workers about their own positive HIV-status or about the status of their child (78.5%). 70.8% spoke about their HIV-status to friends/close people and social workers. 64.1% - to spouses and partners, 61.4% - to other PLHIV. Only every fourth woman (25.7%) disclosed her status to colleagues at work (Figure 11).

Figure 11. Who knows about HIV status of the respondent or about the status of her HIV-positive child (n=404), %

The question suggested the possibility of multiple choice of answers.

76.7% (n=310) of the respondents encountered some manifestations of stigma and discrimination related to her or her child’s HIV-positive status (Figure 12).
Those respondents who answered no to the question about the experience of stigma (n=94, 23.3%), explained this by the fact that they did not make their status known (“Maybe this is because I devote almost all of my time to children and don’t go anywhere else” (R04), “There was no bad attitude from others (yet), because we keep this problem secret” (R156)); also because the respondent and her immediate circle accepted her HIV status, and they lived together with an HIV-positive partner (“I accepted [my] HIV-status right away, and I live ok with it” (R243), “My close people always support me, that is why I don’t experience such attitude towards me” (R270), “My husband is the same as me, with the status” (R399), “I have a wonderful environment – all my family members and friends are literate in this matter” (R213)), as well as knowing her rights (“I work in the community of PLHIV and I know how to respond in a legal way to those who stigmatise” (R268)). Some respondents noted that hiding their HIV status from doctors and attending paid medical establishments allowed them to avoid biased attitude towards themselves (“I did not visit medical establishments very often and did not always tell doctors about my HIV status” (R182), “My income allows me to get services in paid clinics, and where patients pay, the doctors are wonderful” (R243)).

Over the past year, 42.1% (n=170) of women participating in the survey faced stigma. Of these, 72.3% experienced it less than three times during the whole year, 21.8% - from three to six times, 5.9% - from seven times or more (Figure 13). 25.2% (n=102) of the responding women did not face stigma in the last year, 32.7% (n=132) faced stigma earlier.
It is worthy to note that women who belong to several KPs (n=99), experienced stigma and discrimination more often in the last year than women who belong to only one key population group (women living with HIV, or mother raising an HIV-positive child) (n=305). The share of women, who identify with several KPs and who experienced stigma in the last year, is 13.8% more than the share of women who belong to only one KP (Fig. 14).

Figure 14. Experience of stigma in the last year, by belonging to one or several KPs, %

**Manifestation of stigma and discrimination by medical workers**

78.5% (n=317) of the respondents encountered various forms of stigma and discrimination while addressing and being serviced in medical facilities. On average, every second woman participating in the survey faced rude or prejudicial treatment by healthcare providers (50.2%) and/or she was asked questions about how she got infected with HIV (48.5%). 35.4% of the respondents dealt with veiled or outright refusal to provide medical care. Every fourth women during hospitalization were placed in a separate ward or isolator (26.5%) (Figure 15).

The share of the responding women who encountered violation of rights in the sphere of sexual and reproductive health makes 13.1%. The following forms of violation of rights were reported by the participants:

- Forced to terminate pregnancy (have an abortion) by the medical professionals (11.6%)
- Refusal to perform IVF (in vitro fertilization) (1.5%)
The question suggested the possibility of multiple choice of answers.

Considerable differences in the amount of stigma and discrimination are observed depending on the place of residence (Figure 16). The proportion of the respondents from rural areas is notably higher compared to women from cities, who faced the following forms of stigma and discrimination:

- Rude or prejudicial treatment by healthcare professionals: 13.4% more women from rural areas versus city dwellers;
- Veiled or outright refusal to provide medical service: the share of women from rural areas is 19.7% larger;
- Admitted in the very last turn (i.e., after all other patients were served or treated) – 24.6% more frequent in rural areas than in the cities.
There was also a significant difference in the proportion of respondents who experienced stigma in healthcare settings, depending on their belonging to one (n=305) or several key populations (n=99). The share of the respondents belonging to several key groups who were deliberately not provided with the information about available medical services is twice as high as the share of those belonging to one KP (27.3% and 12.1% respectively). 47.5% of survey participants belonging to several KPs received veiled or outright refusal to provide medical services, which is 16% more compared to those who belong to one KP (31.5%). 9% more respondents belonging to several KPs faced disclosure of the diagnosis to other persons without permission (32.3% and 23.3%, respectively). Refusal to perform IVF - 21.0% more of those women who identify themselves with several KPs (22.0% and 1.0%, respectively) (Figure 17).

![Figure 16. Manifestations of stigma in healthcare settings depending on the place of residence, %](image)

The question suggested the possibility of multiple choice of answers.
Figure 17. Manifestations of stigma and discrimination in healthcare settings depending on the number of KPs respondents belong to, %.

The question suggested the possibility of multiple choice of answers.

**Manifestations of stigma and discrimination at workplace or job recruitment**

Every fourth women participating in this study faced stigma and discrimination while being recruited for a job or at the workplace (n=97, 24.0%). Almost 10% of the respondents dealt with the request to be tested for HIV at recruitment or during employment, 6% faced disclosure of their HIV status to colleagues, 5.2% were denied the job due to their HIV status, and 5.2% were sacked when their HIV status became known to the management or the team (Figure 18).
The majority of the participants of the survey who gave a detailed answer regarding their experience of stigma at the workplace, noted that they did not inform their colleagues of their HIV status: “No one at work knows about my problem, that is why there are no manifestations of stigma” (R143); “I did not inform my employer about the diagnosis” (R348); “They just didn’t know [about my HIV status], otherwise there definitely would’ve been stigma” (R299); “I try not to work at places where stigma is possible” (R167). There are also participants who left their jobs to avoid disclose of their status: “I did not encounter [stigma], because I left my job in the medical establishment voluntary after learning about my HIV status” (R96); “Where blood tests were required, I had to refuse these jobs” (R189).

**Manifestations of stigma and discrimination at obtaining legal services**

22.8% of the survey participants encountered stigma and discrimination while obtaining legal services (n=92). Every tenth respondent was asked the question about how she got infected (9.9%). Women also faced verbal humiliation (5.7%), received low-quality service (6.2%), dealt with the disclosure of diagnosis without permission (5.2%) and received veiled or outright refusal to provide services (4.5%) (Figure 19).
Some of the respondents shared the situations that happened to them while in legal settings: “I was asked questions about how I got infected. The judge requested another pen, they wore masks and gloves at court during my interrogation” (R153); “At court they demanded a different pen, put on masks, demonstrated disgust” (R390).

**Manifestations of stigma and discrimination in educational settings**

The share of the respondents who experienced stigma in obtaining education was 10.9% (n=44), which is two times less than the share of those who experienced stigma at work or when receiving legal services and seven times less than when receiving medical care. The main thing that women dealt with was the illegal demand for additional medical certificates (2.5%) and the disclosure of status by a medical worker of an educational institution (2.5%) (Figure 20).
Some respondents reported individual information about the situations they faced while getting educational services. "I received the right for scholarship by myself, and then I told the Headmaster about my HIV status. The next day I was called and told that I failed, even though I submitted the papers already. When I came there [to the educational establishment], they spoke rudely with me. Then I wanted to enter the same department for a fee, but they told me that I did not get enough points" (R15); "I was denied the opportunity to learn hairdresser craft in prison" (R365). Free form answers from the respondent mention “non-displaying” of HIV status in educational environments: “HIV-positive child is not yet in kindergarten/school, at school where the other children study no one knows about my status” (R95); “At the child’s school nobody knows about the child’s status, and therefore we didn’t not face any stigma” (R143); “Nobody knows about my child’s status, not at school, not anywhere” (R75).

Separate analysis was carried out on the experience of stigma in educational establishments among women who described themselves as mothers of HIV-positive children (n=47), while women themselves can be both with HIV-positive status, and without it. In this group, there are more cases of stigma and discrimination in educational settings: 21.3% (n=10) of the respondents raising HIV-positive children faced stigma. Among them, the majority dealt with the disclosure of the status of the child by a medical worker of the educational establishment (8.5%) and the deprivation of the opportunity to engage in physical training lessons in the general group (8.5%) (Figure 21). “There was a disclosure of status by the medical worker of the childcare establishment, [they] forced me to withdraw the child from kindergarten” (R196).
The question suggested the possibility of multiple choice of answers.

**Stigma and discrimination by family members (parents, siblings, children)**

31.2% (n=126) of the respondents experienced some form of stigma and discrimination from family members (parents, siblings, children). Insults and abuse (psychological, financial, physical) and isolation as a family member, including the prohibition to use common things (toilet, bathroom, dishes), the prohibition to attend family parties and the prohibition of contact with children, became the most common types of stigma and discrimination, experienced by the survey participants. 15.6% and 14.6% of respondents, respectively, faced them. Also, every tenth woman who took part in the survey (11.1%) faced the disclosure of her HIV status by a close family member (Figure 22).
It should be noted that women belonging to several key populations encounter various forms of stigma and discrimination from family members more often than women from just one KP. The share of the respondents belonging to several KPs who faced isolation as a family member is twice as high (23.2% and 11.8% respectively), 3.5 times more – insult and abuse (45.5% and 12.5% respectively) and 2.5 times more – deprivation of housing or inheritance right (6.1% and 2.3% respectively) (Figure 23).

The question suggested the possibility of multiple choice of answers.
Stigma and discrimination by spouse/partner

Stigma and discrimination from spouses/partners are widespread among the respondents. The share of women who experienced it makes 29.7% (n=120). The main form is insults and abuse (psychological, physical and financial) (19.1%), blackmail and threats of status disclosure (13.1%) and status disclosure per se (10.4%) (Figure 24).

![Fig. 24. Manifestations of stigma and discrimination by spouse/partner (n=404), %](image)

The question suggested the possibility of multiple choice of answers.

