Unofficial translation

THE PEOPLE LIVING WITH HIV STIGMA INDEX

Sociological Research

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MOLDOVA

Abbreviations

AIDS - Acquired Immunodeficiency Syndrome

HIV – human immunodeficiency virus

NGO – nongovernmental organizations

MDL - Moldovan Leu

MSM – men who have sex with men

PLWH – people living with HIV

PLWHIV – people living with HIV

PWID – people who inject drugs

STI – sexually transmitted infections

SW – sex workers

UN – United Nations

UNAIDS – Joint UN Porgramme on HIV and AIDS

US$ - United States dollar

Acknowledgments

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We are grateful to Liudmila Untura, expert, NGO “League of persons living with HIV” from the Republic of Moldova for the involvement, facilitation, mobilizing the community of people living with HIV, as well as the interviewers who had a valuable contribution to data collection process.

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In a remarkable way, we’d like to underline the important role of the people living with HIV, who participated, involved themselves and contributed to the implementation of the research as interviewers, and interviewees, thus sharing their stories and experiences. We are strongly convinced the results will contribute to improve the quality of life of people living with and affected by HIV.

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Introduction

Background of HIV-related stigma and discrimination

Stigma is an "attribute that is deeply discrediting", which results in reducing a person or a group "from a whole and usual person to a tainted, discounted one"[1]. Therefore, stigma's final effect is to reduce the chances to a qualitative and dignified life of the one who is subject to stigma through discriminatory actions[2].

In turn, discrimination implies a different and unjust treatment, biased and prejudicial, often based on real or perceived allegiance of the one subject to discrimination to a group. Discrimination consists of actions and omissions that are the result of stigma and are aimed at people who are stigmatized. In other words, discrimination is "stigmatization"[3]. At the same time, a person may feel stigma towards another one, but not necessarily to act in an inappropriate and discriminatory way. Discrimination may appear on different levels: individual, familial, community or national[4].

In the Republic of Moldova Law no. 121 of 25.05.2012 on equality, discrimination is defined as "any distinction, exclusion, restriction or preference in the rights and freedoms of the person or group of persons, as well as the support of discriminatory behaviour based on real criteria". This law aims at preventing and combating discrimination "as well as ensuring the equality of all persons living on the territory of the Republic of Moldova in the political, economic, social, cultural and other spheres of life regardless of race, colour, nationality, ethnic origin, religion or belief, sex, age, disability, opinion, political affiliation or any other similar criterion." It identifies several types of discrimination, such as "direct – treatment of a person on the basis of any prohibitive criteria in a less favourable manner than treating another person in a comparable situation; indirect discrimination - any apparently neutral provision, action, criterion or practice that results in the disadvantage of a person to another person on the basis of the criteria set forth in this law, unless that provision, action, criterion or practice is justified in objectively, through a legitimate aim, and whether the means of achieving that purpose are proportionate, appropriate and necessary; discrimination by association - any act of discrimination against a person who, although not part of a category of persons identified according to the criteria laid down by this law, is associated with one or more persons belonging to such a category of persons. "

HIV-related stigma is often built and consolidated on other existent bias, such as related to sex, sexuality or race. For example, stigmatization associated with HIV is often based on the association of HIV and AIDS with already marginalized and stigmatized behaviours, such as sex work, use of drugs and practicing sex with people of the same gender or transsexual relations[5]. HIV-related stigma affects people living with HIV and, often, people with whom they are associated, such as partners or spouses, children or other members of their households.

Internal stigma, also called “felt” stigma or "self-stigmatization" is a concept used to describe the way in which a person living with HIV self-defines, particularly if one feels shame being HIV+. Internal stigma may lead to lower self-esteem, to a sense of lack of value or depression. Internal stigma as well may determine a person living with HIV to renounce his social and intimate relations.

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[1] Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. New York: Simon & Schuster Inc.

[2] Ibid.

[3] IPPF (2008) HIV/AIDS Update Issue 13

UNAIDS (2005) HIV-related stigma, discrimination and human rights violations: case studies of successful programmes. UNAIDS best practice collection. Geneva.

[4] UNAIDS (2005) HIV-related stigma, discrimination and human rights violations: case studies of successful programmes. UNAIDS best practice collection. Geneva

[5] Ibid.

Country Background

In the Republic of Moldova, the first HIV infection was recorded in 1987. At the end of 2017, 11887 cases of infection were registered on both sides of river Nistru. The country remains as one with a concentrated[6] HIV epidemic. Moldova continues to record a HIV epidemic concentrated among people who inject drugs (PWID), men who have sex with men (MSM), sex workers (SW) and their clients, as well as their sexual partners. Also during this period, sexual transmission is the main probable way of infection in new-registered cases[7].

In 2017, 835 new HIV + cases were registered in the Republic of Moldova, of which 217 were in the eastern territories of the country. Of the cases registered in 2017 - 55.9% are men, 49.5% are from urban area, and with the share of young people aged 15-24 about of 11.9%[8].

The Republic of Moldova is part of the global commitments under the Sustainable Development Objectives, including Objective 3.3.1 "By 2030 reducing HIV transmission and sexually transmitted infections, especially in key populations as well as HIV-related mortality", the Declaration Commitment to the Special Session of the UN General Assembly on HIV / AIDS in 2016, the 90-90-90 initiative and of universal access.

For assuring the coordination of measures of response to HIV and STI during period 2011-2015, the Government adopted the National Programme on Prevention and Control of HIV/AIDS and STI 2011–2015, and afterwards the same Program for period 2016 – 2020. These programs provide a substantial number of activities, such as information campaigns, training, surveys etc. in the field of protecting the rights of PLWHIV and in combat of stigmatization and discrimination.

These programs identify the priorities in the field, the results to be achieved, the interventions, the necessary budget, the monitoring and evaluation framework of the NP, as well as its management. The strategic directions of the program are aimed at preventing the transmission of HIV infection in key groups, diagnosis, treatment and care of and support for people living with HIV, information campaigns in the field of protection and realization of PLWH rights and combating stigma and discrimination, and of synergy with other national programs.

Objectives

The current study follows to provide data with the goal to reflect on the ongoing situation regarding the stigma and discrimination of the PLWH in the Republic of Moldova.

Methodology

Data were collected in the period September – December 2017.

Sample Population: people diagnosed with HIV, right bank of r. Nistru, aged 18 years and older.

Inclusion criteria: Persons were included in the study, if respecting the following criteria:

- A person living with HIV, who has a confirmed HIV-positive diagnosis;
- Mentally and physically able to answer the questionnaire;
- Provides information consent to the study.

Sample Size: 469 interviewed.

Interviewing method: face-to-face interview with the aid of the computer application (CAPI).

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[6] REPUBLIC OF MOLDOVA, PROGRESS REPORT ON HIV/AIDS, UNAIDS, 2017

[7] Idem

[8] Idem

Sampling Strategy:

Sampling population has included the 4352 registered cases of PLWH on the right bank of the Dniester River.

From the initial list, the following cases were excluded:

- Dead people;
- Lack of information regarding the administrative territory;
- Citizens of other states;
- People under 18 years.

Sample type: stratified, simple randomised through the layers.

Stratification criteria: gender, age, the probable route of infection.

Structure of planned sample

	Sampling Universe				Planned Sample		
	Females	**Males**	**Total**		**Females**	**Males**	**Total**
Right Bank	**2102**	**2250**	**4352**		**217**	**233**	**450**
16-19 years	459	235	694		47	24	72
30-39 years	938	938	1876		97	97	194
40-49 years	470	752	1222		49	78	126
50+ years	235	325	560		24	34	58

The structure of the obtained sample is presented in Table 1.

Table 2. Socio-demographic structure of sample

		PLWHIV	
		Count	**%**
Gender:	Males	237	50,5%
	Females	232	49,5%
Age groups:	18 - 29 years	78	16,6%
	30 - 39 years	204	43,5%
	40 - 49 years	130	27,7%
	50+ years	57	12,2%
Length of life living with HIV:	Less than a year	40	8,5%
	1 – 4 years	169	36,0%
	5 – 9 years	123	26,2%
	10 – 14 years	80	17,1%
	15 and more years	57	12,2%
Marital status:	Married or in a live-in partnership	246	52,5%
	Single	127	27,1%
	Divorced/widowed	96	20,5%
Occupational status:	Full-time employee	231	49,3%
	Part-time employee	69	14,7%
	Unemployed	169	36,0%
Residency:	Rural	182	38,8%
	Small urban	88	18,8%
	Big urban	199	42,4%

Prior to undertaking the survey, the approval of the National Ethics Committee was obtained.

The study was realized through a face-to-face interview, with a printed questionnaire. The Stigma Index questionnaire was available in Romanian and Russian, the language of use being selected by the respondent.

The employees of nongovernmental organisations that offer care and support services to PLWH collected the data. The interviews took place at the facilities where support services are provided to PLWH.

The data validation was conducted through direct observation by survey supervisors at the field sites (that the interview took place), the validation being realized by both the supervisor and the interviewer.

The results of the survey were processed and tabulated using SPSS software.

Study Limitations

Although the selection of subjects was random, due to issues related to low accessibility to some segments of PLWHIV for service providers, a shifting of the sample towards PLWH subject to service providers is admitted, a fact that cannot be quantified.

What is in this report?

This report is divided into three Sections:

1. General information about the respondents and their households;
2. Reported experience of HIV-related stigma and discrimination, including the obstacles regarding the access to workplaces, health services and education, internal stigma, law, policy and practice and association with communities of PLWH.
3. Experience of testing, disclosure, treatment and having children.

Background characteristics and household composition

The group of PLWH is equal in regards to gender, with a slightly higher share of men (50.5 % compared to 47.4 %) in the general population. As an age structure, the population living with HIV is concentrated in the medium age groups, 43.5% aged 30-39 and 27.7% aged 40-49. Overall, in between PLWH, these two age categories have a double share, compared to the general population.

Regarding the length of life living with HIV, the target group is concentrated between the ranges of 1-4 years (36.0%) and 5-9 years (26.2%). Overall, more than 70% of respondents have a length of live living with HIV up to 10 years.

More than a half of the respondents (52.5%) of the study were married or in a live-in partnership. Nonetheless, their rate is considerably smaller than the general population (66.9%). However, the rate of the single PLWH is double compared to the general population (27.1% compared to 14.7%). Under the circumstances that the rate of divorced or widowed is approximately similar, (20.5% for PLWH and 18.4% for the general population), taking in account the differences in age distribution, the discrepancies according to civil status suggest that HIV is associated with waiver of marriage or with at least with the delay of the first marriage.

Every second respondent (49.3%) at the moment of the study had a full-time job, while 14.7% were part-time employees.

By residency, the population of those living with HIV is concentrated in the municipalities of Chișinău and Bălți (42.4% compared to 23.4% for the general population), having the lowest rate of presence in the rural area rural (38.8% compared to 54.3% for the general population).

Table 3. Socio-demographic structure of the target group

		PLWHIV		**General Population**[9]
		Count	**%**	
Gender:	Males	237	50,5%	47,4%
	Females	232	49,5%	52,6%
Age groups:	18 - 29 years	78	16,6%	26,9%
	30 - 39 years	204	43,5%	20,7%
	40 - 49 years	130	27,7%	15,5%
	50+ years	57	12,2%	36,9%
Length of life living with HIV:	Less than a year	40	8,5%	
	1 – 4 years	169	36,0%	
	5 – 9 years	123	26,2%	
	10 – 14 years	80	17,1%	
	15 and more years	57	12,2%	
Marital status:	Married or in a live-in partnership	246	52,5%	66,9%
	Single	127	27,1%	14,7%
	Divorced or widowed	96	20,5%	18,4%
Occupational status:[10]	Full-time employee	231	49,3%	
	Part-time employee	69	14,7%	
	Unemployed	169	36,0%	
Residency:	Rural	182	38,8%	54,3%
	Small urban	88	18,8%	22,3%
	Big urban	199	42,4%	23,4%

In comparison to the general population, where the average age of men is lower than of females due to lower life expectancy, among PLWH the male population is slightly older compared to female population,

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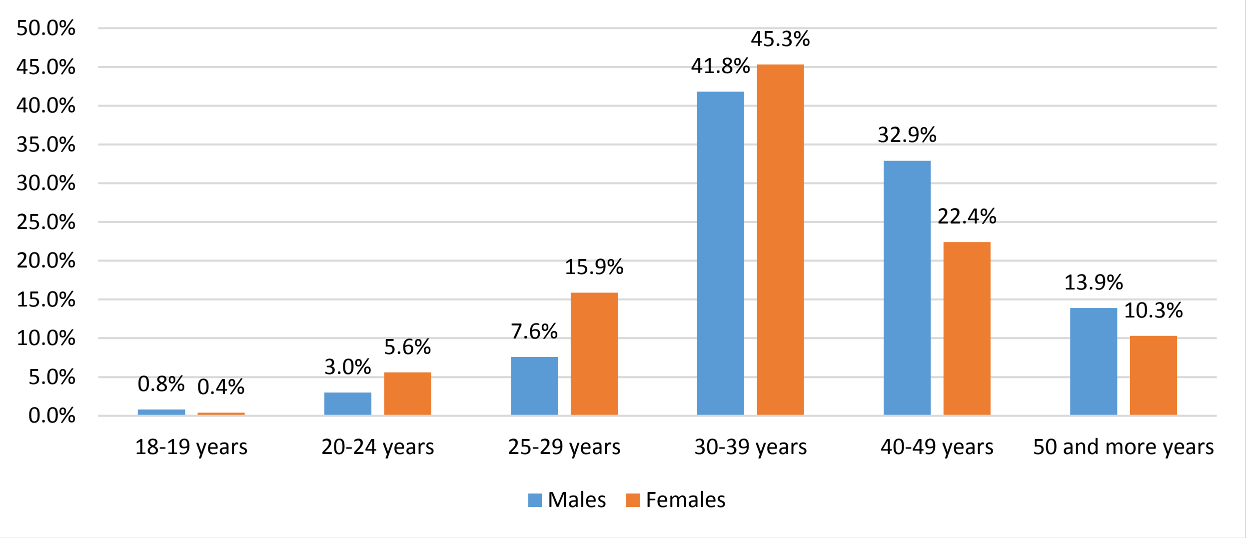
[9] National Bureau of Statistics of the Republic of Moldova.

[10] For general population, data is presented from the Barometer of Public Opinion – November 2017.

the share of people respondents aged 40-49 being bigger than the female one. Overall, respondents aged 40 and more had a share of 46.8% between males and only 32.4% among females.

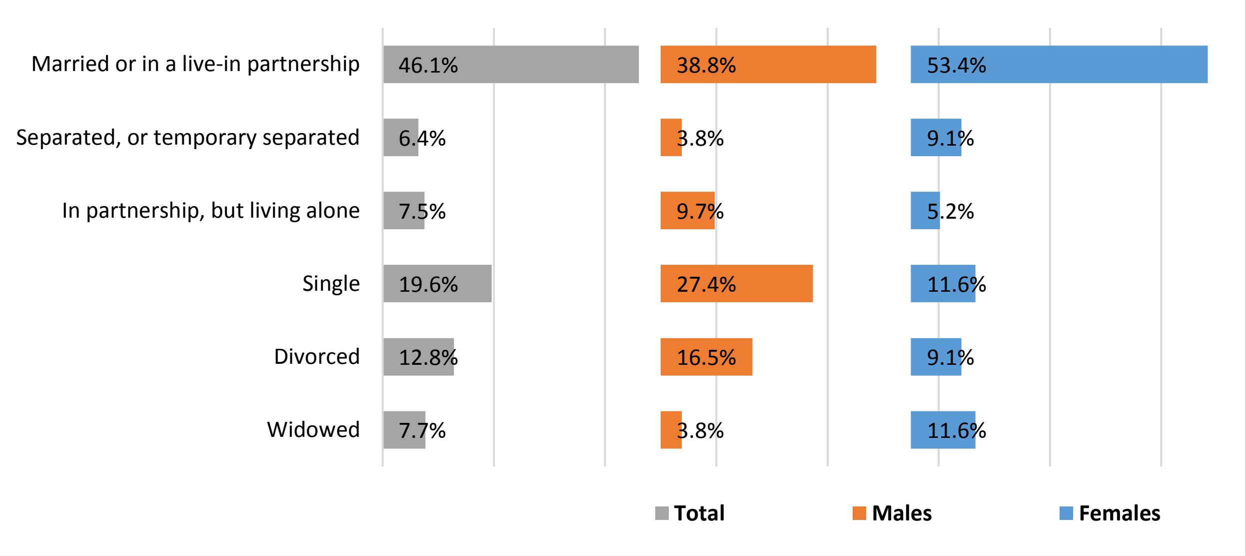
Figure 1. Gender and age of respondents



Per civil status, 52.5% of the respondents were married or in a live-in partnership, including 6.4% which, at the same time, were separated from their partner. Other 27.1% were single, including 7.5% that declared themselves in partnership, but living alone.