The proportion of the respondents belonging to several key populations who experienced the disclosure of HIV status by a partner/spouse is 3.5 times more, compared to the proportion of those belonging to only one key population (41.4% and 11.8 %, respectively), 6.7% more survey participants belonging to several KPs faced blackmail and threats of the disclosure of the status (14.8% and 8.1%, respectively) (Figure 25).

![Figure 25. Manifestations of stigma and discrimination from a spouse/partner depending on the number of KPs the respondents belong to, %](image)

The question suggested the possibility of multiple choice of answers.
Stigma and discrimination by neighbours/friends/acquaintances

Experience of stigma in interactions with neighbours, friends and acquaintances is a frequently observed problem among women who participated in the survey. The share of women who reported cases of stigma involving these people makes 27.7% (n=112). The survey participants encountered disclosure of status (14.6%), insults (13.6%), harassment and bullying (7.7%), and blackmail and threats to disclose HIV status (4.2%) (Figure 26).

Figure 26. Manifestations of stigma and discrimination from neighbours/friends/acquaintances (n=404), %

The question suggested the possibility of multiple choice of answers.

Some of the respondents share their experience of stigma by neighbours and friends: “Neighbours were speaking behind my back, but did not say anything openly [to me], although it was very unpleasant to notice their side looks” (R325); “I was told that one of my acquaintances washed dishes meticulously after I left and that she said: “She has HIV, and she comes to visit us, what if she infects us”, while she smiled to me looking in my eyes” (R216).

Participants of the survey who belong to several key populations encounter insults, bullying and blackmailing/threats of status disclosure from neighbours/acquaintances/friends two times more often than women who identify with just one key population group (Figure 27).
Figure 27. Manifestations of stigma and discrimination from neighbours/friends/acquaintances depending on the number of KPs the respondents belong to, %

The question suggested the possibility of multiple choice of answers.

**Internal stigma and self-discrimination**

**Manifestations of internal stigma**

After learning about the positive HIV status of themselves or their child half of the respondents experienced feelings of uselessness (51.5%), guilt (52.5%), shame (53.2%), as well as low self-esteem (54.5%). Every third women felt “dirty” (39.6%), was overwhelmed by negative and destructive feelings towards the person, who infected her (31.2%), felt the urge to commit suicide (32.2%). Every tenth respondent felt she deserved to be punished (9.7%) (Figure 28).

Figure 28. Feelings of the respondents after learning about HIV-positive diagnosis (n=404), %

The question suggested the possibility of multiple choice of answers.
62.6% of the respondents experienced the fear of becoming the object for gossip after they learnt about their HIV-positive status or the status of their child. Half of the women who participated in the research felt fear of living a life with HIV (55.4%), fear of being rejected (52.5%) and fear of slow painful death (50.0%). 43.8% of the participants felt the fear of imminent death due to the lack of medicines, 38.1% - fear of taking antiretroviral therapy for life, 37.6% experienced the fear of giving birth to an HIV-positive child. Every third respondent felt fear of someone not wanting to have sex with them (34.4%) and fear of abuse and persecution of children due to the mother’s HIV-positive status (32.4%). Every tenth person dealt with the fear of physical abuse (13.6%) (Figure 29).

![Figure 29. Fears that the respondents experienced after learning about their HIV-positive diagnosis (n=404), %](image)

The question suggested the possibility of multiple choice of answers.

It takes years to accept the diagnosis. It is necessary to note that at the time of the survey the share of women who participated in the research and experienced negative feelings in relation to themselves and their HIV status is not high. Considerable number of the participants (74.3%) reported that they had already learnt to live with HIV. 36.1% of the participating women came to accept HIV as integral part of themselves, and 33.2% are not bothers by HIV anymore (Figure 30).
However, there is a considerable difference to be found in self-perception of women and their attitude towards HIV status depending on the place of residence – between city dwellers and those from rural areas. In comparison to the respondents from cities, the share of rural women who blame themselves is twice as big (16.7% and 32.1% respectively), 1.7 times more of those who are mad at themselves for acquiring HIV (15.0% and 26.4% respectively), and almost 6 times as many rural women blame other people for transmitting HIV to them (9.2% and 52.8% respectively). Among the survey participants living in countryside, compared with those living in the city, there are 1.3 times less of those who began to accept their HIV status as an integral part of themselves (28.3% and 37.7%, respectively) , 1.5 times less the proportion of those who have learned to live with their HIV status (50.9% and 78.7%, respectively), and almost three times less the share of those who are not bothered by positive HIV status (13.2% and 36.6% respectively) (Figure 31).
Manifestations of self-discrimination

After receiving positive HIV diagnosis, self-discrimination of women manifested more often in the form of self-isolation from society (33.9%), avoiding visiting clinics (27.7%), and avoiding sex (27.7%). Somewhat less often, self-discrimination manifested itself in the decision not to marry or have partner (22.8%) and the decision not to have children (17.3%). 31.7% of the survey participants did not limit their needs (Figure 32).

![Figure 32. Cases of self-discrimination among the respondents (n=404), %](image)

The question suggested the possibility of multiple choice of answers.

After the respondents learnt about positive HIV test result, every fifth respondent decided not to have children, fearing that she could pass HIV to the child (19.6%) and allocated separate bed linen for herself (18.1%). Every sixth woman began to disinfect dishes after she ate (16.8%), every tenth stopped kissing their children, fearing to infect them (11.9%). More than half of the respondents (56.4%) did not experience any self-restraint after receiving positive HIV test result (Figure 33).

![Figure 33. Changes in behaviours of the respondents after learning about their positive HIV status (n=404), %](image)

The question suggested the possibility of multiple choice of answers.
Many of the survey participants chose option “Other” and shared their own versions of self-discrimination. For example, on learning about their status some women immediately took away personal hygiene accessories from easy access: tooth brush, shaving stick, manicure scissors – to make sure that no family members would accidently use them by mistake: “Straight away I put out personal hygiene things, saving stick and toothbrush” (R07); “I prohibited children to use my toothbrush and shaving stick” (R96); “I hid personal toiletries from children (scissors, tweezers, files) to prevent anybody taking them by mistake” (R209). They also became more attentive towards traumas and cuttings: “I became cautious with traumas and nicks” (R372); “Looked carefully after myself and cared for every tiny cutting” (R98); “I started disinfecting sharp objects” (R319).

The respondents also reported that after they learnt more about HIV, many of the self-inflicted restrictions disappeared: “I decided to not have children due to the fear to infect the baby. After the peer [consultant] told me that it was possible to have healthy kids when taking ART, I dropped doubts and gave birth to one more child” (R95).

In response to changes in the behaviour of the respondents at home after learning about their HIV-positive status, 7.9% of women report that their family members started to disinfect dishes, 7.2% - to wash their clothes separately from the clothes of the respondent. 80.0% of the respondents marked that they did not notice any such changes in the behaviour of their family. It can be explained by the fact that some of the women live separately with their children, away from parents or other relatives (“I lived alone with kids, just never encountered with this [discrimination in response by family”]), and also by the fact that some of the survey participants did not tell their family about their status (“Now that everyone knows [about my HIV status], there are no such things” (R217)). 6.9% of the respondents faced other situations, for example, the allocation of separate dishes for food (“Mom began to fence off, allocated separate dishes” (R296); “They allocated separate dishes when I came to relatives” (R324)), as well as: “Mom tried to dissuade me from giving birth to a child, because she was afraid that it would be infected” (R216), “My husband kept saying that I would infect him” (R310); “Relatives constantly asked why I did not breastfeed the child, and I tightened my breasts and said that there was no milk” (R89) (Figure 34).

It is worth noting such survey participants who reported that they received support from children when they became aware of the mother’s HIV-positive status: “On the contrary, my son reassured me and said that there was nothing to worry about and that HIV was not transmitted in day-to-day interactions” (R285); “I told the child [about my HIV-positive status], and he began to take care of me!” (R67).
When comparing data on self-discrimination by the place of residence (urban or rural areas), we observe that self-discrimination in both groups is more frequent than discrimination from family members after they learn about the HIV-positive diagnosis of the respondent. However, women in cities started to disinfect dishes twice as often (18.2% and 9.4% respectively), and there are 5.4% more of those who decided to have no children after they learnt about their HIV status (20.2% and 15.1% respectively). However, the share of women in rural areas who stopped kissing their children is two times bigger than in the cities (22.6% and 10.4% respectively), 7.2% more of those who allocated separate bed linen for themselves (24.5% and 17.3% respectively) and 3.9% more of those who decided to sleep in a separate room (9.4% and 5.5% respectively) (Figure 35).

![Figure 35. Changes in behaviours of the respondent after she learnt about her HIV-positive status, by the place of residence, %](image)

The question suggested the possibility of multiple choice of answers.

There are no noticeable differences in the forms of discriminatory activities by people from immediate circle depending on residence in urban or rural areas, expect for washing clothes: in rural areas 4.7% more women noticed that their family members started to wash their clothes separately from her clothes, than women in cities (Figure 36).
Figure 36. Behaviours of the respondent’s family members after they learnt about her positive HIV status, by the place of residence, %

The question suggested the possibility of multiple choice of answers.

Applying for help and support

70.8% of the respondents applied to for help in cases of experiencing stigma and discrimination (n=286) (Figure 37).
The following difference was detected between the groups of women who had the experience of getting help and those who didn’t, depending on age (Figure 38):

- In the age group of 26-25 y.o. the share of women who did not ask for help is 9% more than the share of those who did (29.7% and 20.6% respectively);
- In the age group of 46-55 y.o. the proportion of women who asked for help is 8.5% more than the proportion of those who did not have such experience (23.8% and 15.3% respectively).

![Figure 38. Getting help depending on the age group of the respondents, %](image)

Among those who did ask for help (n=286), 48.5% applied for help to social workers/consultants, 36.1% applied to social psychologists, and 34.5% asked other PLHIV for help. Only 20.3% of women went to their close people, 17.3% to spouses or partners, and 15.1% to friends (Figure 39).

![Figure 39. Where the respondents asked for help (n=286), %](image)

The question suggested the possibility of multiple choice of answers.
Half of the respondents asked for support in self-help groups of PLHIV (50.3%). 43.3% applied to state institutions (AIDS centers, social services), 41.3% went to various NGOs including those that provide HIV-related services. Every fifth respondent did not apply for any help (21.3%) (Figure 40).

![Figure 40. Organisations/networks where the respondent applied for help (n=404), %](image)

The question suggested the possibility of multiple choice of answers.

The respondents who live in rural areas 8.1% less frequently applied for help compared to those who live in cities (Figure 41).

![Figure 41. Applying for help depending on the place of residence of the respondents, %](image)
Among those who asked for help, in contrast to women living in cities, the proportion of respondents from rural areas who seek help from other PLHIV and friends is twice as small compared to women from urban areas (other PLHIV – 26.5% and 52.0% respectively, friends - 11.8% and 22.6%). However, women living in the village seek help from a partner or spouse two times more often (44.1% and 21.8% respectively), 12.4% more often apply to specialised organisations (44.1 % and 31.7%, respectively) and 19.0% more often seek help from social workers and consultants (85.3% and 66.3%, respectively). It should also be noted that in the village there are significantly more respondents who applied for but did not receive support (17.6% and 0.4%, respectively) (Figure 42).

![Figure 42. Where the respondents apply for support, by the place of residence of the respondents, %](image)

The question suggested the possibility of multiple choice of answers.

### Resisting stigma and discrimination

For the majority of the survey participants, manifestations of stigma and discrimination by the medical professionals are perceived as most hurtful and unpleasant (69.6%). For 34.7% of the respondents it is most unpleasant to experience stigma and discrimination from their family members, for 23.5% - from their partner. For every tenth respondent the most painful experience is stigma expressed by their neighbours, legal organisations staff and service organisations (Figure 43).
The survey participants have the opinion that in order to reduce stigma and discrimination towards women living with HIV it is necessary to take the following actions (Figure 44):

- Work with doctors to ensure they have the right information about HIV (83.2% of the respondents);
- Produce more TV programs about HIV that raise awareness and dispel myths about HIV (80.7%);
- Physicians must communicate correct information about HIV to relatives and friends of the women living with HIV (74.4%);
- It is necessary to broadcast social videos on TV and radio with correct information about HIV infection (73.4%);
- Hold seminars for law enforcement officers (64.2%);
- Disseminate social videos via social media (52.9%).
For the majority of the survey participants (74.8%) television is the main information channel through which the information campaign against stigma and discrimination in relation to WLHIV is best to run. For every second woman (52.0%) such channels are information booklets disseminated in medical establishments, and certain number of social media. Every third woman who participated in the research considers Tik Tok (43.6%), Instagram (43.8%) and videos in supermarkets and other establishments (42.1%) to be the best channels for the campaign. Advertising in public transport is the least popular information channel: only 38.1% of the respondents suggest using it (Figure 45).

Figure 45. Information channels necessary to use for the information campaign on reducing stigma and discrimination, in the opinion of the respondents (n=404), %

The question suggested the possibility of multiple choice of answers.

Main survey results by country

Main survey results by country are presented in Appendices 2-6

In Kazakhstan, Russia and Ukraine almost every second respondent experienced stigma and discrimination in the past year (from 44.1% in Russia to 52.4% in Ukraine), meanwhile, in Kyrgyzstan and Uzbekistan only every fourth responding women encountered such cases (29.6% - in Kyrgyzstan, 26.3% - in Uzbekistan). This difference among countries can be explained by the fact that the respondents belong to key populations most vulnerable to HIV. If in Kyrgyzstan 9.1% of the respondents belong to these groups, 7.9% in Uzbekistan, then 42.9% in Kazakhstan, 25.0% in Russia and 25.3% in Ukraine. Belonging to a key population group is an additional risk factor for encountering stigma and discrimination related to HIV.

In each country a large proportion of the respondents experienced stigma in healthcare settings. A little over half of the respondent in Kazakhstan (54.9), Kyrgyzstan (52.3%), Russia (54.8%) and Ukraine (55.3%) encountered rude and prejudicial treatment from healthcare professionals. In Uzbekistan the majority of the respondents (36.8%) had to deal with questions about how they got infected with HIV, while only every fourth respondent from this country (23.7%) experienced rude attitude. The survey participants from Kazakhstan and Uzbekistan encountered violation of their sexual and reproductive health rights two times
more often (19.8% and 21.0% respectively) than respondents from other countries (6.8% in Kyrgyzstan, 9.5% in Russia and 12.6% in Ukraine).

Most of the respondents who faced stigma and discrimination at work or at recruitment are from Kazakhstan (31.9%) and Russia (27.4%). Mainly, they were requested to be tested for HIV. Respondents from Kyrgyzstan experienced discrimination when receiving legal services (33.0% compared to 14.3%-23.7% in other countries). This manifested in the form of poor-quality services, verbal humiliation, and questions about getting infected with HIV.

Speaking of interactions with people from the immediate environment (family members, spouse/partner, neighbours), respondents from Russia experienced stigmatisation and discrimination most of all (33.3%-39.3% of respondents). The survey participants noted that the most spread stigmatising behaviours from their close people were disclosure of HIV status, insults and isolation as a family member (including prohibition to use common utensils and things, prohibition to go to family events and prohibition to communicate with children).

It is important to highlight manifestations of internal stigma. In Kyrgyzstan, a larger proportion of the respondents compared with the respondents from other countries wanted to commit suicide (45.5%). It should also be noted that respondents from Kyrgyzstan, compared with the participants from other countries, are twice as likely to experience negative feelings towards themselves because of their HIV status (in particular, they blame themselves and blame other people for their positive status). Accordingly, the proportion of survey participants who accepted their HIV status and learned to live with it is also significantly lower among respondents from Kyrgyzstan. This situation may be due to the fact that 42.0% of the survey participants from Kyrgyzstan live in rural areas, as well as because 36.0% of the respondents are mothers of HIV-positive children, who experienced severe stigma and discrimination from their families and close people. Russian respondents, along with those from Kyrgyzstan, have a rather small share of those who accepted their HIV status and learned to live with it.

The survey participants from Ukraine experience various fears related to HIV-positive status more often compared with the participants from other countries. Fear of physical abuse stands apart being experienced 2.5 times more often by the respondents from Ukraine (28.2%), compared with Kazakhstan (11.0%) and Kyrgyzstan (10.2%), and almost 5 time more often than the respondents from Russia (6.0%) and Uzbekistan (5.3%). Likewise, the fear of death due to lack of medicines was 1.5-1.8 times higher among Ukrainian respondents (61.2%) compared with the survey participants from other countries (32.1%-46.6%).

Almost half of the respondents from Uzbekistan (47.4%) did not apply for any help when they faced manifestations of stigma and discrimination, while in other countries this proportion makes 20.4%-34.1%. Respondents from Ukraine marked additional support services where they applied to, namely, HIV hotline, support group meetings and paid sessions with psychologists/psychotherapists. In Russia and Ukraine there are two times more respondents who marked applying for help to other PLHIV and to close people. It is important to note the extremely low level of applying for help to non-governmental organisations in Russia and Uzbekistan: only 13.2%-15.5% of the responding women had an experience of calling NGO for support in comparison with 51.6%-54.5% in Kazakhstan, Kyrgyzstan and Ukraine.

Informing and learning events for the staff of healthcare facilities, as well as TV programmes devoted to informing about HIV are the main actions offered by the majority of the respondents of each country. Accordingly, respondents from all countries recommend television as the main channel for the information campaign. However, large share of women from Kazakhstan (82.4%) and Ukraine (77.7%) advice paying attention to law enforcement agencies and providing trainings regarding HIV for them as well.
RESULTS OF QUALITATIVE SURVEY

External stigma and discrimination

Stigma and discrimination in healthcare settings

Mainly the respondents spoke about their experience of stigma and discrimination from the medical professionals because they had to interact with them quite often and inform them about their HIV status. Scornful and disgustful treatment coming from doctors and nurses is most painful and difficult to withstand for women: “I was in stupor. Medical workers treated me with disgust. I felt filthy” (R76); “I understood that doctors treated me worse than people that surrounded me” (R206); “It is very hurtful when medical workers bully us and our children, loath and ignore” (R388).

Quite often stigma in medical staff was manifested in the form of unnecessary precautions: “When the doctor [gynecologist] heard that I had HIV – I told her myself – she put on two pairs of gloves and screamed at me for keeping quiet and telling her in the last moment” (R179); “I was told to have our own thermometer, they used two pairs of gloves when checked the child’s temperature” (R93).

Disgustful treatment of the medical staff is particularly painful for the respondents when it is addressed to their children: “I felt very bitter for my child and myself. As if we were second-rate, as if we were not humans. Such attitude was unpleasant for me, it is especially hurtful now as my child’s started to fear them” (R387). “Feeling of inferiority, especially after visiting medical establishments. Maternity home, where they examined my child with disgust, using gloves for everyone to see. I felt of low social status, dirty and unworthy” (R177).

Often women described violations of their rights by the medical professionals in the sphere of reproductive health: “I went to paid clinic to perform medical abortion. The doctor insisted on it and told me it was right for me to come, there was no reason to give birth to a sick child, what if it were born infectious. I was very surprised the doctor decided to speak to me like this. Usually they try to dissuade against the abortion, but with me they insisted. I was astounded” (R179); “When I went for a Cesarian, [the doctors] told me straightaway they would tie my tubes” (R115); “They didn’t even accept me for [pregnancy] maintenance, when I arrived in an ambulance into one of the maternity homes in Kiev” (R307); this also includes circumstances of in vitro fertilization: “They questioned me about my chronic illnesses in front of other patients in clinics and hospital. When I was undergoing an IVF procedure, they told me one price for it and sent home to prepare, and when everything was done, all recommendations fulfilled and I came to a different city for the procedure itself, they told me a much bigger price than at the start. I asked why the sum was so big, and the doctor answered that I had HIV and required everything separate” (R216).