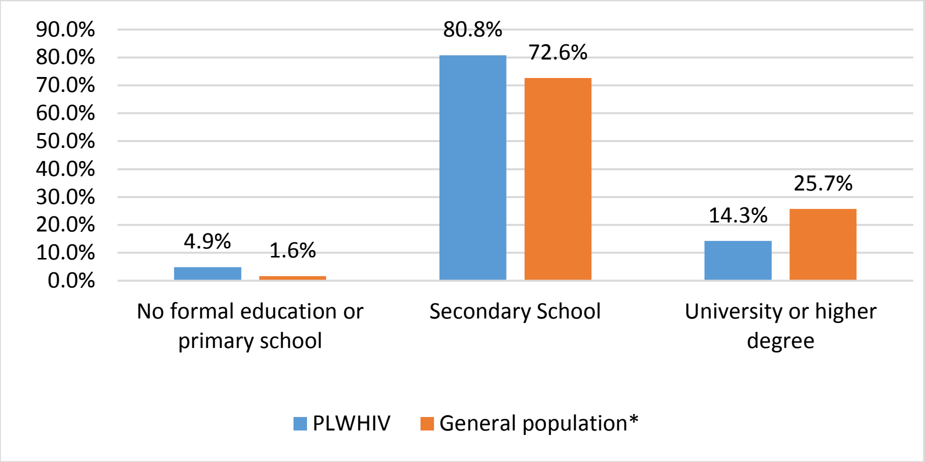
It is important to mention in this case some differences between male and female PLWH. In the case of male PLWH, the rate of married and widowed is smaller, with higher rates for single and divorced respondents.

Figure 2. Civil status and gender of respondents



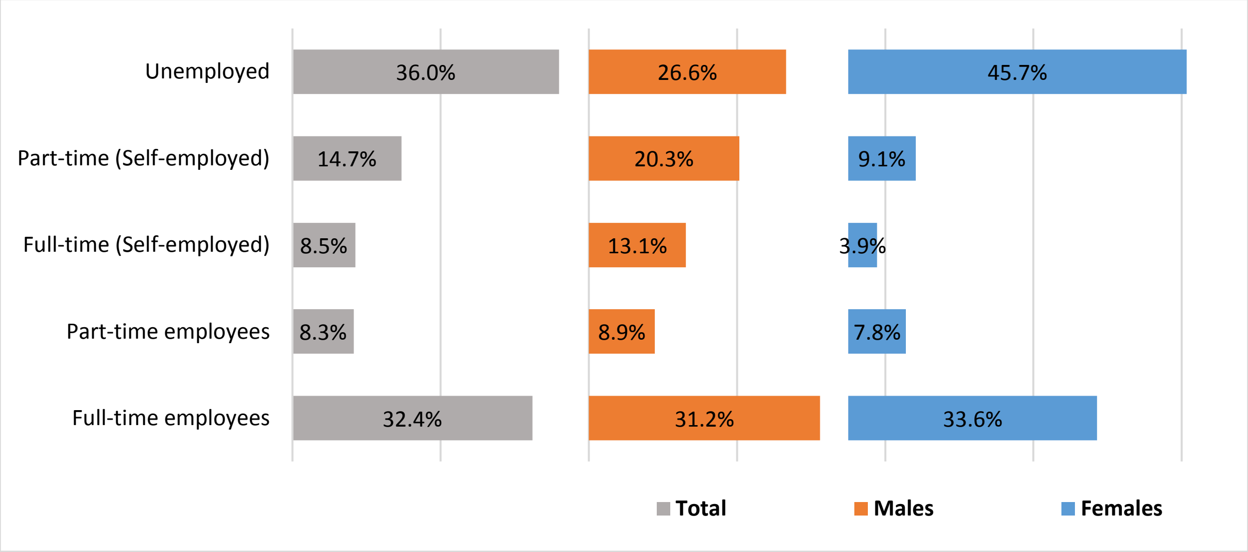
Eight out of ten PLWH have an educational level of secondary school, professional school or lower. Only 14.3 % reported a university or higher degree, which is twice lower than the general population (25.7%).

Figure 3. Level of studies



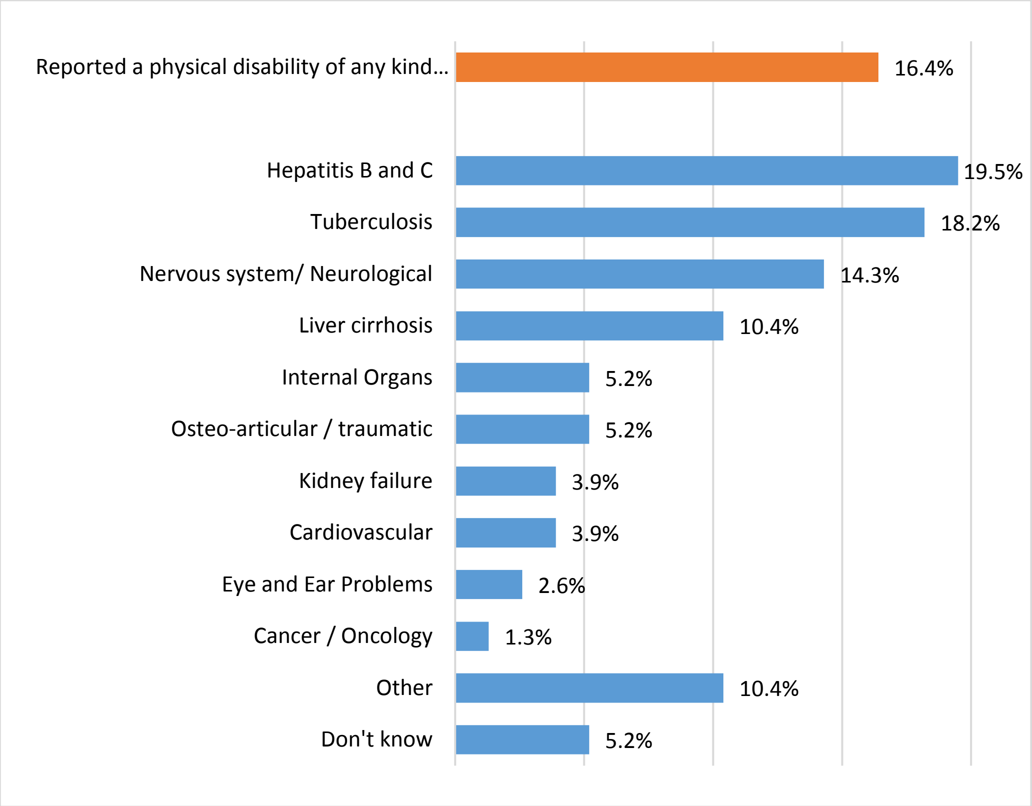
As mentioned previously, a third of the respondents (36.0%) are unemployed, while 14.7% were temporarily self-employed. In the rest of the cases, 32.4% are full-time employees, while 8.5 % are self-employed and 8.5 % part-time employed. Overall, over half of the respondents reported being unemployed, temporarily employed or part-time. Females living with HIV are especially vulnerable, in their case - 45.7% are completely unemployed.

Figure 4. Employment status



At the time of the study, 16.4% of the respondents reported a physical disability of any kind (not including general ill health related to HIV). Most often, the degree was assigned to Hepatitis B and C (19.5%), tuberculosis (18.2%), nervous system issues (14.3%) and liver cirrhosis (10.4%).

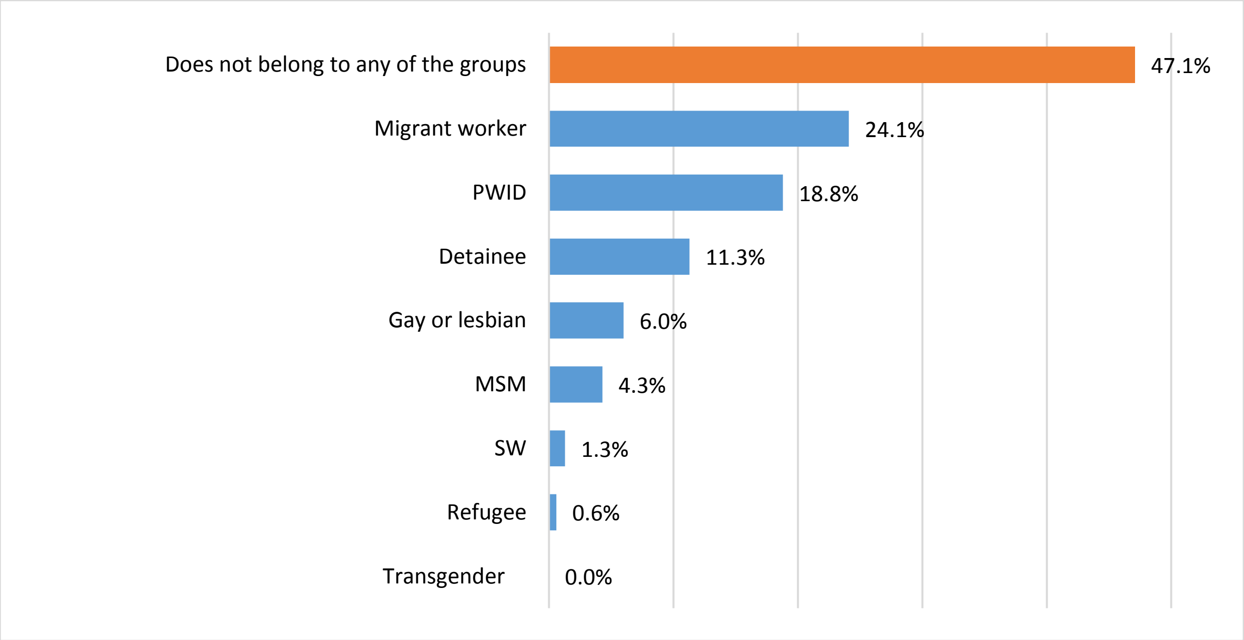
Figure 5. Degree of health disorders



Nine out of ten respondents reported being sexually active (88.5%), with little variation between different socio-demographic categories, such as age and civil status. The greatest percentage of respondents that claimed to be sexually active was registered in the group of young PLWH (98.7%) and the lowest in the “50 and more years” (63.2%). Concerning their civil status, the greatest share of sexually active PLWH is the one of the married (97.6%), and the lowest between the widowed/divorced (68.8%).

One in two respondents belongs to at least one of the key populations, associated with a high risk of infection. One-fourth of the respondents have been involved in labour migration, 18.8% are drug users, while 11.3% are former detainees. Overall, MSM make 10.3% of all PLWH respondents.

Figure 6. Key populations



In particular, the share of PLWH that belong to key populations are increased among gay-men (11.8%) and MSM (8.4%), PWID (26.6%), former detainees (19.0%). Migrant workers are concentrated in the rural area (41.2%), while groups such as gay, PWID and former detainees belong more to the PLWH living in big urban areas.

Table 1. Respondents belonging to key populations, disaggregated by gender and area of residence

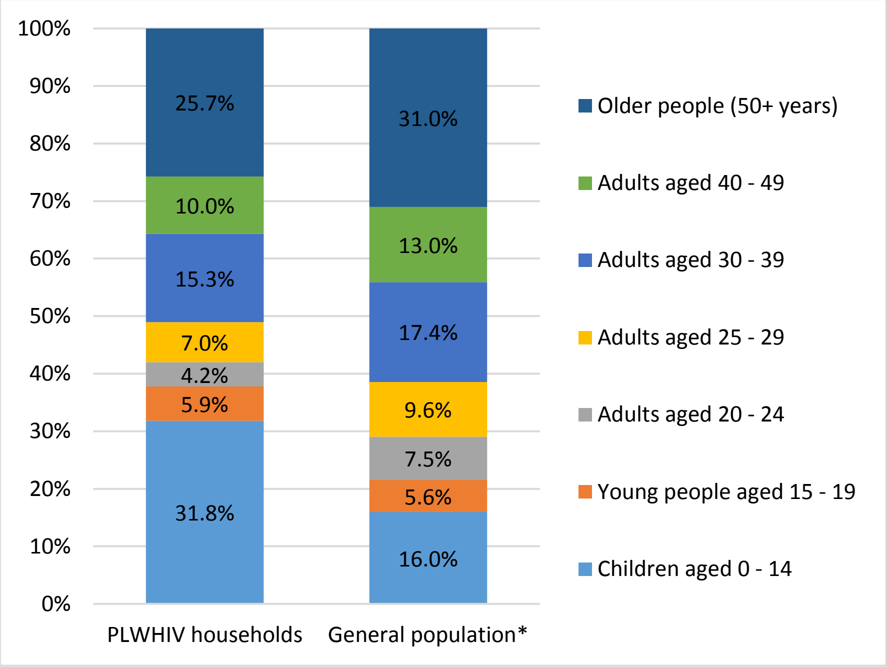
	Gender:		**Residency:**		
	Males, %	**Females, %**	**Rural, %**	**Small urban, %**	**Big urban, %**
MSM	8,4%	-	2,7%	4,5%	5,5%
Gay or Lesbian	11,8%	0,0%	0,5%	2,3%	12,6%
SW	0,0%	2,6%	0,5%	2,3%	1,5%
PWID	26,6%	10,8%	4,9%	21,6%	30,2%
Refugee	0,4%	0,9%	1,1%	1,1%	0,0%
Migrant worker	26,6%	21,6%	41,2%	19,3%	10,6%
Detainee	19,0%	3,4%	10,4%	4,5%	15,1%
None of above	29,1%	65,9%	50,5%	55,7%	40,7%

PLWH households are considerably smaller compared to the general population, being composed on average from 2.0 persons, compared to 2.9 in the general population[11].

In 40.3% of PLWH households, there are children of 0-14 years old, 9.8% have teenagers between 18-19 years old and in 37% of households, live people of 50 and more years.

The age structure of PLWH households differs substantially compared to the general population, which is in line with the discrepancies found in the comparison of the age structure and civil status of the population living with HIV in comparison to the general population as mentioned previously. Between PLWH, the average age group prevails. As a consequence, in the PLWH households there is twice as large, in comparison to the general population, the share of children (31.8% compared to 16.0%) and a bit smaller the share of elders (25.7% compared to 31.0%). The discrepancy, especially in the case of children, makes the rate of economic dependence, expressed as a ratio between the number of elderly people unable to work (children and elders) and the ratio of persons able to work, in the PLWH households to be bigger – 0.9 children and older persons 50+ years per one person able to work, in comparison to 0.7 in the general population.

Figure 7. Age structure of PLWHIV households



*** National Bureau of Statistics*

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[11] Population and Housing Census in the Republic of Moldova, May 12-25, 2014

The average household income reported by the respondents is equal to 4348 lei (249.9$) and ca. 52 000 lei per year. The highest average household income was recorded among respondents from the big urban areas, about 25% higher than the average on the sample.

In addition, it is worth mentioning that 1.3% of the respondents have reported no household income.

Table 2. Average household income

		Per person	**Per household**			
		Total		**Rural**	**Small urban**	**Big urban**
Monthly average income	MDL	2288	4348	3423	3721	5417
	US$	131,5	249,9	196,7	213,9	311,3
Yearly average income	MDL	27464	52181	41076	44658	64999
	US$	1578,4	2998,9	2360,7	2566,6	3735,6

The monthly average income is 2288 lei (131.5$). In every second PLWH household, the monthly average income per person is under the subsistence minimum, estimated by the National Bureau of Statistics for the year 2017 as 1862.4 lei.