The respondents also led refusals of the medical workers to provide care and referrals to other medical specialists: “I felt unpleasant and hurt due to medical workers’ treatment who sent us away and referred to someone else just to get rid of us. I felt even more hurt because of the rude attitude towards my child” (R126); “They refused to hospitalize us, told us – get treatment at home, learn how to make injections. Put on multiple layers of gloves” (R154); “They made me have injections and droppers strictly at home” (R171).

As a result of experiencing stigma and discrimination from doctors, some of the interviewed women noted loss of trust in doctors and fear of seeking medical help. They delay calling for medical help until they become seriously ill. Sometimes this applies not only to the respondents themselves, but also to their children, especially if they are HIV-positive. One respondent says: “After I learnt about the status of my child, I started to hide away from people and hid my child. I did not go to children’s clinic, I didn’t go to
the AIDS center, too, if they called me. We only stayed at home. Even if other children fell sick, I didn’t call for a doctor, because I lost trust in them. I refused to give my child ARV medications – I thought the test result was incorrect and the diagnosis was wrong. I refused to believe, I thought my child was not like that. Then he started to have frequent fevers, got coughs, sore throat, hepatitis and diarrhea. He became very thin. Because of it all I had to apply to polyclinics, to the group of family doctors, but these doctors and nurses disclosed the child’s diagnosis. Now the whole area knows that my child has HIV. I was distraught, cried so much” (R145).

Stigma and discrimination in the sphere of education and employment

Respondents spoke about cases when they faced HIV-related stigma and discrimination in educational institutions in relation to their children. This was often due to putting the HIV status onto the child's documents in an educational establishment: “They wrote “HIV contact” on the medical record in kindergarten” (R233); “They put a specific code on the child’s documents in kindergarten” (R309), also due to the stop of communication between classmates and HIV-positive child: “Classmates turned away from my son when they learned about his status, who disclosed it was unknown” (R260).

Changing schools and moving to a new place of residence when being confronted by stigmatisation, as well as after intended or accidental disclosure of the diagnosis, is perceived by the respondents to be one of the ways to cope with the situation and solve conflict: “After an incident at school, pressure rose. My child and I were stressed. On coming home, I had a row with my husband. It was a very difficult situation. I wanted to withdraw the child from school at all, but she had to study somewhere, at least to finish the 9th grade. Finally, this year she finished school and entered college. I was very happy that she went to the region’s central town and now no one can hurt her because of her HIV status” (R152).

The majority of the respondents noted that they try to keep quiet about their HIV status during employment and at work, especially if there is no need for disclosing it (“I work in a kindergarten and I am afraid to talk about [my HIV status], I conceal it” (R354)), and are also forced to decline jobs if tests are required upon admission: “Where tests were mandatory, I had to decline those jobs” (R189).

For some respondents, acquiring HIV-positive status led to dismissal from work, often voluntary: “I did not encounter [stigma], because I left my job in the medical establishment voluntarily after learning about my HIV-status” (R96); “I was told I had AIDS like my husband, and they said: “You will die”. I was employed as a medical nurse in TB hospital. I so wanted to stay working there. I loved my job, but they humiliated me so much” (R100).

Stigma and discrimination from the immediate environment

During their life with the positive HIV status the respondents faced various manifestations of stigma and discrimination from close people (spouse/partner, family members, friends and acquaintances). Often this comes in forms of isolation, separation of an HIV-positive person from the family. This separation takes both physical forms (forced to leave home, to have separate dishes, bed linen) and the form of emotional alienation (refusal to talk). “My sister kicked me out of the house saying “You disgrace us” (R167); “My mother-in-law kicked me out of the house, prior to that she isolated my dishes and scolded me, felt squeamish” (R111); “My relatives have stopped communicating with me and they don’t let me visit, they don’t even call on the phone” (R218); “For the first two months after I found out about the status, my
mother allotted me separate dishes, and towels. Later everything returned to normal” (R176). “[Husband] threatened that he would forbid contact with children” (R346).

Some respondents indicated that they experienced refusals of relatives to accept visits from them: “I myself don’t even think about the fact that I live with HIV, I forget about it, and I take pills automatically. But there are moments when I go into self-stigma. For example, recently my own father could not accept me and my children as guests, as his wife forbade me to come because of my status. She bypasses me – she doesn’t approach me closer than two meters. At these moments, I feel bad. All of it comes from her illiteracy about HIV, I understand. It is good that there are places and people who can offer support at such moments and bring back to life” (R01).

Some respondents noted that their close people also forbade them from talking about their HIV status to other people because of their fear of facing secondary stigma themselves: “Mom forbade me from telling [about HIV status] to relatives, fearing that they would turn away and stop communication with me and my parents. She forbade to tell the gynecologist she knows, fearing that others would find out and she might also get fired from her job” (R216).

There are those respondents who faced attempts by family members to deprive them of their housing due to their HIV status: “The sisters tried to deprive me of housing, and when I was released, they said: “You have AIDS, you won’t live long anyway” (R188).

Insults from close people, humiliating treatment cause the respondents to feel inferiority, suppression, hatred for themselves and loved ones, depression. “I thought I had many friends and a strong family, but everything went into pieces at once” (R210); “I wanted to die, everyone pulled away from me. I felt useless to anyone, as if the world crashed. I fell into depression” (R100); “The act of my sister and a friend killed me emotionally” (R348), as well as “distrust of people whom I used to trust” (R209).

However, it is necessary to note positive cases of relationship dynamics and communication with close people after the respondent’s HIV status became known: “My partner told me: “We all walk under God, so everything is ok”, the partner is negative” (R97); “He [husband] already knew and never offended me, on the contrary, he gave support” (R94); “The husband said: “As we’ve lived, so we will continue” (R120); “After the training I asked my best girlfriend: “If you learnt that I had HIV, would you stop talking to me?” She said: “Are you a fool, or what?” We laughed” (R97).

Almost all cases of stigma and discrimination described by the responding women, were connected with the relationships with family members and close relatives, but there are also experiences of stigma coming from one of the communities: “I went to church, and people there, when they learned, they started bullying and insulting my children” (R96).

The survey participants explain bad attitude towards themselves from other people and society by the fact that “society see us being bad, because everyone is used to thinking that HIV is a disease of bad people” (R151). They associate good attitude with knowledge about HIV, ways of transmission and protection. “Everyone who knows about the status treats me normally, with understanding. They know that HIV is not dangerous in everyday life” (R148). As the respondents noted, sometimes relationships improved after the information about HIV, ways of transmission and prevention was provided to relatives: “There was the only relationship in which I did not immediately disclose my status. It is quite natural that a person had a nervous breakdown and insulted. But then, when I explained everything about the therapy, that we used contraception, after a few days he calmed down and apologized” (R176); “I tried to ignore, but it came to physical fighting. Then I brought brochures about HIV and the ways of transmission - I informed them myself. When they [the neighbours] understood everything, they stopped treating me like that and stopped being afraid” (R94).
Internal stigma and self-discrimination

Manifestations of self-stigma

Internal stigma or self-stigma is manifested in different forms in the respondents, including the feelings of shame, guilt, uncertainty and loss, low self-esteem, fear, anxiety, depression, suicidal thoughts and suicidal attempts.

The respondents revealed in their interviews that they had negative judgements in relations to themselves, they spoke of their uselessness and guilt. “I felt myself lost, confused, insulted, humiliated and needed by no one” (R102).

The survey participants often spoke about feelings of “dirtiness” and “alienness” which appeared after encountering stigma and discrimination from other people: “I felt myself an outcast. It seems everyone knows about it” (R27); “As if you were alien, you don’t belong with normal people, they fear you. Fear that they can get infected from me” (R123); “Felt myself inferior, dirty, unworthy. I wanted to die” (R216).

Experience of stigma caused such an acute humiliation that the respondents were deeply ashamed of their status and isolated themselves. They reported that their shame prevented them from communicating with others, making them feel lonely. “I felt like an unnecessary thing. Considered myself non-human. Wanted to relocate to where there is no one else” (R127). The feeling of being despondent due to their HIV-positive status the respondents described as uselessness and worthlessness: “I felt myself lost, confused, insulted, humiliated and needed by no one” (R102); “Felt myself a person needed by no one, wanted to die, asked myself questions ‘why me, why with me, for what’” (R115). “Depressed, smashed state. Feel myself like filth” (R62).

In their interviews the respondents justified discriminatory actions of other people against them: “I felt myself dirty, unworthy of normal life. I agreed with those who discriminated and judged me because I felt guilty of everything” (R295). “It was awful, I felt anger, hurt, and shame. There was no energy to stand up for myself. It felt as if they had the right to treat me like that” (R346).

Respondents talked about their desire to commit suicide after experiencing stigma and discrimination. “I was lying flat for a long time in a prolonged depression, wanted to commit suicide, did not want to live” (R48). “I wanted to hang myself, [there was] a terrible depression. I did not want to live and breathe” (R292). “I did not want to live when I found out that there is HIV during pregnancy. I thought that the child would be born sick, and if I die, then who would bring it up” (R89).

Suicide attempts that some respondents made should be noted separately. Suicide attempts are associated with the stigmatising attitudes from family members: “Still in depression, because of my daughter, she is yet not in touch with me. Neighbours are more or less [ok with me]. Tried to hang myself two times. Just wanted to kill myself” (R98). “Didn’t want to live, had thoughts just to die. I bought duct tape to tie my child to me and drown together, but I couldn’t find a fitting pond” (R134). Treatment of healthcare professionals experienced by the respondents also impacts the development of suicidal behaviour: “After narcologist shouted at me and blamed me for getting the infection, she told me I was sluttish and that’s why me and my husband had HIV. I wanted to die then. When I returned home, I hang myself, but my husband saved me” (R160).

Despite of the fact that the majority of the respondents have been living with HIV for more than ten years, the negative feelings towards themselves that appeared initially when they first found out about their status are still alive and affect their lives: “I felt very bad. This experience left an incurable scar on my heart. This pain is still with me, it never leaves me, despite of all the time” (R139).
Incidents of stigma on the part of medical professionals give rise to a sense of fear of being denied medical care when it may be needed. “Fear of being left without medical care” (R285). “I was afraid that the doctors would not provide me with medical care, and this fear has remained to this day. I feel stress when I go to the doctors” (R352). Respondents also talk about the fear of loneliness – the fear of being alone, not having a family and children, “the fear of being left alone or dying alone” (R290).

Fear of disclosure of status and encountering stigma is a special concern for those respondents who never had an experience of stigma and discrimination in relation to themselves and their children, but they heard stories and know about it from other people: “I can’t tell yet how I would feel [after encountering stigma], because there were no cases. I am afraid to even think that such things could happen” (R147). “We did not experience bad treatment due to the child’s HIV status. But we live in fear that it might happen to the child if people know about her HIV status” (R149).

**Manifestations of self-discrimination**

Among women who took part in the research, self-discrimination is mainly manifested in the form of refusal to seek medical care and visit medical facilities after experiencing stigmatisation from medical professionals: “I no longer go to dentistry and cannot fix my teeth. Doctors are prejudiced and squeamish. This is very humiliating. I don’t want to experience this” (R36). “I try to visit doctors less – only in extreme cases and give as little information about my status as possible” (R307); “I won’t give birth anymore” (R231).

Self-discrimination also led women to isolation, restricting themselves in communications and the necessity to relocate. “I was very anxious about the child, I had very severe depression. We even had to move to another city” (R17). “I felt like an outcast, had to move away from the village” (R291).

Relationships are a notable source of stress and lack of self-esteem for the respondents. Treating themselves judgmentally, thinking that they don’t deserve a personal life and family, the respondents reported that they sabotage their relationships themselves, by finishing them or not even trying to have them: “I don’t have a partner since the moment I learned about my HIV status” (R257).

**Applying for help**

**Results of applying for help**

The respondents told how they asked for help and the results of seeking help. They explained that applying to specialised organisations for support (NGOs, AIDS center) helped them to cope with experiences of stigma and discrimination.

The survey participants marked the following results of applying for help:

- **Receiving information about HIV infection and its treatment, attending trainings and seminars**

The respondents reported that they received information about HIV infection and therapy ("I learned a lot of information about living with HIV, I learned what was possible and what was not. “I was born again”" (R285)). They characterize this information as useful, it helped them to tune into caring for themselves and their health (“I knew more about the disease and started to take better care of my health” (R06)). Receiving knowledge about HIV is the first step on the way of accepting one’s status, which, in turn, helps to cope
with internal stigma and self-discrimination: “NGO gave me a lot of useful information, and I started to treat myself in a different way and started to live differently. I began to value life, my health, I had a feeling of being born again” (R100). “I felt tired of taking ARVT, tired of the everyday ritual of taking ARVT. I spoke with PLHIV and felt better. This feeling passed and came understanding why I take therapy” (R181).

- Receiving therapy

There were respondents who decided to begin therapy and applied for help in getting antiretroviral treatment (“I received [ARV] pills, I understood that I was not the only one like that” (R220); “I receive therapy and I want to live. I even started to attend support groups” (R218); “I receive medications that are without side effects” (R107)).

- Psychological support

The respondents highlighted an important role of psychological help they received in the process of accepting themselves, their status and in reducing the level of internal stigma: “The feeling of loneliness and separateness disappeared” (R186); “Acceptance, calm, understanding that I am not alone” (R28). In addition to psychological counseling, the respondents attended support groups. Individual work with a psychologist, as well as visits to self-help groups, helped to get rid of depression and suicidal thoughts, gain self-confidence and confidence in the future, make new acquaintances.

“They helped me, I coped with my feelings and did not commit suicide. I lived through heavy feelings of guilt and shame” (R216); “It became easier when I found out that I was not alone, there were people like me. Learned about my rights. I know that I can always get support, no matter what happens” (R88); “After the training, I felt better, I realized that I was not alone with such a misfortune, that there were many of us and we could help each other. And I also realized that there were good specialists - psychologists who were really interested in my improvement” (R159); “I began to become aware of life and understand how precious it was. I started to just live and enjoy life” (R98).

- Legal and social support

The respondents pointed out that they applied for legal and social support, including cases of encountering discrimination. “[I got] temporal shelter after I lost my apartment due to fraud” (R330); “Applied for legal support. Court judged in my favour, but the accused continue working” (R143). “The medical workers who discriminated me were punished, I can stand up for myself now, I became more confident, I met good social workers in the center who gave me all the necessary information” (R70).

The survey participants applied for social support as well. Social support was related to the restoration of lost documents, execution of childbirth documents, receipt of benefits and pensions, and registration of disability. “There was and is the result. They helped me with documents for receiving benefits and pensions, as I was very weak and did not know the way and my rights and the rights of the child” (R131). “Thanks to all the activities, I received a disability status, paid for OSMS [medical and social security], I was able to see all the necessary medical specialists” (R55).
- Opportunity to help other people, active interaction

After applying for help some of the respondents were engaged into giving support to other people living with HIV, and this opportunity to assist others helped them to overcome negative experience of stigma and self-stigma. “My self-esteem went up; I was invited to a support group in the AIDS center where I was surrounded by others like me and I found myself empowered. I liked everything there at once, I became a leader there at once. Today I continue working there and attending, helping others. I feel in bliss, I found myself there” (R99).

The reasons of not applying for help

Among the survey participants who reported that they did not apply for help, the main reasons for such behaviour were the following:

- Shame, awkwardness, fear;
- Negative opinion about healthcare workers, lack of trust in them, including due to negative experiences with them in the past;
- Absence of information about the organisations where it is possible to seek for help, about specialists who could help;
- Getting enough support from family and friends;
- Self-help, drawing on inner power.

Survival strategies

The respondents told what helped them to withstand stigma and mitigate negative thoughts. These “survival strategies” include support from the community, family and friends, knowledge about HIV and their legal rights, holding pro-active approach to life, turning to religion, and keeping quiet about their HIV status.

- Support of the community

The survey participants noted that applying for support to the community helped them to mitigate self-stigmatising beliefs, reduce feelings of isolation and otherness. This includes both simple communication with other PLHIV and attending self-help and support groups. “I talk to PLHIV – they inspire me” (R103). The respondents highlight that support from the community is priceless and necessary. “This is the community of people with HIV. Whatever happens they react immediately. They help to stay healthy and to not be affected by stigma. They inspire confidence that we are the same people as everyone else” (R89).

The respondents speak a lot about the importance of support groups, how they help to overcome different situations, how safe they are, that group participants would always listen and help to find answers and share their own experience, it is also a method to cope with loneliness. “I found support in the groups. I know that I can ask for help and advice, that I can simply just talk about me worries” (R390). “Support group, doctors coming to give information, and I came to feel that everything was in my hands. I became more
confident” (R98). Also, if there is no understanding and support from family and friends, support groups become a family of a sort.

- **Support from family and friends**

The respondents also describe the importance and necessity of support from the family and friends. If anyone from the family or close friends know about the status and accept it, then it is possible to talk to them easily and to freely discuss the problem. Their support helps to improve the quality of life and to find solid ground under their feet. “After some time had passed, I became calmer. I found a friend who was like me, I could share things with her. I visited psychologist in the AIDS center. Not at once, but later mom started to support me” (R212).

Spouses/partners and children provide special emotional and practical support to women: “My life partner helps me not to crumple” (R255); “Those who help to withstand stigma are my children and support from my husband” (R92); “Support from my family and close people – daughter and husband. I found so much love, warmth, and care in them, I could not let them down” (R120). For many survey participants these are children who engender special power to cope with stigma and other misfortunes: “Children help to survive. I am ready to do a lot for them” (R165).

- **Knowledge about HIV and legal rights, trainings and webinars**

Since the diagnosis is often perceived as a sentence due to the lack of information, the respondents attach a special role in resisting stigma to the acquired knowledge and information about HIV infection, how to protect themselves and how to take care of themselves, as well as knowledge about their rights: “I learn reliable information about HIV. It gives strength, it is not so scary to live with HIV” (R210); “Understanding what HIV is, accepting HIV as a chronic disease and understanding that it is now a part of me. What is the point of destroying yourself with stigma and self-condemnation?” (R176); “The cases of stigma forced me to delve into the law and defend my rights” (R42).

Acquiring knowledge helps to improve life. Many spoke about restoring confidence due to knowledge: “Knowledge about the infection, the more information you have, the more confident you feel, you know your enemy” (R365).

Additionally, the respondents mentioned the importance of participation in various trainings and webinars devoted to personal growth that are held by specialised state facilities (i.e. AIDS center) and HIV-servicing NGOs. “The trainings I attended helped me very much. Engendered confidence that there was no need to shrink into myself, that one needs to go on and study further” (R95); “After the personal growth trainings I can speak freely now and protect my personal boundaries” (R120); “Personal growth training helped, I felt lightness. In the past I squeezed, held everything inside, and after the training I was able to come out and speak to my best friend. And I became more confident and courageous. It is my personal victory and a big leap in development” (R97); “Knowing my rights. Trainings help to raise self-esteem really well” (R11).

The respondents point out that the more information there are about HV, the better they can help themselves and others: “Attended trainings help, especially when you see that people need you and when you explain to them that they don’t know yet. It is great to feel myself useful and needed” (R99).