Every tenth respondent (11.1%) has reported the existence of cases of confrontation with insufficient food over the past 30 days.

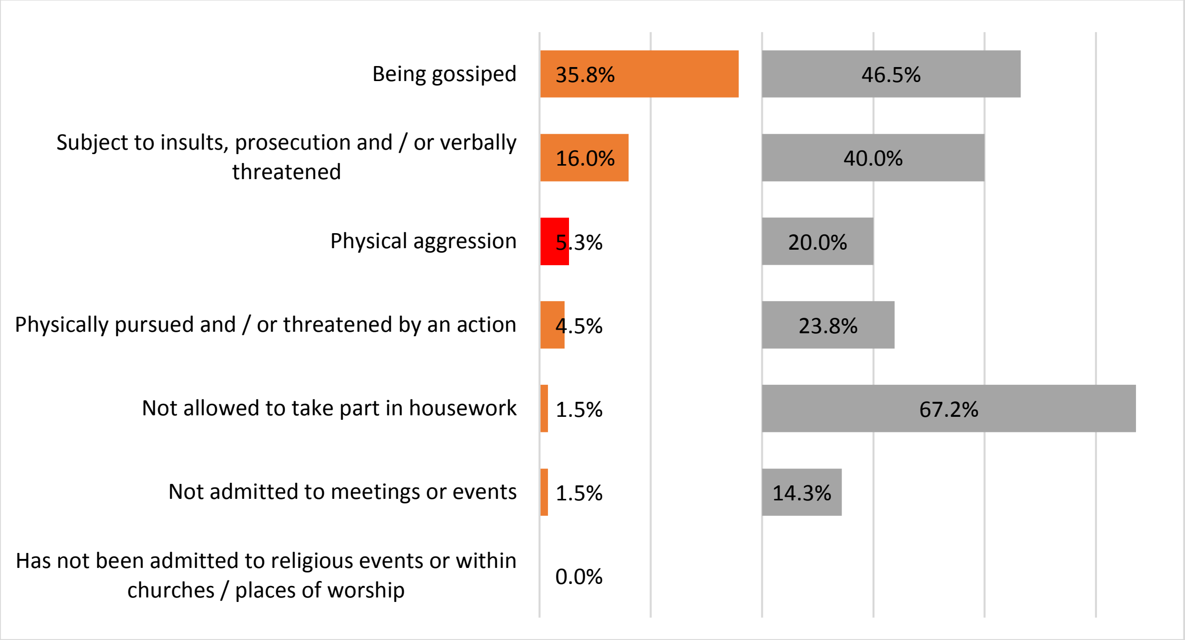
Experience of stigma and discrimination

This section addresses the exposure to stigma and discrimination of PLWH, through the five dimensions of social life: experiences of HIV-related stigma and discrimination; access to work and health and education services; internalised stigma; the protection of the rights of people living with HIV through the law, policy or practice; and effecting change.

Experience of HIV-related stigma and discrimination

Discriminatory treatment is often addressed towards PLWH. Most often, it takes the form of being gossiped (35.8%), insults and verbal threats (16.0%). Less often, it takes the form of more serious forms, such as physical aggression (5.3%) or threats related to physical aggression (4.5%). Moreover, such treatment is not always based on the HIV status. We will see further, that exposure to discriminatory treatment towards PLWH is also aggravated by their membership to risk groups. If we strictly refer to treatment caused directly or partially by HIV status, by HIV+ status is subject every second case of being gossiped (46.5%), every four out of ten cases of insults or verbal threats and every fifth of physical aggression.

Figure 8. Subject to discriminatory treatment, including ones' due to HIV status, last 12 months



Overall, 39.3 % of respondents were subject to discriminatory treatment in the last 12 months. In particular to these treatments were subject young persons (18-29 years – 43.9%), those relatively recently diagnosed (less than a year – 48.1%) or on the opposite, those living with HIV for 15 and more years (55.4%), single (50.8%).

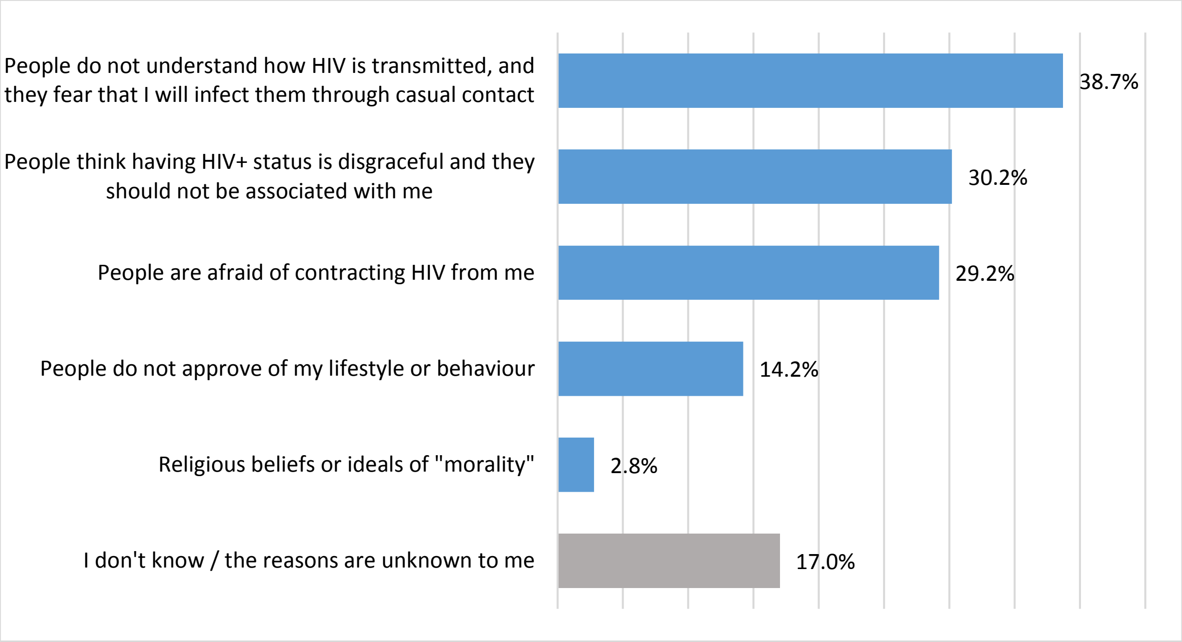
Table 3. Frequency of discriminatory treatment (regardless of form), disaggregated by socio-demographic categories

		%
Total		**39,3%**
Gender:	Males	38,0%
	Females	40,6%
Age groups:	18 - 29 years	43,9%
	30 - 39 years	41,7%
	40 - 49 years	38,9%
	50+ years	25,3%
Length of life living with HIV:	Less than a year	48,1%
	1 – 4 years	35,1%
	5 – 9 years	36,6%
	10 – 14 years	38,2%

		%
	15 and more years	55,4%
Marital status:	Married or in a live-in partnership	36,3%
	Single	50,8%
	Divorced/widowed	32,8%
Occupational status:	Full-time employees	38,5%
	Part-time employees	38,0%
	Unemployed	41,0%
Residency:	Rural	39,9%
	Small urban	35,8%
	Big urban	41,0%

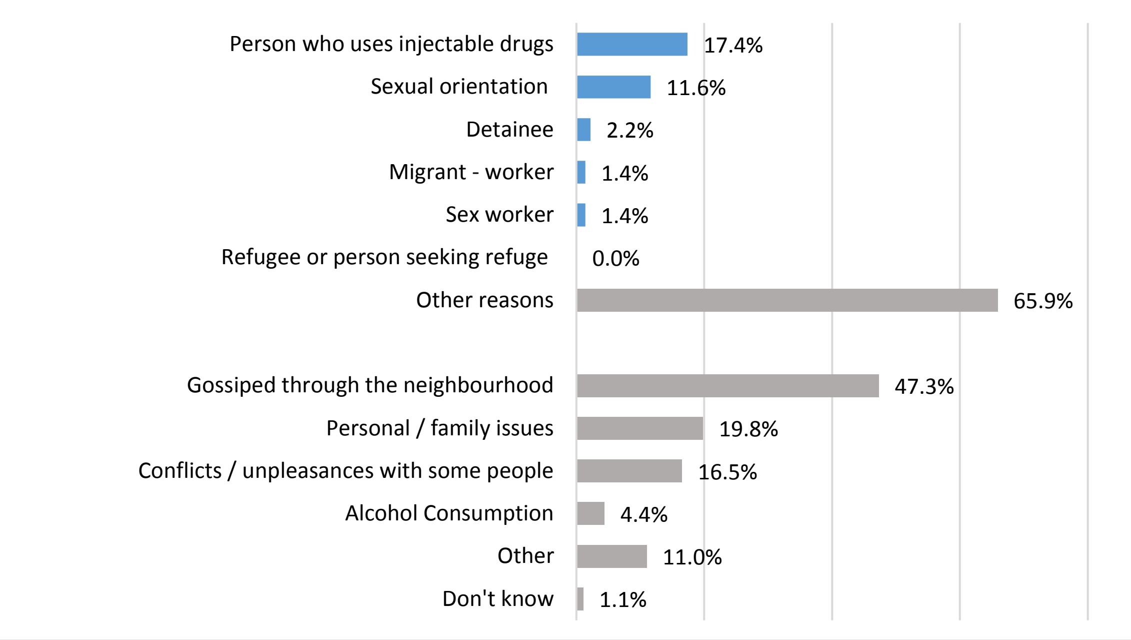
Discrimination and marginalization of PLWH are due first by the low and fragmentary level of knowledge of the population about the HIV infection. Most often PLWH, who have reported discriminatory treatment on the grounds of HIV status, believe that the behaviour is caused by the fear of others to infect them by casual contact due to lack of knowledge of the ways of transmission of the infection (38.7%) and general fear of infection (29.2%). The second reason is related to the association of the HIV infection to disgraceful behaviours, HIV + status being a shameful one (30.2%).

Figure 9. Reasons that stand for HIV-associated discrimination



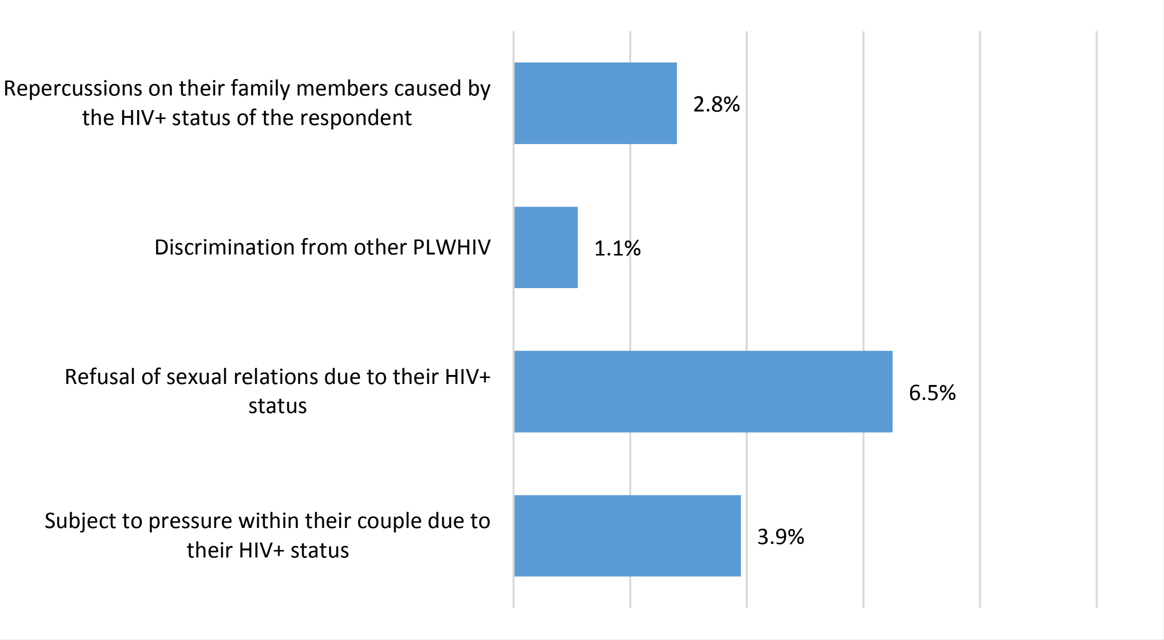
To the discrimination associated with HIV status is also overlapped by the discrimination caused by the association of PLWH with other marginalized groups. In the cases in which discriminatory treatment was not caused by HIV status, they were related to drug use (17.4%) or due to sexual identity orientation (11.6%).

Figure 10. Reasons that stand for discriminatory treatment, non-associated with HIV



Although less often, PLWH still confront themselves with rejection within their couple or even in the PLWH community, as well as with the reflection of discrimination due to their HIV+ status to other family members. Therefore, 6.5% of respondents have reported cases of refusal of sexual relations due to their status during the last 12 months, 3.9% were subject to pressure within their couple due to their HIV+ status, while 2.8% reported repercussions on their family members caused by the HIV+ status of the respondent.

Figure 11. Discriminatory treatment in PLWHIV couples or community

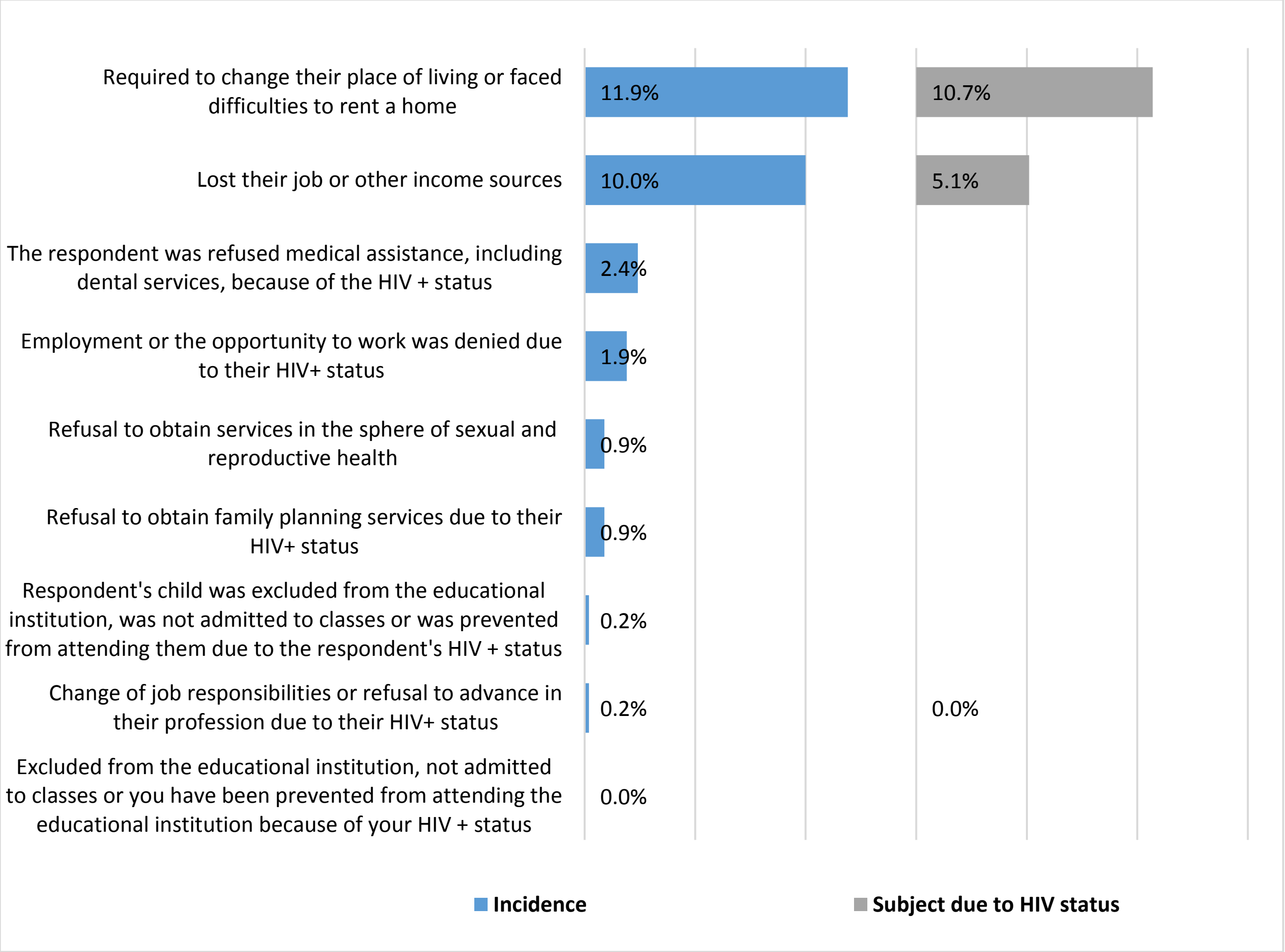


Access to work, health and education services

In the realization of their fundamental rights and freedoms, the PLWH confront two major problems that designate violations of articles 27 and 43 from the Constitution of the Republic of Moldova. In the previous 12 months, 11.9% of respondents declared situations in which they were required to change their place of living or faced difficulties to rent a home. Other 10.0% lost their job or other income sources. These two major impediments are strongly related to the HIV status. Thereby, every tenth case (10.7%) of the limitation of the right to establish their residence was caused, in the respondents' appreciation, by their HIV+ status. In regard to the right to work, the HIV+ status was cited in 5.1% of all cases. To these cases should be added another 1.9% of the whole sample, where the respondents considered that they were refused employment or the opportunity to work due to their HIV+ status, as well as 0.2% of responses related to a change of job responsibilities or refusal to advance in their profession by invoking the same reason.

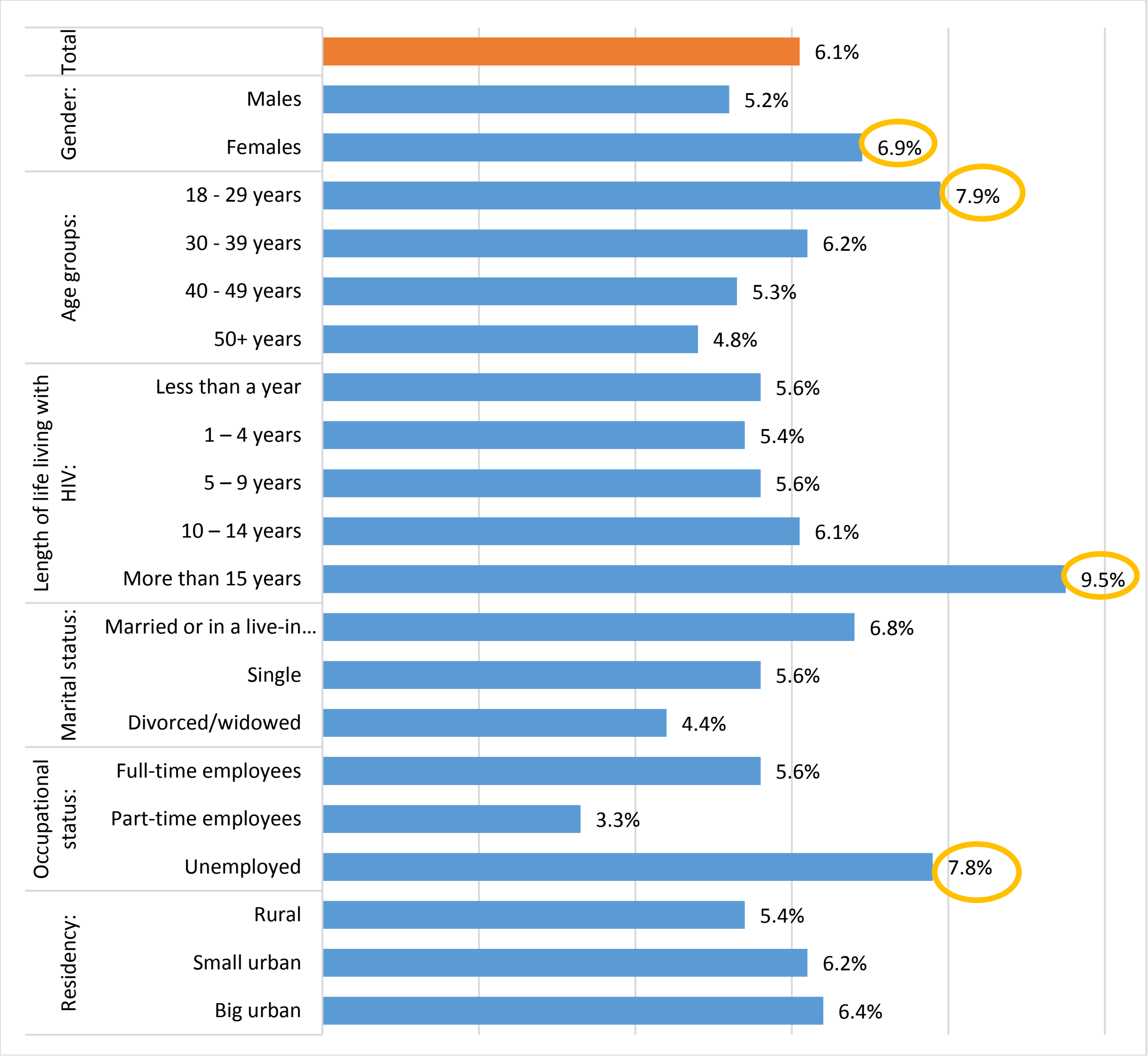
Although in smaller proportions, there are still recorded cases of restriction of the right to health protection, under the form of refusal of health care from the state (2.4%) or of the refusal to obtain sexual and reproductive health services (0.9%).

Figure 12. Frequency of cases of limitation of certain rights, including ones' due to HIV+ status



Overall, 6,1% of the respondents have reported that over the past 12 months, they have struggled with at least one of the situations of restriction of their rights mentioned above (figure 11), mentioning that the violations were based on the HIV+ status of the respondent. The comparison of incidence rates helps to identify the categories of PLWH that are most exposed to such risks. Therefore, more than average of PLWH with a long length of life with HIV ((more than 15 years) – 9.5%) struggle in regards to the violation of the rights of free consent to establish their place of living, the right to work, health care and education, as well as those unemployed – 7.8% and females – 6.9%. Likewise, there is a reverse relationship between the incidence and the age of the respondent, as the younger categories encounter more often violations / limitations in the realization of their rights.

Figure 13. Frequency rates of limitation of access due to HIV+ status disaggregated on socio-demographic categories



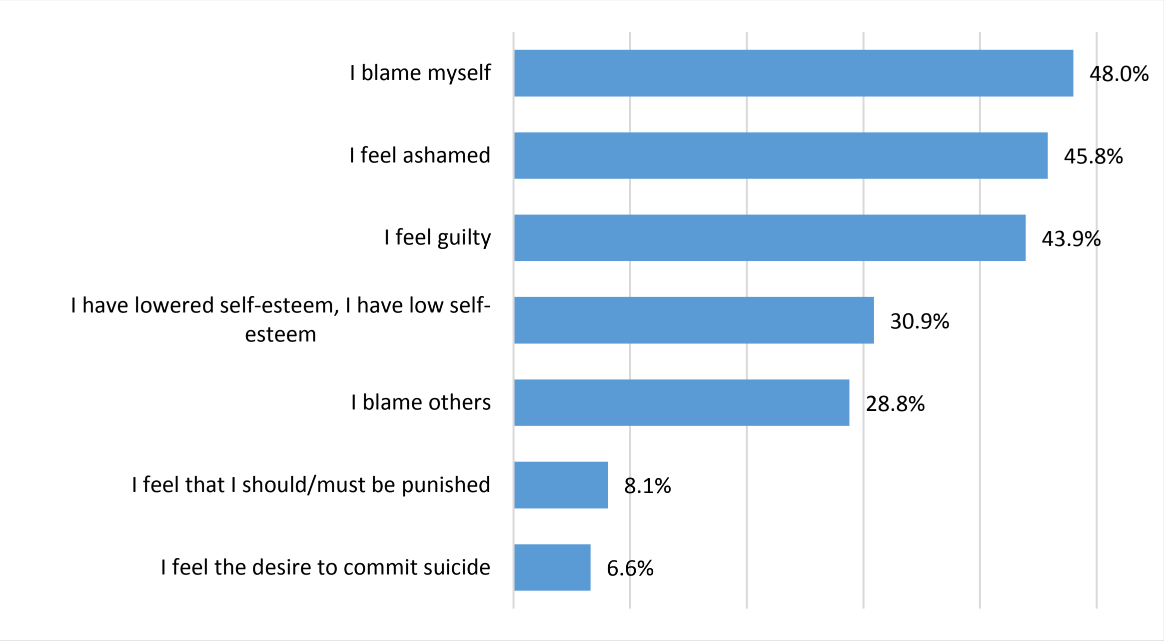
Internal Stigma

This sub-section focuses on identifying forms of internalized stigma among PLWH. As the findings of the study suggest, in the condition of living with the HIV infection, which is linked to higher social risks, frequently PLWH resort due to their own beliefs and fears to forms of isolation and states of depression.

Most of the respondents have reported different depressing states in the last 12 months due to their HIV+ status. Most often, these are feelings of guilt and shame. Every third respondent has experienced a low self-esteem, while 28.8% had tendencies to blame others.

There are neither rare the most serious forms, such as accepting to be punished (8.1%) or the desire to commit suicide (6.6%).

Figure 14. Feelings perceived due to HIV+ status, last 12 months



There are obviously specific variations of internal stigma for different socio-demographic categories of PLWH. The tendencies pinpoint the fact that women, young people with a short length of life living with HIV, the single or divorced/widowed, those unemployed or from the rural area report higher levels of depressive thoughts.

Table 4. Feelings perceived due to HIV+ status, last 12 months, disaggregated by socio-demographic categories

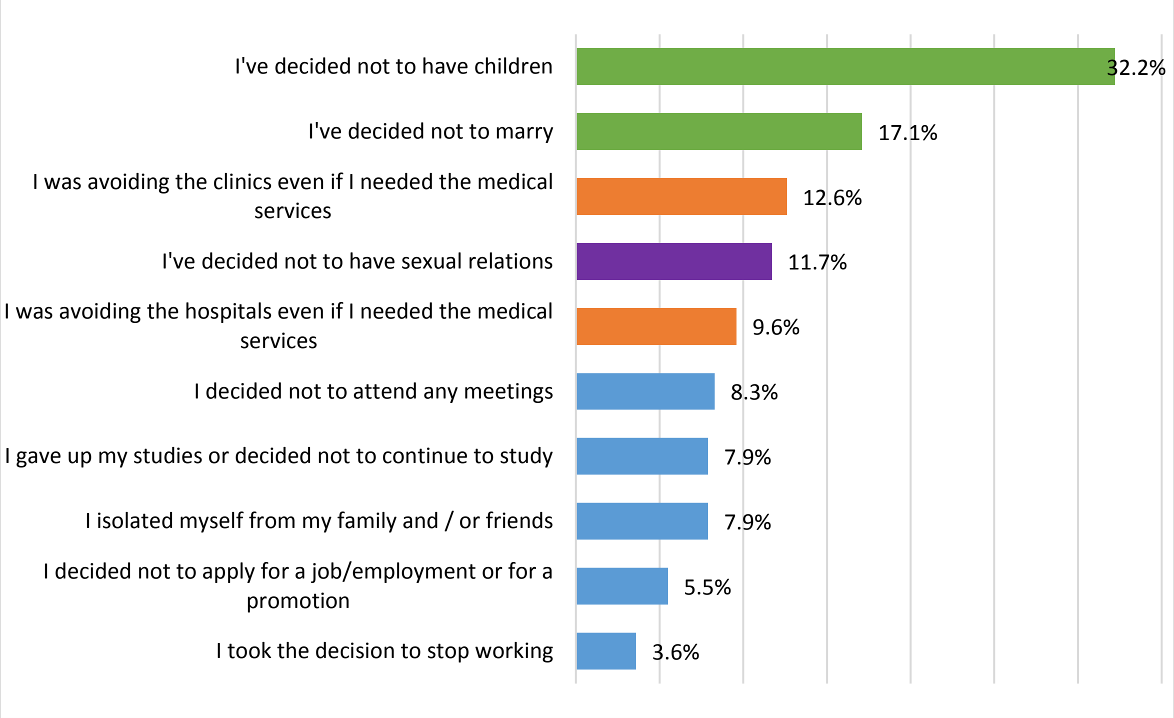
		I feel ashamed, %	**I feel guilty, %**	**I blame myself, %**	**I blame others, %**	**I have lowered self-esteem, I have low self-esteem, %**	**I feel that I should / must be punished. %**	**I feel the desire to commit suicide, %**
Total		**41%**	**41%**	**46%**	**25%**	**28%**	**8%**	**6%**
Gender:	Males	32%	44%	49%	19%	24%	8%	5%
	Females	50%	38%	43%	32%	33%	7%	6%
Age groups:	18 - 29 years	42%	52%	47%	37%	37%	8%	6%
	30 - 39 years	41%	41%	48%	24%	26%	8%	6%
	40 - 49 years	37%	35%	43%	21%	27%	5%	4%
	50+ years	48%	42%	43%	28%	28%	12%	7%
Length of live living with HIV:	Less than a year	48%	41%	46%	52%	28%	7%	11%
	1 – 4 years	48%	51%	53%	28%	28%	6%	6%
	5 – 9 years	38%	37%	40%	21%	28%	9%	5%
	10 – 14 years	40%	37%	43%	24%	34%	8%	5%
	More than 15 years	27%	37%	47%	14%	20%	4%	5%
Marital status:	Married or in a live-in partnership	41%	42%	46%	25%	26%	8%	5%
	Single	37%	41%	49%	23%	33%	7%	10%
	Divorced / widowed	47%	39%	43%	31%	30%	7%	4%
Occupational status:	Full-time employees	35%	35%	40%	24%	24%	6%	5%
	Part-time employees	42%	50%	52%	20%	32%	10%	5%
	Unemployed	49%	48%	52%	29%	34%	8%	7%
Residency:	Rural	54%	48%	50%	29%	33%	10%	6%
	Small urban	35%	37%	42%	18%	20%	5%	5%
	Big urban	34%	39%	45%	27%	30%	8%	6%

In addition to the negative internal emotional states, the HIV infection leads to restrictive modelling of behaviour. First, the HIV infection diminishes birth and marriage desire. In the same period (last 12 months), every third PLWH has taken the decision not to have children (32.2%), while 17.1% decided not to marry.

One in tenth has appealed to restriction his sexual life (11.7%).

There is a frequency of cases in which PLWH have renounced to address to obtain medical services, 12.6% avoided visits to the clinics while 9.6% to hospitals, although they required it. Likewise, PLWH (self) restrict their social contacts, 8.3% have renounced attending events, meetings, while 7.9% have moved away from their narrow social circle (family, friends).

Figure 15. Self-restrictions due to HIV+ status, last 12 months



Giving up sexual relations, marriage and the birth of children due to HIV status is a characteristic in a higher level for older PLWH, with the length of life living with HIV smaller that do not live in couple.

Females and persons with a longer length of life living with HIV renounce more often to access health care services.