- **Pro-active approach to life**

The respondents give much attention in resisting stigma to pro-active approach to life: “I feel strong, I know that I can overcome a lot, I’ve got patience. And I always stand my ground and go to the end, to the goal” (R153). They talk about such qualities as innate perseverance, life optimism, self-confidence, “persistence,
perseverance and determination” (R167), “being positive and self-love” (R265), as well as the development of these qualities (“Working on self-esteem, development of self-confidence” (R209)).

- Religion

For some participants religion is one of the ways to resist negativity and stigma.

- Nondisclosure of HIV status

For a small amount of the respondents nondisclosure of their HIV status is a way, because initially it helps to avoid stigmatisation and discrimination: “I don’t tell about my status to strangers” (R222), “Tell no one to avoid discrimination” (R225).

Suggested measures to combat stigma and discrimination

All the advice and recommendations given by the respondents during the interview fall under two domains: 1) actions aimed at themselves (combatting self-stigma and self-discrimination), and 2) actions aimed at society as a whole and at certain population groups in particular (combating stigma and discrimination).

Combatting self-stigma and self-discrimination

Fighting stigma and self-discrimination involves four main aspects^1

1) Self-informing

- It is necessary to learn everything about HIV infection and its treatment, as one respondent put it, “to delve into the topic of HIV” (R181), since “ignorance of accurate information about HIV/AIDS leads to the consequences of self-stigma in general” (R70); “in order not to experience internal stigma, you need to know more about this disease” (R232).

- It is necessary to study and know your rights: “Receive any information from all available sources related to the fight against stigma and discrimination. Learn your rights” (R02).

- Attending trainings and webinars, listening to podcasts, reading articles on HIV;

- Finding information about organisations that provide support to HIV-positive people (non-profit organisations, specialised state institutions).

2) Psychological help

- Visiting psychologist at the AIDS center or NGO in order to accept “the fact that I am not my diagnosis” (R209), to overcome suicidal thoughts if one has any (“Psychologist brought me back to my senses, when I wanted to jump under the metro train and die”(R161));

- Attend psychotherapy regularly.
3) Support from the community
- Talking to other PLHIV and women who raise HIV-positive children for experience exchange, for “talking to people who are like you” (R121) and knowing that “you are not alone in this world” (R191); “Finding some group or chat at once, where you can talk, learn from other’s experience or share. You will meet many wonderful people there who LIVE” (R15);
- Attending support/self-help groups for people living with HIV;
- Talking to peer consultant (“in the first place you need an adequate peer consultant, who would be able to explain and share their experience” (R176)).

4) Pro-active approach to life
- Do not isolate from society (“There is no need to withdraw to yourself, to go into shadows, instead, go to the lights and be with people” (R103));
- Do not give in to despair and self-blame (“You need to stop to be hard on oneself, it does not lead to anything good. You need to learn to accept yourself the way you are. All people fall ill, it is not terminal” (R96); “Forgive yourself that it happened to you, and understand that this is your life now, and it can be happy” (R211);
- Seek help when one needs it, do not stay alone with your problem, look for support in the circle of friends/family/other PLHIV and support groups;
- Be open for new acquaintances, new information and knowledge;
- Engage with organisations that support HIV-positive people;
- Remember that “every person has a place to be” (R178);
- Care about one’s health, take antiretroviral therapy;
- Do what you love;
- Live and enjoy every day.

Combating stigma and discrimination
Recommendations of the respondents regarding putting end to stigma and discrimination, concern working with three main groups: society in general, medical community and immediate environment of PLHIV.

1) Working with society in general
The main thing that, in the opinion of the survey participants, should be done is to inform about HIV infection, increase literacy on HIV-related issues, and provide useful and truthful information about HIV. For this, the respondents propose to:
- Conduct information campaigns;
- Share stories about the lives of people living with HIV: “Telling that with this diagnosis you can live like everyone else” (R306); “Explain to society that it is not scary to live next to us [HIV-positive people]” (R39);
- Involve influential people and opinion leaders into working with the society;
- Develop social videos and broadcast them on social networks, on television.

Another important aspect of working with society is the need to change society's attitude towards HIV as the "plague of the 20th century".

2) Working with the medical community

The main purpose of working with healthcare professionals is also to inform them about HIV infection, to raise their literacy related to HIV. Healthcare staff of common polyclinics and hospitals should be the core target groups for the informing effort.

It is also important to educate doctors on the matters of professional ethics (“Doctors need to be more careful in choosing words and actions. They are rude and inflict a lot of hurt. Any word may lead to murder or suicide” (R172)). According to the respondents, strengthening of the law, introducing tougher punishment for non-compliance with patient confidentiality, dissemination of information about the diagnosis without the consent of the patient and humiliation of the patient should be made necessary measures in this field.

3) Working with the immediate environment of PLHIV

The survey participants state that working with the close environment of PLHIV (family members, partners/spouses, friends) is very important. It is necessary to provide correct information about HIV and its treatment to these people (“To explain that people living with HIV are like everyone else, that there is nothing to fear from them and turn them into monsters” (R105)). To achieve this goal they suggest running groups for close people, including support groups.

MAIN CONCLUSIONS

Results of the survey indicate that women living with HIV continue to encounter stigma and discrimination in various areas of life – from professional to personal. More often women living with HIV face discrimination from the medical staff, as well as from their immediate environment (family members, partners/spouses).

Discrimination from the medical professionals manifests in the forms of rude and biased attitude, refusal to provide services or referrals to other medical establishments. Unprofessional attitude of medical workers is most hurting and painful for women living with HIV when such behaviour is addressed to their children irrespective of the child’s HIV status.
Insults and abuse (psychological, financial, physical) from the immediate environment are the most frequently observed forms of discrimination in relation to WLHIV.

Experiencing stigma and discrimination impacts self-esteem and mental well-being of women living with HIV, and lead to depression, suicidal thoughts and attempts. The internalized stigma of WLHIV is primarily manifested in feelings of guilt, shame, low self-esteem, and uselessness. One in three women had suicidal thoughts. Self-discrimination of WLHIV is most often expressed in self-isolation from society, avoiding visits to medical establishments and deciding not to have sexual contacts.

Belonging to several key population groups (in addition to having positive HIV status) aggravates and strengthens stigma experienced by women living with HIV. Women who belong to several KPs more often deal with the disclosure of the diagnosis by the medical workers, intended withholding of information about the availability of services and outright denial of medical care. They are also three times more likely to experience insults and abuse from their family members and disclosure of status by a partner, twice as likely to experience isolation and deprivation of housing or the right to inheritance. Additionally, living in rural areas greatly increases the possibility of WLHIV encountering rude or biased treatment by healthcare providers, denial of service, admission at last turn (i.e., after all other patients have been examined or treated). Also, living in rural areas is associated with a higher level of self-stigmatisation of WLHIV, namely, anger at themselves, blaming themselves and other people in connection with acquiring HIV.

Three out of four women turned for help and support to self-help groups, specialised state establishments and NGOs. When asking for support WLHIV interacted with social workers and psychologists, as well as other PLHIV. Every fifth WLHIV did not seek help due to strongest feelings of shame, awkwardness and fear, absence of trust, negative experience of asking for help in the past as well as not knowing where to look for help at all.

Women have developed a number of survival strategies while living with HIV helping them to withstand stigma and cope with the manifestations of discrimination. Such strategies include support from the community, family and friends, deepening knowledge about HIV and their legal rights, and maintaining proactive attitude to life.

The majority of WLHIV think that in order to reduce stigma it is necessary to run information campaigns for healthcare providers and produce more TV programmes to dispel myths about the infection and living with HIV. In WLHIV’s opinion, the undoubted leader among the information channels for conducting an information campaign is television.

**MAIN RECOMMENDATIONS**

**General recommendations**

Based on the data obtained through the survey of women living with HIV and/or having children with HIV-positive status, recommendations were articulated aiming to reduce the level of stigma and discrimination against WLHIV:

1. **Reducing the level of stigma and discrimination in the medical establishments:**
   - Increasing the level of awareness and understanding of healthcare workers, especially those located in rural areas, about stigma and discrimination in the context of HIV;
- Monitoring the provision of services by medical workers with the focus on medical organisations located in rural areas, including the organisation of a hotline; organising monitoring of the provision of medical services by employees of HIV service organisations while facilitating interaction with medical establishments; advice by patients.

- Increasing the level of awareness and understanding of students of medical professional colleges and higher educational establishments on the issues of stigma and discrimination in the context of HIV.

2. Improving the implementation of existing legislation affecting the rights of PLHIV:

- Monitoring the implementation of existing legislation affecting the rights of people living with HIV by the community of women living with HIV.

3. Reducing the level of self-stigma in the community of people living with HIV:

- Organisation of acceptance and disclosure programs for women living with HIV with the involvement of the necessary professionals (psychologists, peer consultants);

- Organisation of the work of the community of women living with HIV in small towns and rural areas (organisation of support groups, consultations by peer consultants);

- Increasing the level of knowledge and skills of women living with HIV on patient rights;

- Increasing the participation of women living with HIV in social support programs to ensure access to healthcare and social protection services;

- Mobilising and developing leadership skills in the community of women living with HIV and empowering legal literacy of women living with HIV.

4. Reducing stigma and discrimination in general population:

- Conducting an information campaign to develop tolerance towards women living with HIV via mass media (with television in focus), including informing about HIV infection, using examples from the lives of people living with HIV;

- Engaging people from the immediate environment of women living with HIV in non-profit educational programs, including workshops for partners, family members, and friends, that will focus on understanding HIV-related stigma and building relationships between people living with HIV and people living close to them.
Additional recommendations by country

Kazakhstan
- Pay attention to situations related to discrimination against women living with HIV in medical facilities, and above all to situations related to violation of reproductive rights;
- Promote the improvement of knowledge of women living with HIV about their rights at job recruitment, at work, as well as for receiving healthcare services.