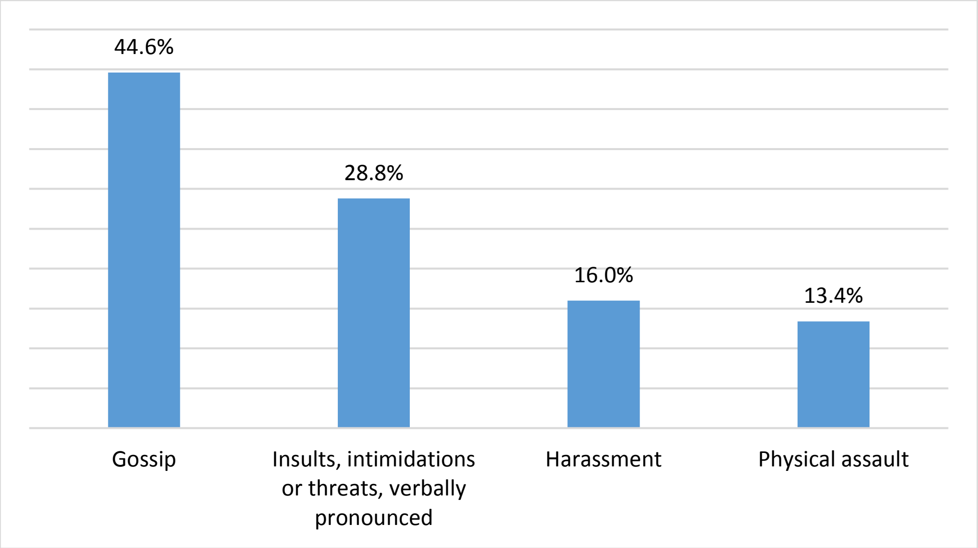
Table 5. Self-restrictions due to HIV+ status, last 12 months, disaggregated by socio-demographic categories

		I've decided not to marry, %	I've decided not to have sexual relations, %	I've decided not to have children, %	I was avoiding the clinics even if I needed the medical services, %	I was avoiding the hospitals even if I needed the medical services, %
Total		**15%**	**11%**	**31%**	**10%**	**8%**
Gender:	Males	16%	10%	29%	7%	4%
	Females	15%	13%	34%	13%	12%
Age groups:	18 - 29 years	9%	9%	22%	10%	5%
	30 – 39 years	14%	8%	29%	11%	9%
	40 - 49 years	19%	16%	40%	11%	11%
	50+ years	19%	16%	34%	6%	5%
	Less than a year	11%	15%	24%	4%	7%

		I’ve decided not to marry, %	I’ve decided not to have sexual relations, %	I’ve decided not to have children, %	I was avoiding the clinics even if I needed the medical services, %	I was avoiding the hospitals even if I needed the medical services, %
Length of live living with HIV:	1 – 4 years	22%	14%	34%	11%	9%
	5 – 9 years	10%	8%	28%	7%	6%
	10 – 14 years	15%	11%	33%	12%	9%
	More than 15 years	15%	11%	37%	16%	14%
Marital Status:	Married or in a live-in partnership	3%	3%	26%	10%	9%
	Single	25%	15%	36%	9%	7%
	Divorced / widowed	36%	27%	41%	11%	9%
Occupational status:	Full-time employees	16%	11%	35%	10%	9%
	Part-time employees	14%	15%	27%	8%	4%
	Unemployed	15%	10%	28%	11%	9%
Residency:	Rural	12%	10%	26%	11%	9%
	Small urban	14%	11%	27%	8%	7%
	Big urban	19%	12%	38%	11%	9%

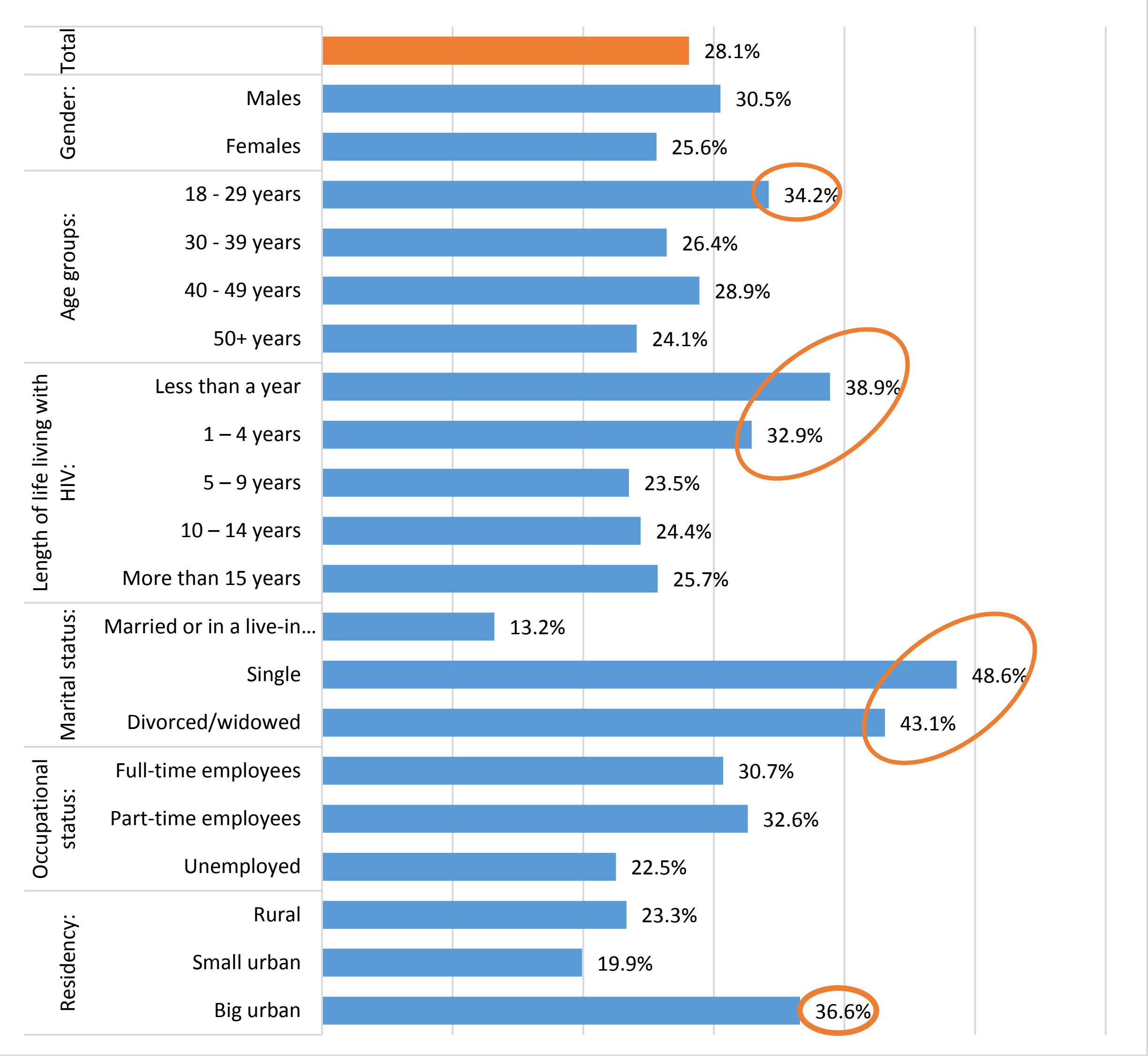
Internal stigma is determined by the expected stigmatizations from the society. The respondents mentioned fears such as being gossiped about (44.6%), being intimidated or threatened verbally (28.8%), harassment (16.0%) or even physical assault (13.4%).

Figure 16. Perceived fears due to HIV+ status, last 12 months



Likewise, an equally significant share of respondents reported fear that other people would refuse to have sexual relations with them because of HIV+ status (28.1%). More often, such fear is shared by young persons, with a short length of life living with HIV, by those who are not in a relationship now, and, surprisingly, by the inhabitants of big cities.

Figure 17. Share of respondents who had fears that someone wouldn't want to experience sexual relations with them, due to HIV+ status, last 12 months

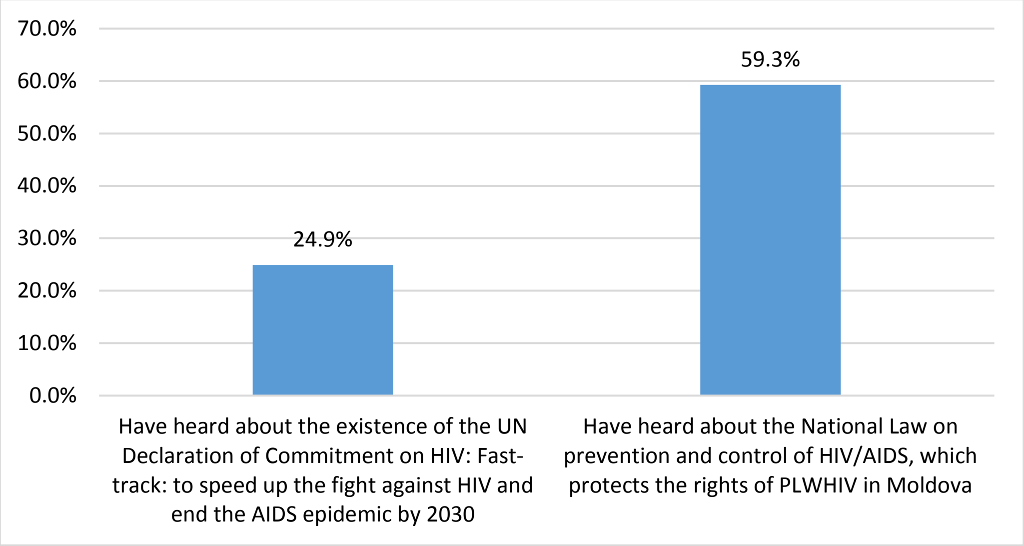


Rights, laws and policies

This sub-section focuses on awareness and familiarity of the 2016 UN Declaration of Commitment on HIV[12] and on the National Law on prevention and control of HIV/AIDS [13], assessments of human rights violations based on their HIV+ status, as well as on the efforts to defend these rights.

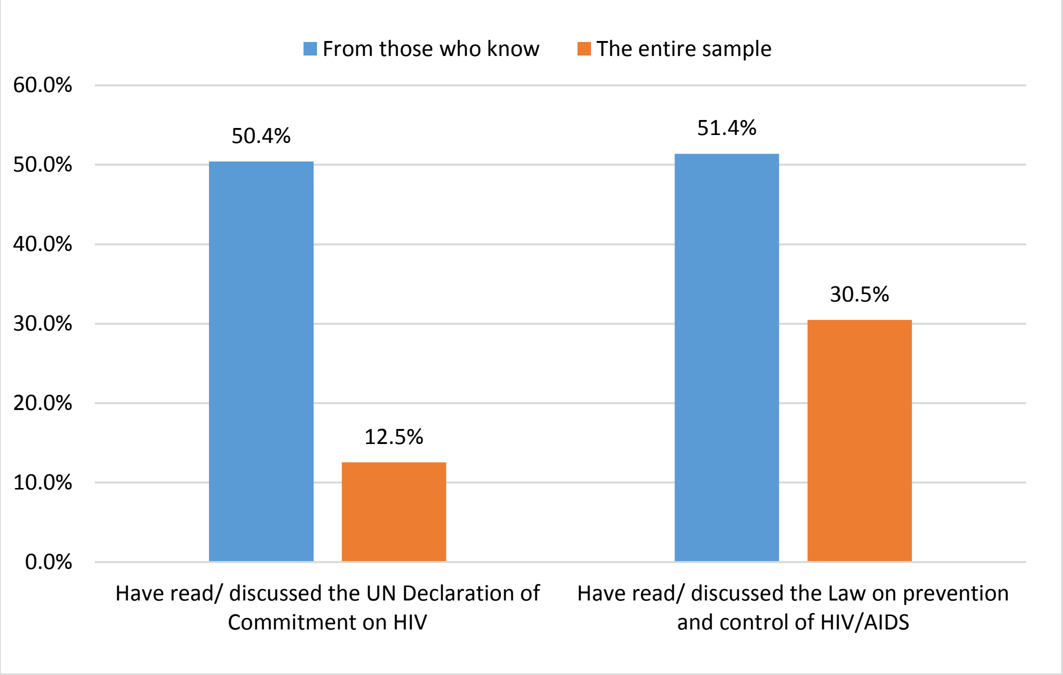
At least at declarative level, every fourth respondent claims to have heard about the existence of the UN Declaration of Commitment on HIV and 59.3% about the Law on prevention and control of HIV/AIDS.

Figure 18. Awareness about HIV declaration on commitment and National HIV law



At the same, the familiarity with these documents seems a low one, as only one out of two respondents of those who claimed to have heard about the declaration and the HIV/AIDS law have ever spoken about their contents. Per whole sample, 12.5 % have heard and have ever discussed about the UN Declaration of Commitment on HIV and 30.5% about the Law on prevention and control of HIV/AIDS.

Figure 19. Acquaintance with the HIV declaration on commitment and National HIV law



During the previous 12 months, 92.5% of respondents reported no experience of discriminatory practices by governmental institutions. Meanwhile, 5.3% were being forced to take a medical procedure (including

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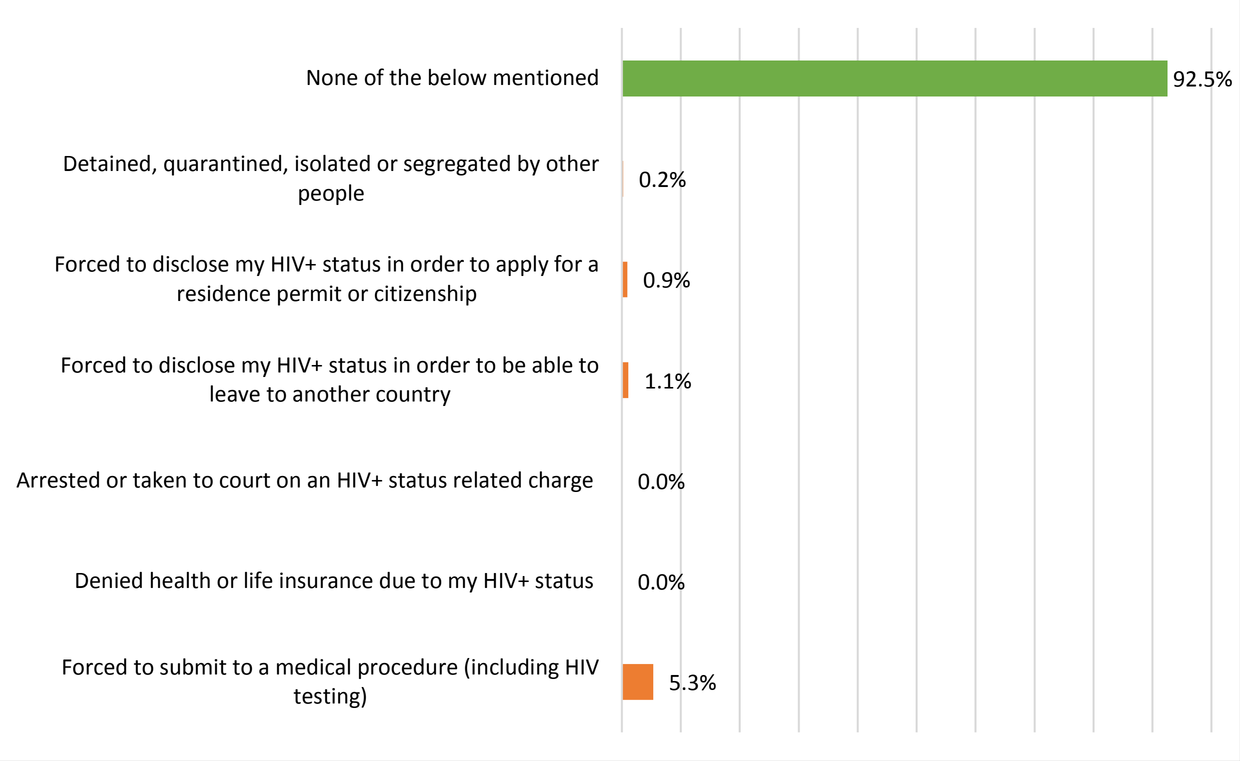
[12] http://aids.md/aids/files/628/law-hiv-aids-2007-en.pdf

[13] http://lex.justice.md/document_rom.php?id=1A87453F:B292311C

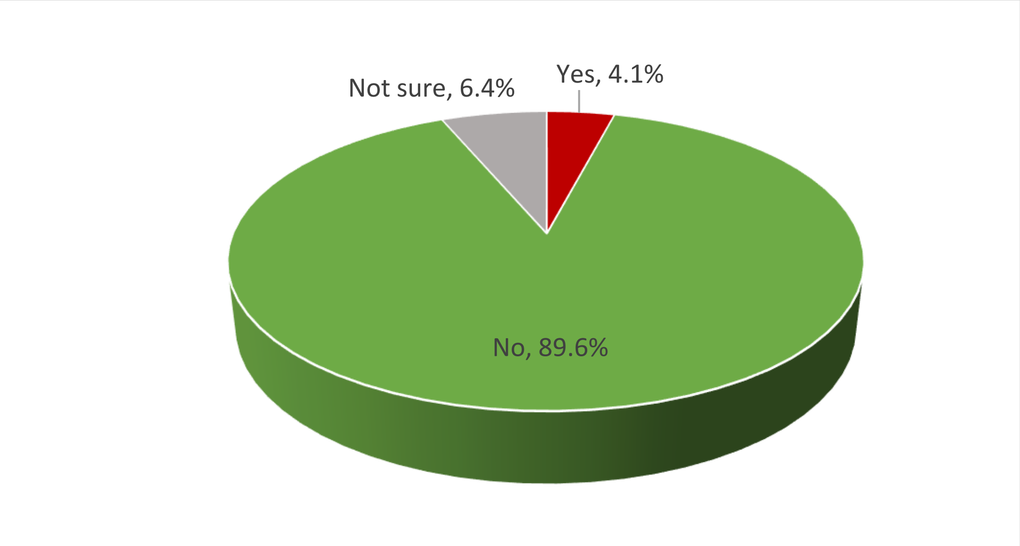
HIV testing), 1.1% of respondents mentioned having been forced to disclose their HIV status in order to be able to leave to another country, while 0.9% to apply for a residence permit or citizenship. Other 0.2% reported cases (n=1) when they were detained, quarantined, isolated or segregated. There were no cases in which the respondent to be arrested or taken to court on an HIV-related charge or to be denied health or life insurance.

Figure 20. Frequency of cases of violation of human rights, due to HIV+ status, last 12 months



Per overall, 4.1% of respondents reported that their rights had been violated in the previous 12 months due to their HIV status, while other 6.4% have reported that they have encountered violations but cannot accurately state that they were due to their status.

Figure 21. Perceived violation of human rights, due to HIV+ status, last 12 months



Out of those 4.1% (n=19) respondents who claimed reported that their rights had been violated due to their HIV status, only 5 persons had tried to receive legal support to defend and restore their rights, 4 persons had tried to get a government employee to take action, while other 3 had tried to get a local politician to take action.

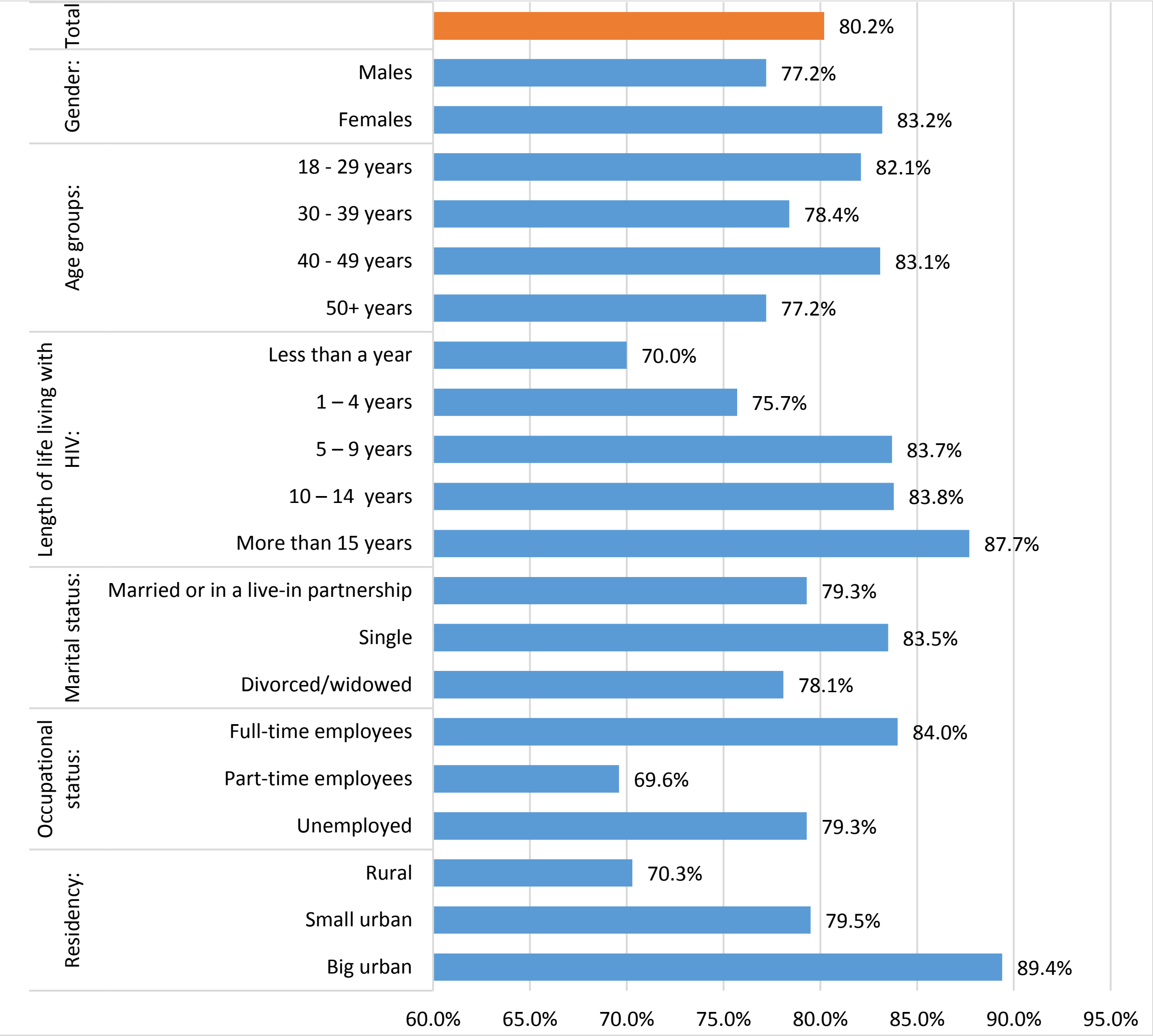
Association of civic groups of PLWH

During the last 12 months, one out of ten respondents (11.9%) was subject to stigma or discriminatory attitudes during debates or heated discussions with another person in regard to HIV.

In terms of accessibility and infiltration of services for PLWH, both institutions and civil society service organizations are continually striving to broaden the access and inclusion of the target group into the spectrum of rendered services. In this context, 80.2% of respondents claimed to know of an organization or groups providing support to those experiencing stigma or discrimination.

Obviously, there are discrepancies related to this indicator among different socio-demographic groups, which indicates indirectly over the PLWH categories that are more difficult to encompass within the services provided. Therefore, the biggest discrepancies are related to the length of living with HIV, from 70.0% among those who live with HIV less than a year compared to 87.7% among those who live with HIV for more than 15 years. Likewise, major discrepancies are attested in regards to the place of residence, from 70.3% among those from rural areas compared to 89.4% among those from big urban areas. It is worth mentioning that no group is noticeable by a level of knowledge lower than 50 %, even 60 %.

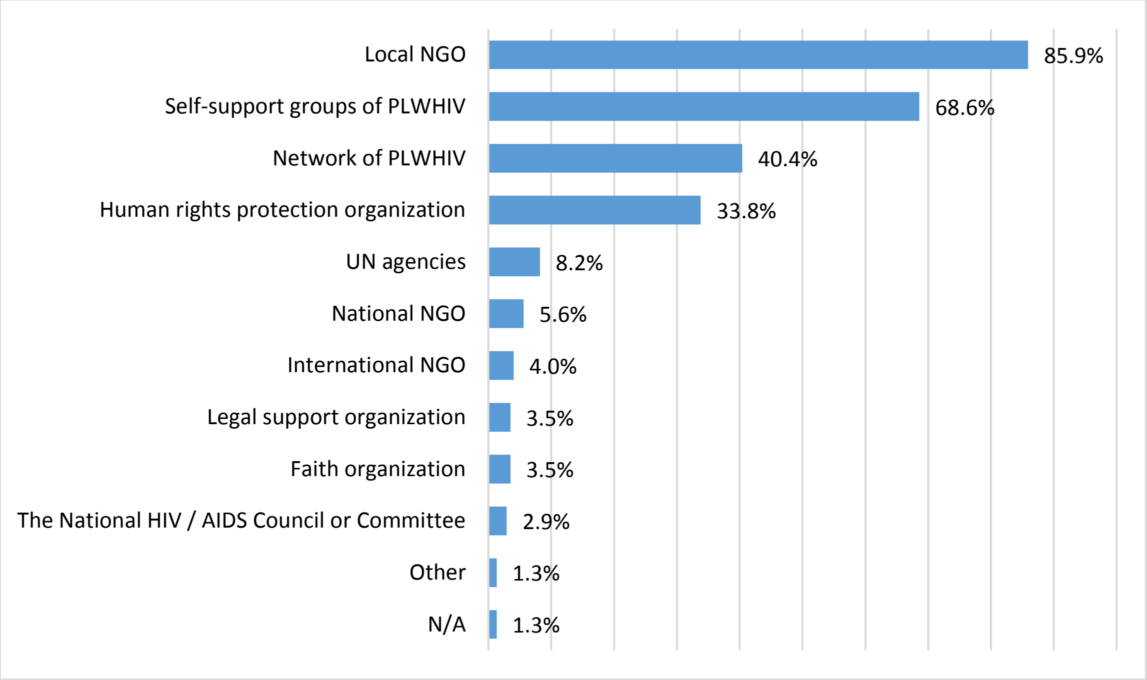
Figure 22. Awareness about the organizations/groups that offer help in cases of stigma and discrimination



There are four types of organisations best known by PLWH. The highest level of coverage is provided by local organizations (85.9%), which however varies depending on the presence of this type of organization in the territory. Therefore, 67.8% of PLWH in big urban areas have cited to know such organisations and only 50.0% and 43.4% from small urban areas and rural areas, respectively.

Per notoriety level, self-support groups of PLWH follow (68.6%). The networks of PLWHIV report a remarkable level with 40.4% of respondents claiming to know such organisations and, while 33.8% cited other NGO's concerned with human rights protection, including PLWH. The respondents cite fewer other types of organisations.

Figure 23. Percentage of respondents identifying groups/organizations that offer help in cases of stigma and discrimination



According to the study's data, the rate of involvement of PLWH in association actions to help the PLWH community from the inside is imposing. Every third respondent claimed to offer help to other PLWH during the previous 12 months (35.8%), while the level of association to groups/networks of PLWH is of 24.5%. One out of ten respondents (11.9%) has volunteered for programs or projects related to PLWH. However, even though the study has targeted a random selection of respondents, the substitutions conceived due to difficult access to the selected respondent have shifted the sample to the more involved PLWH, therefore making it easier to access for the service providers through whom the collection of data was assured. Therefore, in this context, the percentage of the participation rates estimated in the study should rather be treated as increased.

Figure 24. Associate joint actions in support of PLWH

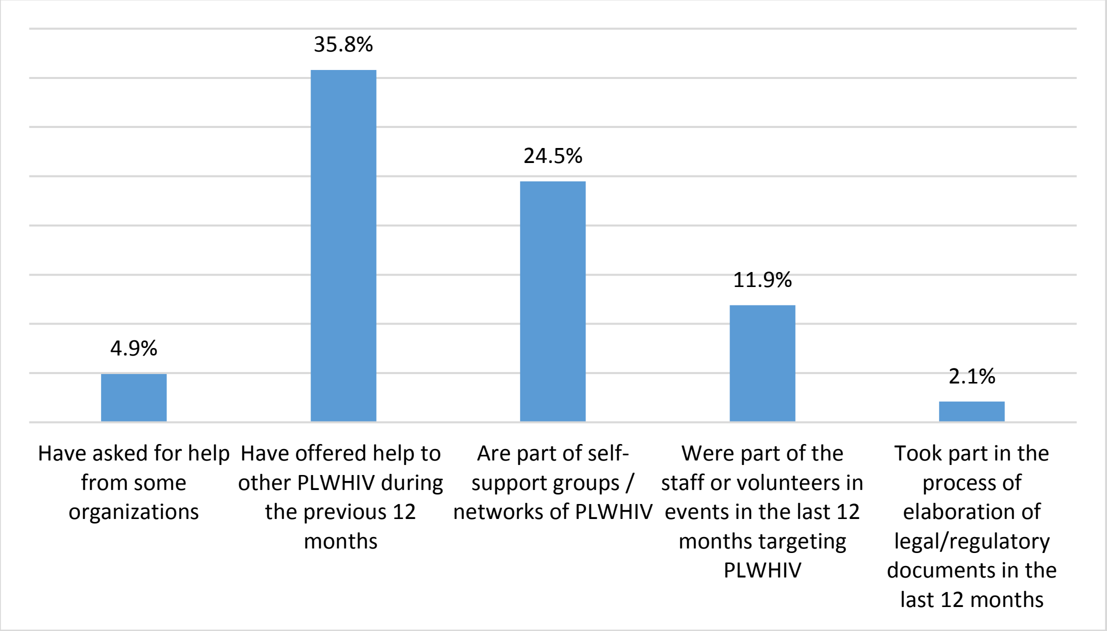
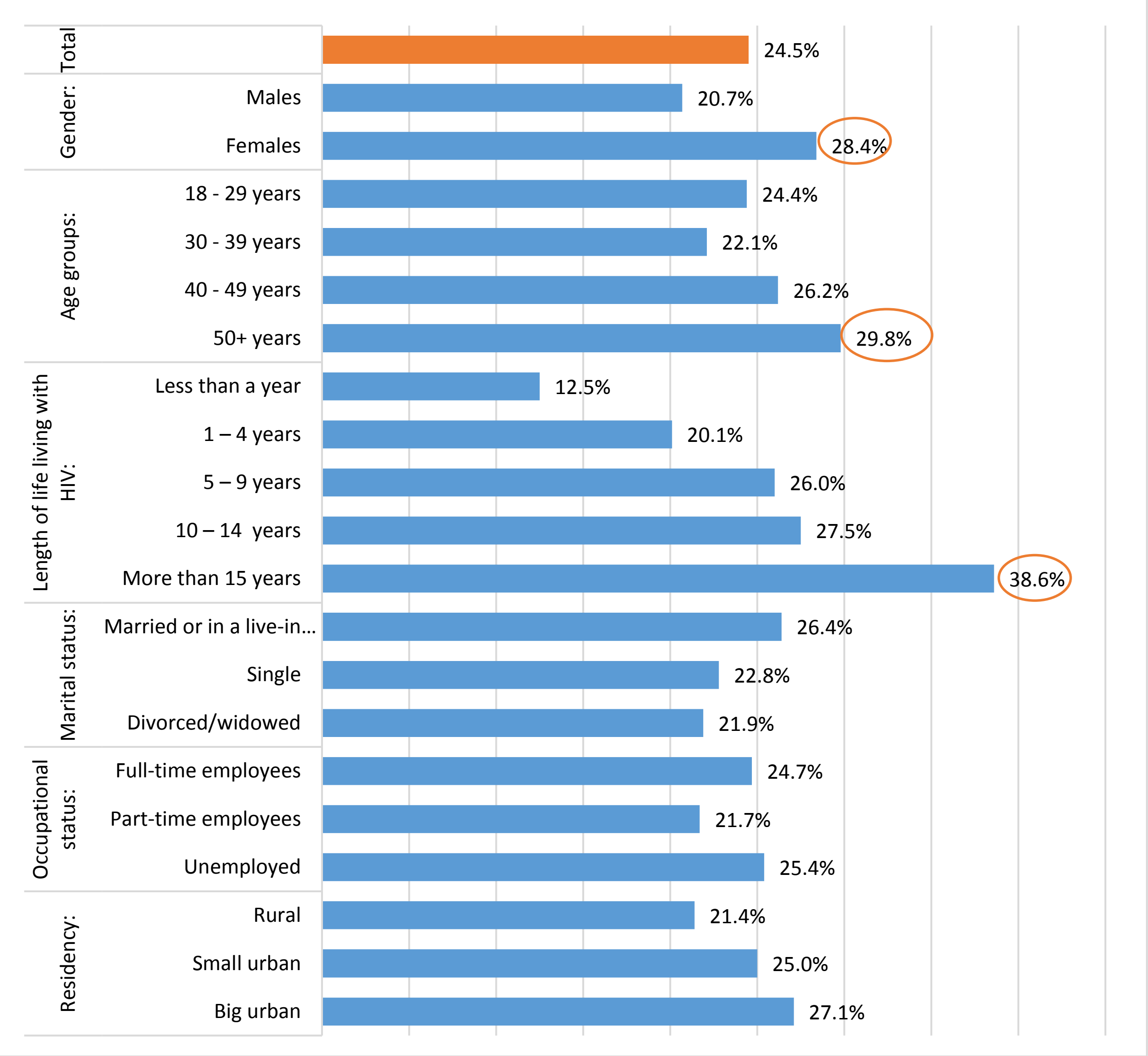