Kyrgyzstan:
- Facilitate the development of communities of women living with HIV and support groups in small towns and rural areas;
- Facilitate the availability of psychological counseling to reduce the high level of self-stigmatisation among WLHIV, especially those living in rural areas, possibly through the development of an HIV hotline;
- Promote the improvement of knowledge of women living with HIV about their rights in the sphere of services, and analyze cases of rights violations when applying for legal support.

Russian Federation:
- Ensure dissemination of information about existing HIV-service organisations and the services they provide inside AIDS centers and other organisations that provide services and support to HIV-positive women, as well as via social networks popular in the community, including chatbots;
- Pay attention to the high level of self-stigmatisation of WLHIV; develop self-help and support services for keeping and restoring mental health, as well as programmes for the rehabilitation of women living with HIV who experienced various types of abuse; develop and maintain closed online support groups for the community;
- Pay attention to the situations of discrimination of women living with HIV at recruitment and at work, promote knowledge of WLHIV about their employment rights;
- Develop programmes targeted for the people from the immediate environment of WLHIV, in order to provide them information about HIV, help them understand stigma and discrimination in HIV context.

Uzbekistan:
- Ensure dissemination of information about active HIV-service organisations and the services they provide inside AIDS centers and other organisations that provide services and support to WLHIV;
Special attention should be paid to violations of WLHIV rights in the sphere of sexual and reproductive health; improve WLHIV knowledge about their right to healthcare.

Ukraine:
- Facilitate accessibility of psychological assistance to reduce the level of self-stigmatisation of WLHIV;
- Pay attention to the high level of self-stigmatisation of WLHIV; develop self-help and support services for keeping and restoring mental health, as well as programmes for the rehabilitation of women living with HIV who experienced various types of abuse; organize offline and online community support groups;
- Pay attention to a large number of women in difficult life circumstances and women temporarily displaced due to hostilities. It is necessary to develop services for the provision of material assistance to those in need, to facilitate the opening of social hostels and shelters;
- Create conditions for the integration of internally displaced persons who need social protection, develop services for the acquisition of new professions and retraining, and provide assistance in finding employment;
- Develop fundraising activities to raise funds to open services for women who are in difficult life circumstances; attract volunteers.

LIST OF LITERATURE:


### APPENDICES

#### Appendix 1. Socio-demographic characteristics of the respondents

<table>
<thead>
<tr>
<th>Characteristics of the respondents</th>
<th>Kazakhstan</th>
<th>Kyrgyzstan</th>
<th>Russian Federation</th>
<th>Uzbekistan</th>
<th>Ukraine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
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<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
<td>Number %</td>
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<td>1</td>
<td>3</td>
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</tr>
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<td>19,8%</td>
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<td>29,5%</td>
<td>8</td>
</tr>
<tr>
<td>56-65</td>
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<td>3,3%</td>
<td>5</td>
<td>7,1%</td>
<td>1</td>
</tr>
</tbody>
</table>

| **Place of residence**            | Number %   | Number %   | Number %           | Number %   | Number % |
| City/town                         | 89         | 97,8%      | 81                 | 96,4%      | 38      |
| Countryside                       | 2          | 2,2%       | 1                  | 1,2%       | 0       |
| Other                             | 0          | 0,0%       | 2                  | 2,4%       | 0       |

| **Education**                     | Number %   | Number %   | Number %           | Number %   | Number % |
| University graduate/Diploma       | 18         | 19,8%      | 13                 | 14,8%      | 21      |
| Community college graduate        | 33         | 36,2%      | 14                 | 15,9%      | 49      |
| Senior High school graduate       | 36         | 39,6%      | 55                 | 62,5%      | 10      |
| Junior High school graduate       | 3          | 3,3%       | 5                  | 5,7%       | 2      |
| Without education                 | 0          | 0,0%       | 0                  | 0,0%       | 1       |
| Other                             | 1          | 1,1%       | 1                  | 1,1%       | 2      |

| **Marital status**                | Number %   | Number %   | Number %           | Number %   | Number % |
| Unmarried                         | 17         | 18,7%      | 11                 | 12,5%      | 11      |
| Divorced                          | 14         | 15,4%      | 22                 | 25,0%      | 15      |
| Officially married                | 19         | 20,8%      | 33                 | 37,5%      | 29      |
| In relationship                   | 6          | 6,6%       | 6                 | 1,1%       | 18      |
| Not in a relationship             | 12         | 13,2%      | 8                  | 9,1%       | 3       |

| **Children**                      | Number %   | Number %   | Number %           | Number %   | Number % |
| Have a child/children             | 77         | 84,6%      | 83                 | 94,3%      | 62      |
| Have no children                  | 14         | 15,4%      | 5                  | 5,7%       | 22      |

| **Children's age**                | Number %   | Number %   | Number %           | Number %   | Number % |
| 0-3                               | 17         | 22,0%      | 13                 | 15,7%      | 15      |
| 4-7                               | 12         | 15,6%      | 31                 | 37,3%      | 14      |
| 8-12                              | 28         | 36,4%      | 32                 | 38,6%      | 21      |
| 13-18                             | 24         | 31,2%      | 45                 | 54,2%      | 19      |
| Over 18                           | 36         | 46,8%      | 34                 | 41,0%      | 25      |

| **Employment**                    | Number %   | Number %   | Number %           | Number %   | Number % |
| I work officially                 | 43         | 47,2%      | 28                 | 31,8%      | 43      |
| I work unofficially               | 21         | 23,1%      | 14                 | 15,9%      | 22      |
| Unemployed                        | 11         | 12,1%      | 12                 | 13,6%      | 8       |
| Housewife                         | 7          | 7,7%       | 26                 | 29,6%      | 8       |
| Pensioner                         | 1          | 1,1%       | 7                  | 8,0%       | 1       |
| Student                           | 0          | 0,0%       | 0                  | 0,0%       | 1       |
| Other                             | 8          | 8,8%       | 1                  | 1,1%       | 2       |

| **Income level**                  | Number %   | Number %   | Number %           | Number %   | Number % |
| Low                               | 34         | 37,4%      | 38                 | 43,2%      | 21      |
| Average                           | 50         | 54,9%      | 44                 | 50,0%      | 52      |
| Above average                     | 3          | 3,3%       | 3                  | 3,4%       | 7       |
| High                              | 1          | 1,1%       | 0                  | 0,0%       | 3       |
| Other                             | 3          | 3,3%       | 3                  | 3,4%       | 1       |

| **Social status**                 | Number %   | Number %   | Number %           | Number %   | Number % |
| Temporarily displaced people      | 0          | 0,0%       | 0                  | 0,0%       | 0       |
| Migrant                           | 1          | 1,1%       | 1                  | 1,1%       | 2       |
| Woman in difficult life circumstances | 22   | 24,2%      | 20                 | 22,7%      | 7       |
| Woman raising a child alone       | 29         | 31,9%      | 35                 | 39,8%      | 18      |
| Woman with a disability           | 3          | 3,3%       | 5                  | 5,7%       | 2       |
| Woman raising an HIV-positive child | 7        | 7,7%       | 32                 | 36,4%      | 4       |
| Woman raising a child with a disability | 4 | 4,4%       | 5                  | 5,7%       | 1       |
| None of the above                  | 45         | 49,5%      | 19                 | 21,6%      | 59      |

* Multiple answer question
Appendix 2. Country profile: Kazakhstan

1. Respondents belonging to key population groups and their living with HIV

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Former prisoners</td>
<td>22.0%</td>
</tr>
<tr>
<td>LGBT</td>
<td>2.2%</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>18.7%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>3.3%</td>
</tr>
<tr>
<td>Mothers of HIV-positive children</td>
<td>5.5%</td>
</tr>
<tr>
<td>Women living with HIV</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Figure 1. Respondents belonging to key population groups, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 2. Duration of living with HIV, respondents from Kazakhstan, %
2. Public stigma and discrimination

Figure 3. Who knows about the HIV status of the respondents, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 4. Number of cases of experiencing stigma and discrimination over the past year, respondents from Kazakhstan, %
Figure 5. Manifestations of stigma and discrimination in healthcare settings, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 6. Manifestations of stigma and discrimination at work place, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Figure 7. Manifestations of stigma and discrimination while obtaining legal services, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 8. Manifestations of stigma and discrimination in education, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Figure 9. Manifestations of stigma and discrimination by family members, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 10. Manifestations of stigma and discrimination by a spouse/partner, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Figure 11. Manifestations of stigma and discrimination from neighbors/friends, respondents from Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

3. Manifestations of internalised stigma

Figure 12. Fears experienced by respondents after a positive HIV diagnosis, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Figure 13. Feelings experienced by respondents after a positive HIV diagnosis, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 14. Respondents’ attitudes towards their HIV status and the HIV status of their children at the time of the survey, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
4. **Self-discrimination**

Figure 15. Changes in the respondent's behavior after she became aware of her HIV-positive status, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 16. Changes in the respondent's behaviour at home after she became aware of her HIV-positive status, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Figure 17. Changes in the behaviour of family members towards the respondent after she changed her behavior as a result of her HIV-positive status, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

5. Getting help and support

Figure 18. Getting help and support, respondents from Kazakhstan, %
Figure 19. Groups of people to whom the respondents turned for help and support, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 20. Organizations and networks where respondents turned to for help, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
6. Resisting stigma and discrimination

Figure 21. People from whom the manifestations of stigma and discrimination are most painful for the respondents, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.

Figure 22. Actions that respondents say should be taken to combat stigma and discrimination, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Figure 23. Information channels that, in the opinion of respondents, should be used when conducting an information campaign aimed at reducing stigma and discrimination, Kazakhstan, %

The question suggested the possibility of multiple choice of answers.
Appendix 3. Country profile: Kyrgyzstan

1. Respondents belonging to key population groups and their living with HIV

![Figure 1. Respondents belonging to key population groups, Kyrgyzstan, %](image1)

The question suggested the possibility of multiple choice of answers.