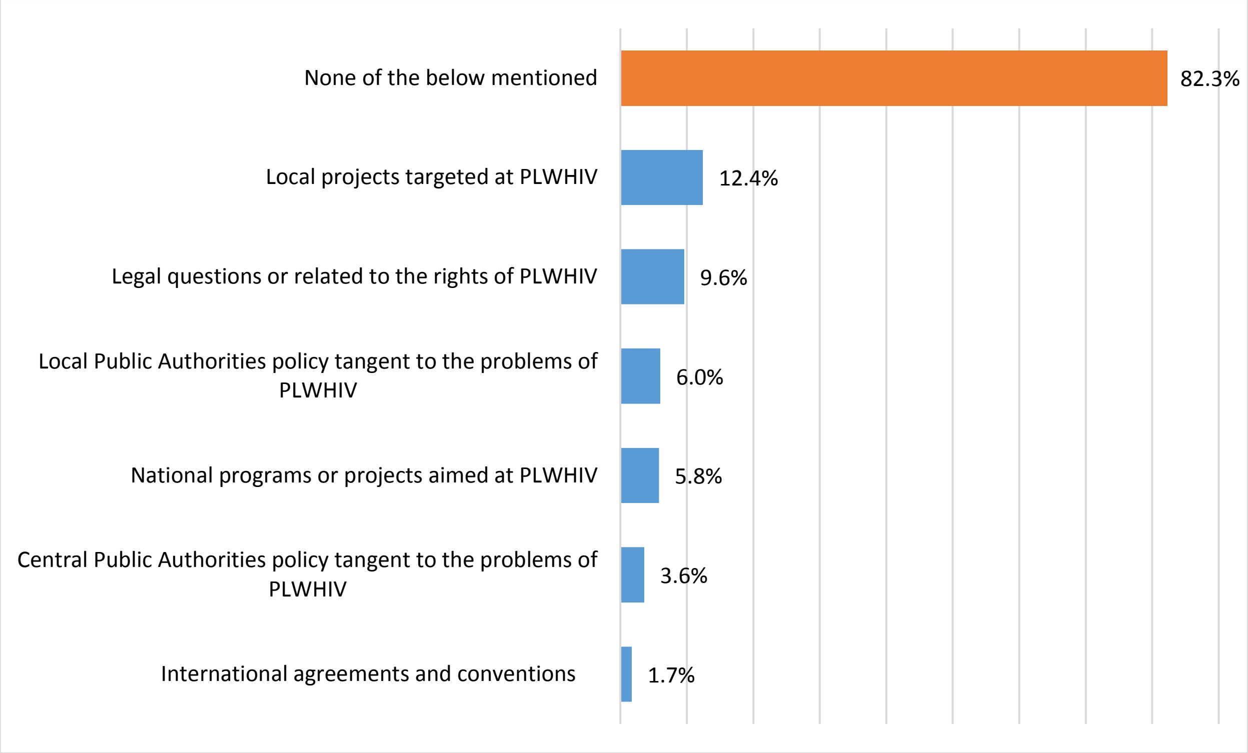
Figure 25 shows a suggestive image of the rate of involvement of different categories of PLWH in groups/networks of support of PLWH. The results of the study indicated over a higher involvement of women, with aging and especially (very pronounced otherwise) with the increase of the length of life living with HIV. Likewise, a variance is attested, although not so big, depending on the residency area, with a slightly lower involvement of those in rural areas and somewhat higher in urban areas, especially in bigger urban areas.

Figure 25. Member of a people living with HIV network/support group, disaggregated on socio-demographic categories



Despite a somewhat impressive level of involvement (at least declaratively), the large majority of PLWH deny the existence of any possibility for influence over decisions taken on different levels and in various circumstances within organizations to eradicate stigma and discrimination. Thereby, 82.3% have denied any possibility for influence regardless of the type and nature of the decision.

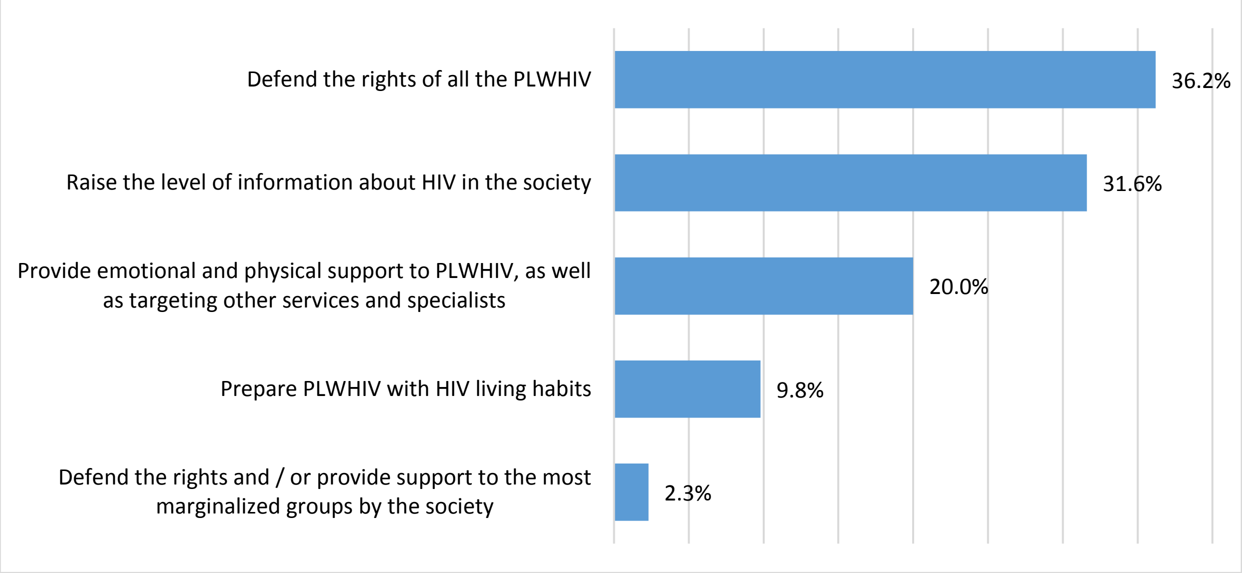
Figure 26. Assessment of the possibility of influence on decision-making



Moreover, three basic recommendations are settled in order to reduce the stigma and discrimination of PLWHIV for the organizations covering this direction. It is worth mentioning that these recommendations firstly refer to the degree of coverage of the PLWH community – „defend the rights of all the PLWH" (36.2%), "remove the informational background on which discrimination is based", and „raise the level of information about HIV in the society" (31,6%).

Only afterwards, per share of percentage, follows the literal support of PLWH (20.0%).

Figure 27. Recommendations for organizations in fighting stigma and discrimination



Experience of testing, disclosure, treatment and having children

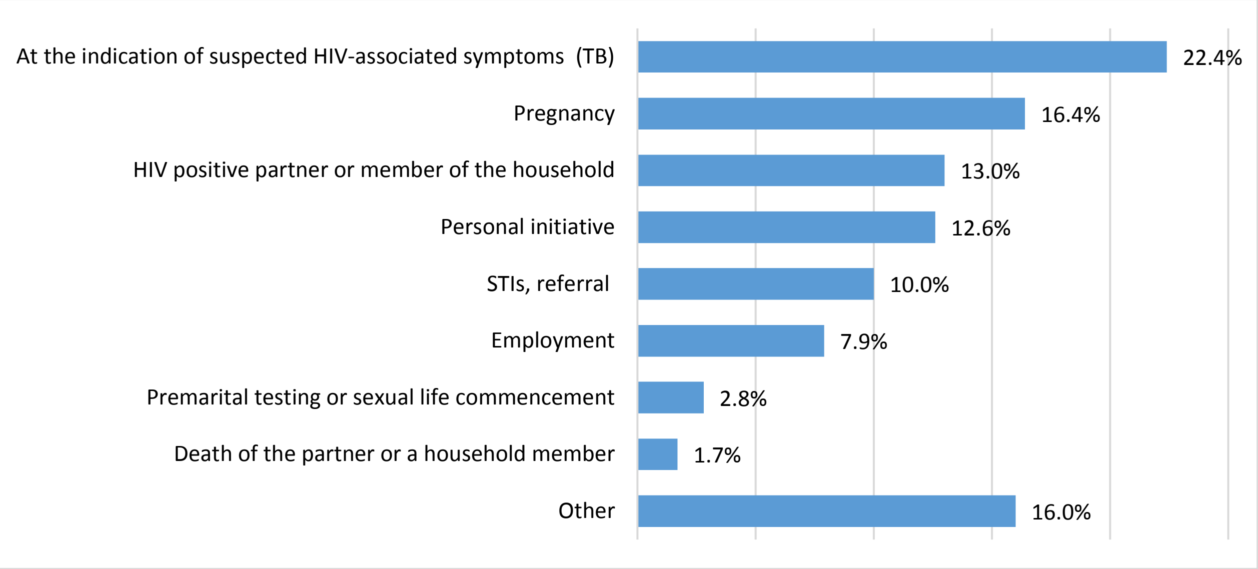
This section comprises the particularities of possible discriminatory treatments in the processes of diagnosis, confidentiality, treatment as well as the experience of the right to have children.

Testing and diagnosis

It is important to mention that the circumstances for determining the diagnosis are very varied. Most often, (although far from prevailing) the test, for which the HIV+ status was established, was realized at the indication of suspected HIV-associated symptoms (22.4%). Furthermore, per share of respondents follows, obviously associated only with females, testing during pregnancy (16.4%). In addition, 13.0 % of respondents underwent HIV testing due to an HIV+ partner or member of the household.

Seldom, the status was established because of premarital testing or sexual life commencement (2.8%) or as an outcome to the illness or death of the partner or a household member (1.7%).

Figure 28. Reasons for undergoing HIV testing



It is obvious that specific variations exist, which are related to the age or to the length of life living with HIV of the PLWH. Testing during pregnancy is characteristic to women, during their maximum birth rate period (18-39 years). To the same age groups, it is characteristic to obtain the HIV status as an outcome of taking the test on their personal initiative.

Testing at the indication of suspected HIV-associated symptoms is more distinctive for elder persons (50+ years).

The variation related to the length of life living with HIV shows the change of accents in setting diagnostics. Thereby, the results of the study reveal the increase, through time, of the tests done on personal initiative (bigger rates of respondents with a smaller length of life living with HIV who have established the status under these circumstances). Meanwhile, the frequency of infection detection cases following the test performed at the indication of the medical institution has decreased (double rate of cases among those with the longest length of life living with HIV).

Setting the HIV+ status as an outcome of pregnancy testing is more specific to the groups with a smaller or average length of life living with HIV, although, this seems to decrease over time.

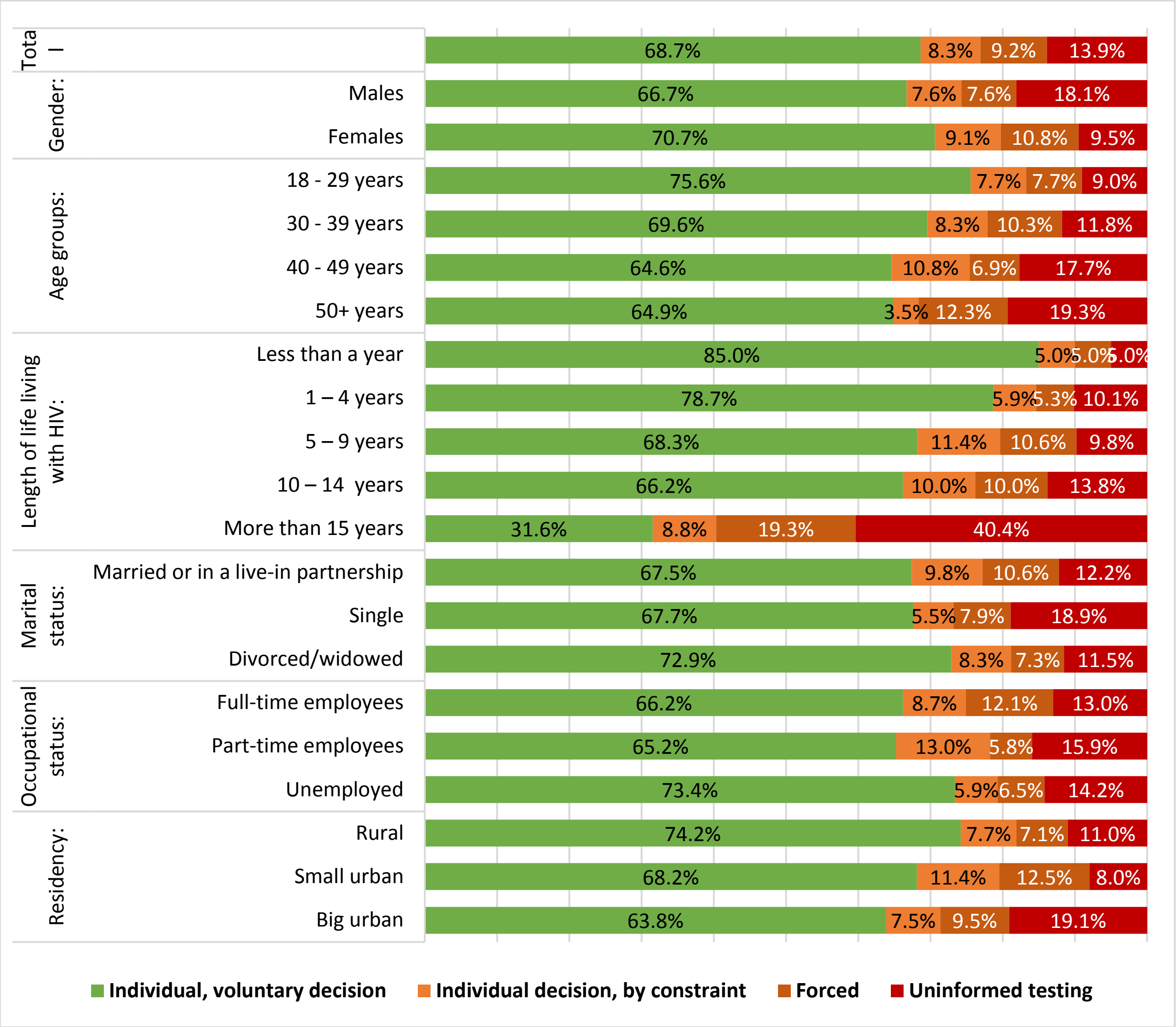
Table 6. Reasons for undergoing HIV testing disaggregated by age groups and length of living with HIV

		Employment, %	Pregnancy, %	Premarital testing or sexual life commencement, %	STIs, referral, %	AIDS related symptoms (TB), %	HIV positive partner or member of the household, %	Illness or death of the husband/partner/ household member, %	Personal initiative, %
Total		**8%**	**16%**	**3%**	**10%**	**22%**	**13%**	**2%**	**13%**
Age groups:	18 - 29 years	8%	33%	4%	9%	8%	12%	1%	15%
	30 - 39 years	7%	20%	3%	11%	19%	15%	2%	13%
	40 - 49 years	7%	7%	2%	9%	28%	12%	2%	12%
	50+ years	12%	2%	2%	12%	44%	9%	2%	9%
Length of life living with HIV:	Less than a year	5%	13%	0%	10%	20%	8%	0%	33%
	1 – 4 years	8%	17%	1%	8%	23%	14%	2%	15%
	5 – 9 years	9%	19%	5%	9%	24%	13%	2%	10%
	10 – 14 years	10%	24%	5%	8%	26%	14%	0%	8%
	More than 15 years	4%	4%	4%	21%	14%	14%	2%	4%

In the majority of cases, the test on which the HIV status was established was done voluntarily at the decision of the respondent (68.7%). Nonetheless, testing due to constraint or without the knowledge of the person remains a reality. 8.3 % of respondents believe that they were constrained to take the test, while 9.2% reported being forced to take it. Other 13.9% were not informed that the sample would be taken for an HIV testing at the time of the test.