![Figure 2. Duration of living with HIV, respondents from Kyrgyzstan, %](image2)
2. Public stigma and discrimination

Figure 3. Who knows about the HIV status of the respondents, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 4. Number of cases of experiencing stigma and discrimination over the past year, respondents from Kyrgyzstan, %
Figure 5. Manifestations of stigma and discrimination in healthcare settings, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 6. Manifestations of stigma and discrimination at work place, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Figure 7. Manifestations of stigma and discrimination while obtaining legal services, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 8. Manifestations of stigma and discrimination in education, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Figure 9. Manifestations of stigma and discrimination by family members, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 10. Manifestations of stigma and discrimination by a spouse/partner, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Figure 11. Manifestations of stigma and discrimination from neighbors/friends, respondents from Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

3. Manifestations of internalised stigma

Figure 12. Fears experienced by respondents after a positive HIV diagnosis, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Figure 13. Feelings experienced by respondents after a positive HIV diagnosis, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 14. Respondents' attitudes towards their HIV status and the HIV status of their children at the time of the survey, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
4. Self-discrimination

Figure 15. Changes in the respondent's behaviour after she became aware of her HIV-positive status, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 16. Changes in the respondent's behaviour at home after she became aware of her HIV-positive status, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Figure 17. Changes in the behavior of family members towards the respondent after she changed her behavior as a result of her HIV-positive status, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

5. Getting help and support

Figure 18. Getting help and support, respondents from Kyrgyzstan, %
Figure 19. Groups of people to whom the respondents turned for help and support, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 20. Organizations and networks where respondents turned to for help, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
6. Resisting stigma and discrimination

Figure 21. People from whom the manifestations of stigma and discrimination are most painful for the respondents, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.

Figure 22. Actions that respondents say should be taken to combat stigma and discrimination, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Figure 23. Information channels that, in the opinion of respondents, should be used when conducting an information campaign aimed at reducing stigma and discrimination, Kyrgyzstan, %

The question suggested the possibility of multiple choice of answers.
Appendix 4. Country profile: Russian Federation

1. Respondents belonging to key population groups and their living with HIV

Figure 1. Respondents belonging to key population groups, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 2. Duration of living with HIV, respondents from Russian Federation, %
2. Public stigma and discrimination

Figure 3. Who knows about the HIV status of the respondents, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 4. Number of cases of experiencing stigma and discrimination over the past year, respondents from Russian Federation, %
Figure 5. Manifestations of stigma and discrimination in healthcare settings, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 6. Manifestations of stigma and discrimination at work place, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Figure 7. Manifestations of stigma and discrimination while obtaining legal services, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 8. Manifestations of stigma and discrimination in education, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Figure 9. Manifestations of stigma and discrimination by family members, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 10. Manifestations of stigma and discrimination by a spouse/partner, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Figure 11. Manifestations of stigma and discrimination from neighbors/friends, respondents from Russian Federation, %

The question suggested the possibility of multiple choice of answers.

3. Manifestations of internalised stigma

Figure 12. Fears experienced by respondents after a positive HIV diagnosis, Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Figure 13. Feelings experienced by respondents after a positive HIV diagnosis, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 14. Respondents' attitudes towards their HIV status and the HIV status of their children at the time of the survey, Russian Federation, %

The question suggested the possibility of multiple choice of answers.
4. Self-discrimination

Figure 15. Changes in the respondent's behavior after she became aware of her HIV-positive status, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 16. Changes in the respondent's behaviour at home after she became aware of her HIV-positive status, Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Figure 17. Changes in the behavior of family members towards the respondent after she changed her behavior as a result of her HIV-positive status, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

5. Getting help and support

Figure 18. Getting help and support, respondents from Russian Federation, %
Figure 19. Groups of people to whom the respondents turned for help and support, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 20. Organizations and networks where respondents turned to for help, Russian Federation, %

The question suggested the possibility of multiple choice of answers.
6. Resisting stigma and discrimination

Figure 21. People from whom the manifestations of stigma and discrimination are most painful for the respondents, Russian Federation, %

The question suggested the possibility of multiple choice of answers.

Figure 22. Actions that respondents say should be taken to combat stigma and discrimination, Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Figure 23. Information channels that, in the opinion of respondents, should be used when conducting an information campaign aimed at reducing stigma and discrimination, Russian Federation, %

The question suggested the possibility of multiple choice of answers.
Appendix 5. Country profile: Uzbekistan

1. Respondents belonging to key population groups and their living with HIV

Figure 1. Respondents belonging to key population groups, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 2. Duration of living with HIV, respondents from Uzbekistan, %
2. Public stigma and discrimination

Figure 3. Who knows about the HIV status of the respondents, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 4. Number of cases of experiencing stigma and discrimination over the past year, respondents from Uzbekistan, %
Figure 5. Manifestations of stigma and discrimination in healthcare settings, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 6. Manifestations of stigma and discrimination at work place, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
Figure 7. Manifestations of stigma and discrimination while obtaining legal services, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 8. Manifestations of stigma and discrimination in education, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
Figure 9. Manifestations of stigma and discrimination by family members, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 10. Manifestations of stigma and discrimination by a spouse/partner, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
3. **Manifestations of internalised stigma**

4. **Figure 11.** Manifestations of stigma and discrimination from neighbors/friends, respondents from Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

**Picture 12.** Fears experienced by respondents after a positive HIV diagnosis, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
Figure 13. Feelings experienced by respondents after a positive HIV diagnosis, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 14. Respondents' attitudes towards their HIV status and the HIV status of their children at the time of the survey, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
5. **Self-discrimination**

![Graph showing changes in respondent's behavior after becoming aware of HIV-positive status in Uzbekistan.](image)

**Figure 15.** Changes in the respondent's behavior after she became aware of her HIV-positive status, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

![Graph showing changes in respondent's behavior at home after becoming aware of HIV-positive status in Uzbekistan.](image)

**Figure 16.** Changes in the respondent's behavior at home after she became aware of her HIV-positive status, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
Figure 17. Changes in the behavior of family members towards the respondent after she changed her behavior as a result of her HIV-positive status, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

6. Getting help and support

Figure 18. Getting help and support, respondents from Uzbekistan, %
Figure 19. Groups of people to whom the respondents turned for help and support, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 20. Organizations and networks where respondents turned to for help, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
7. Resisting stigma and discrimination

Figure 21. People from whom the manifestations of stigma and discrimination are most painful for the respondents, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.

Figure 22. Actions that respondents say should be taken to combat stigma and discrimination, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
Figure 23. Information channels that, in the opinion of respondents, should be used when conducting an information campaign aimed at reducing stigma and discrimination, Uzbekistan, %

The question suggested the possibility of multiple choice of answers.
Appendix 6. Country profile: Ukraine

1. Respondents belonging to key population groups and their living with HIV

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Former prisoners</td>
<td>11.7%</td>
</tr>
<tr>
<td>LGBT</td>
<td>1.0%</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>12.6%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>3.9%</td>
</tr>
<tr>
<td>Mothers of HIV-positive children</td>
<td>3.9%</td>
</tr>
<tr>
<td>Women living with HIV</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Figure 1. Respondents belonging to key population groups, Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 2. Duration of living with HIV, respondents from Ukraine, %
2. Public stigma and discrimination

![Bar chart showing the percentage of respondents in Ukraine who know about the HIV status of various groups.](image)

**Figure 3.** Who knows about the HIV status of the respondents, Ukraine, %

The question suggested the possibility of multiple choice of answers.

![Pie chart showing the number of cases of experiencing stigma and discrimination over the past year in Ukraine.](image)

**Figure 4.** Number of cases of experiencing stigma and discrimination over the past year, respondents from Ukraine, %
Figure 5. Manifestations of stigma and discrimination in healthcare settings, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 6. Manifestations of stigma and discrimination at work place, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.
Figure 7. Manifestations of stigma and discrimination while obtaining legal services, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 8. Manifestations of stigma and discrimination in education, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.
Figure 9. Manifestations of stigma and discrimination by family members, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 10. Manifestations of stigma and discrimination by a spouse/partner, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.
Figure 11. Manifestations of stigma and discrimination from neighbors/friends, respondents from Ukraine, %

The question suggested the possibility of multiple choice of answers.

3. Manifestations of internalised stigma

Figure 12. Fears experienced by respondents after a positive HIV diagnosis, Ukraine, %

The question suggested the possibility of multiple choice of answers.
Figure 13. Feelings experienced by respondents after a positive HIV diagnosis, Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 14. Respondents' attitudes towards their HIV status and the HIV status of their children at the time of the survey, Ukraine, %

The question suggested the possibility of multiple choice of answers.
4. Self-discrimination

Figure 15. Changes in the respondent's behavior after she became aware of her HIV-positive status, Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 16. Changes in the respondent's behavior at home after she became aware of her HIV-positive status, Ukraine, %

The question suggested the possibility of multiple choice of answers.
Figure 17. Changes in the behavior of family members towards the respondent after she changed her behavior as a result of her HIV-positive status, Ukraine, %

The question suggested the possibility of multiple choice of answers.

5. Getting help and support

Figure 18. Getting help and support, respondents from Ukraine, %
Figure 19. Groups of people to whom the respondents turned for help and support, Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 20. Organizations and networks where respondents turned to for help, Ukraine, %

The question suggested the possibility of multiple choice of answers.
6. Resisting stigma and discrimination

Figure 21. People from whom the manifestations of stigma and discrimination are most painful for the respondents, Ukraine, %

The question suggested the possibility of multiple choice of answers.

Figure 22. Actions that respondents say should be taken to combat stigma and discrimination, Ukraine, %

The question suggested the possibility of multiple choice of answers.
Information channels that, in the opinion of respondents, should be used when conducting an information campaign aimed at reducing stigma and discrimination, Ukraine, %

The question suggested the possibility of multiple choice of answers.