The variances based on socio-demographic categories suggest improvements over time. The percentage of voluntary testing decreases with the increase of lifetime with HIV. Thereby, if the percentage of respondents with the length of life living with HIV is 85.0% and only 31.6% among those diagnosed 15 years ago and behind. Likewise, there are differences related to the area of residence, with a hare rate of voluntary testing in rural areas (74.2% compared to 68.2% in small urban areas and 63.8% in big urban areas).

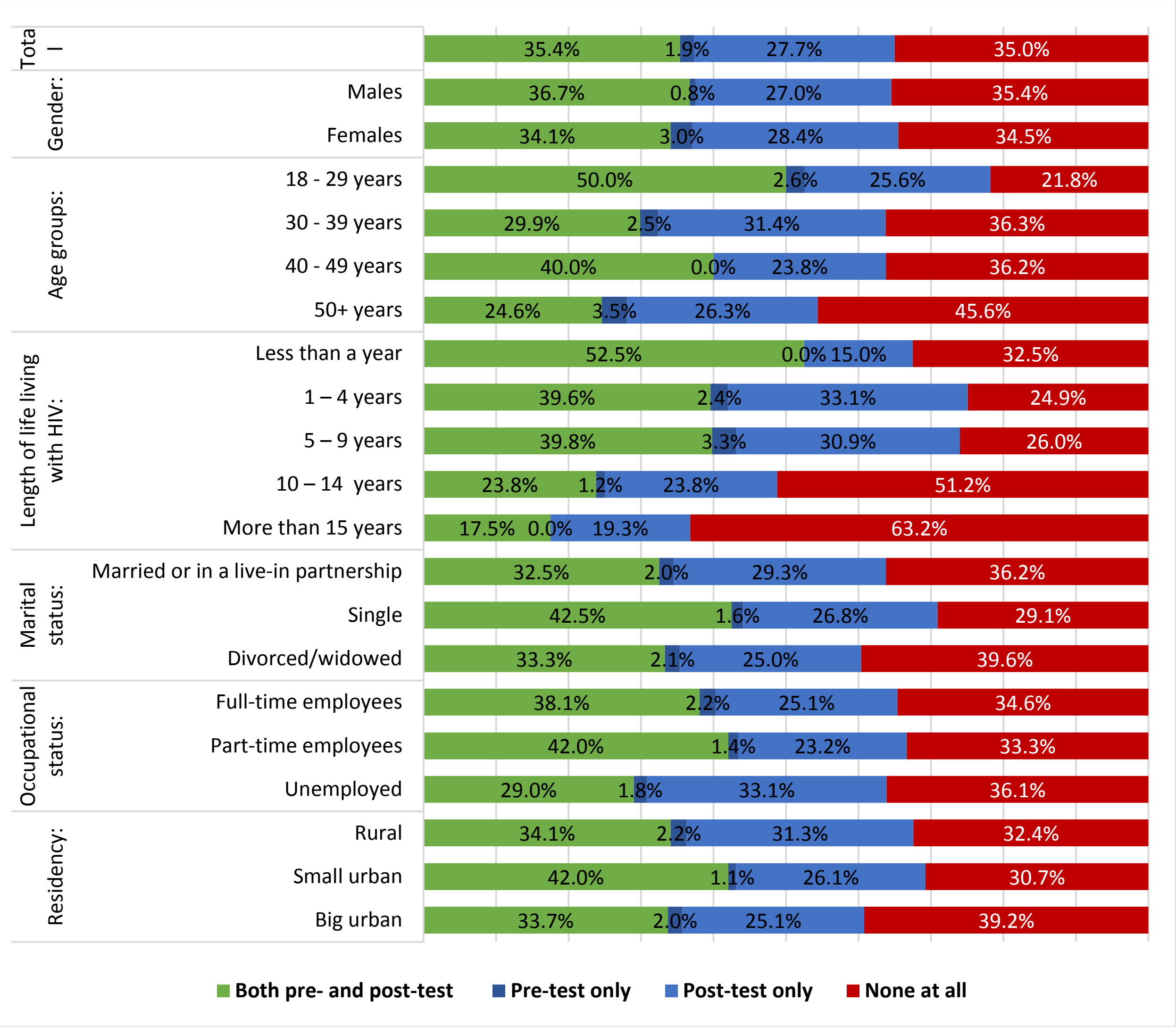
Figure 29. Independence of the decision of HIV testing



In one out of three cases, the patient has received no pre and post-test counselling (35.0%), a situation characteristic to the elder respondents, with a longer length of life living with HIV from big urban areas.

A similar proportion (35.8%) of respondents have received both pre- and post-test counselling, while in other cases mostly post-test counselling is performed (27.7% only post-test and 1.9% only pre-test).

Figure 30. Access to counselling during HIV Testing



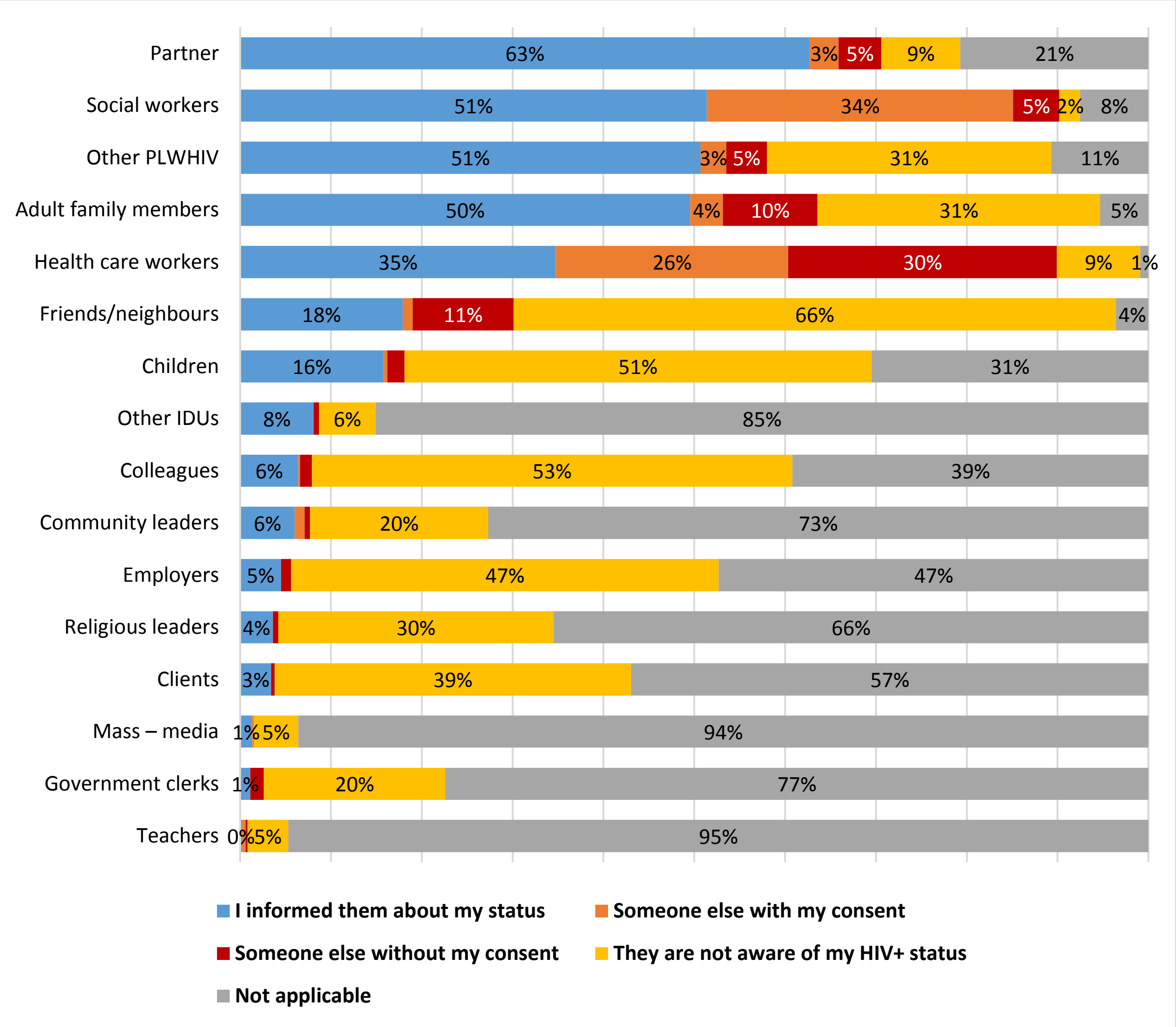
Disclosure and confidentiality

The study focused on the experiences of the respondents in regards to disclosure or keeping secret of their HIV status and on the rates and impact of status disclosure.

There are several categories towards which the respondents have disclosed their HIV+ status on their own behalf, such as their partner (62.7%), social assistants (51.4%), other PLWH (50.7%) and other adult family members (49.5%).

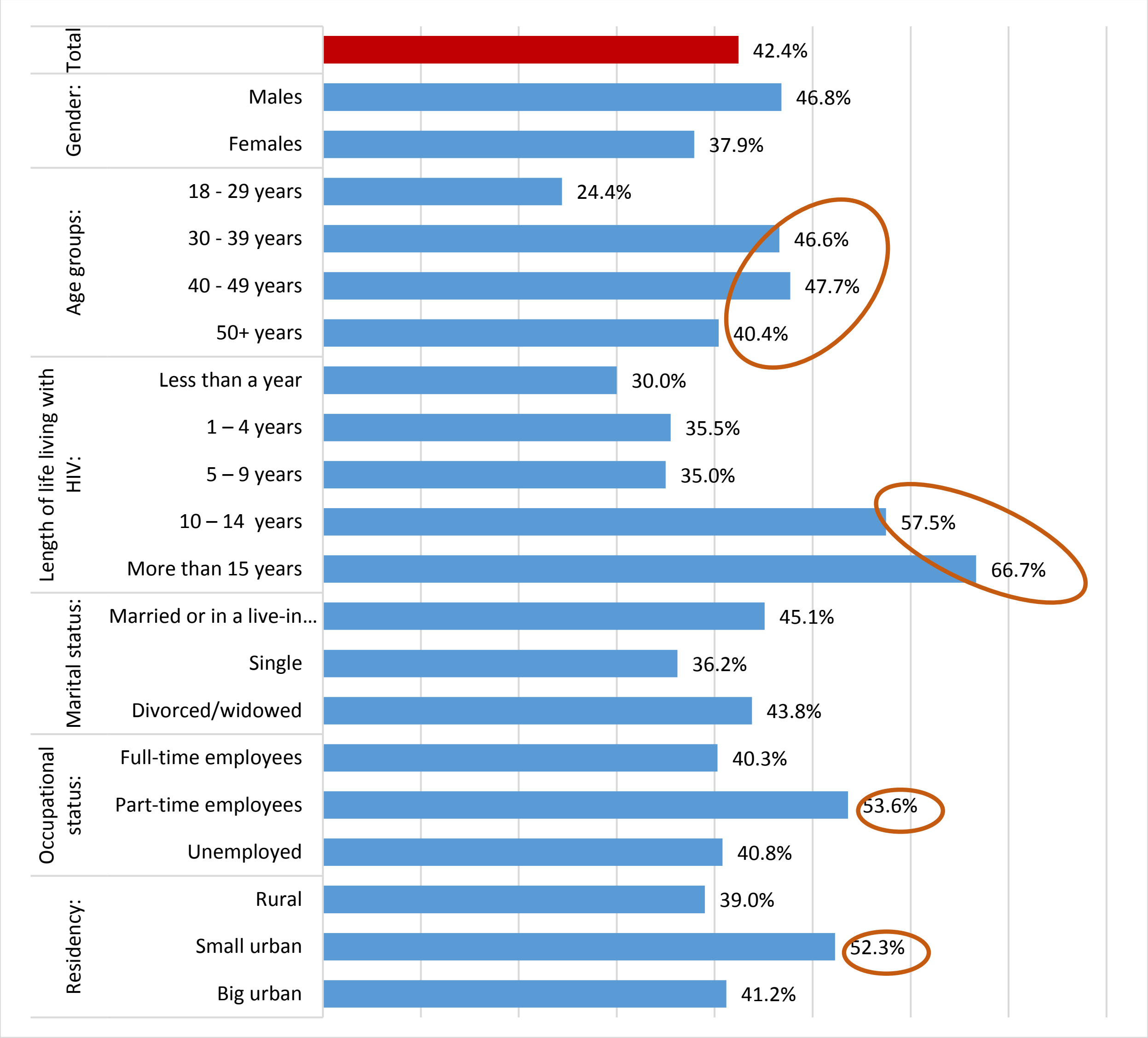
In the case of some categories, the rates of status disclosure without the person's consent are significant. For example, in the case of 29.6% of respondents their status had been communicated to the medical workers without their consent, as well as for 11.1% of total respondents to their friends/neighbours and for 10.4% of total respondents to other adult members of their family.

Figure 31. HIV+ status disclosure



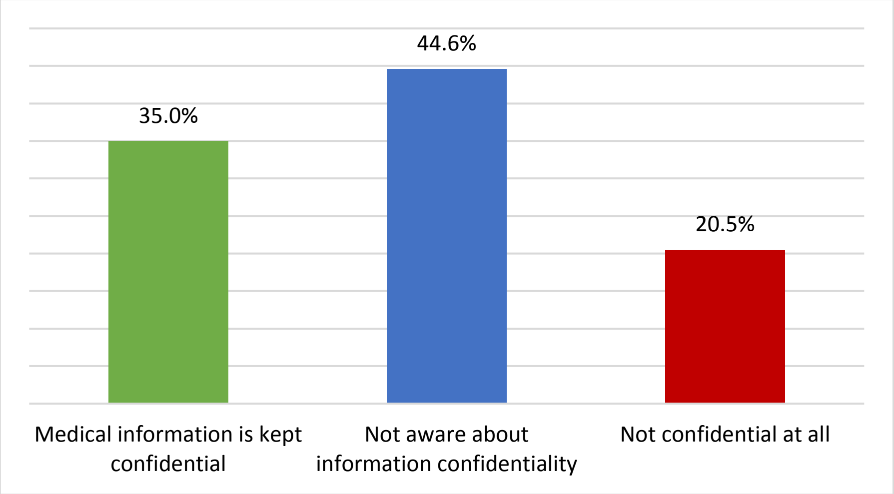
Although it is not so obvious from the distributions presented in figure 31, HIV status disclosure without the PLWH consent is a very frequent practice. Four out of ten respondents (42.4%) reported that in this way their rights were infringed, having their HIV status being disclosed at least in the case of one of the listed categories. More often in this sense are infringed the rights of men, people with a longer length of life living with HIV, medium or advanced age, from small urban areas.

Figure 32. Experience of disclosure of HIV status without consent



Medical institutions are the institutions where most cases of disclosure of HIV+ status occur, a fact that increases distrust in assuring the confidentiality of medical records. Only one-third of PLWH (35.0%) indicated they are certain that their medical records are completely confidential. Otherwise, 44.6% indicated that they do not know if their records are kept confidential, while it was clear to 20.5% of respondents that their medical records were not being kept confidential.

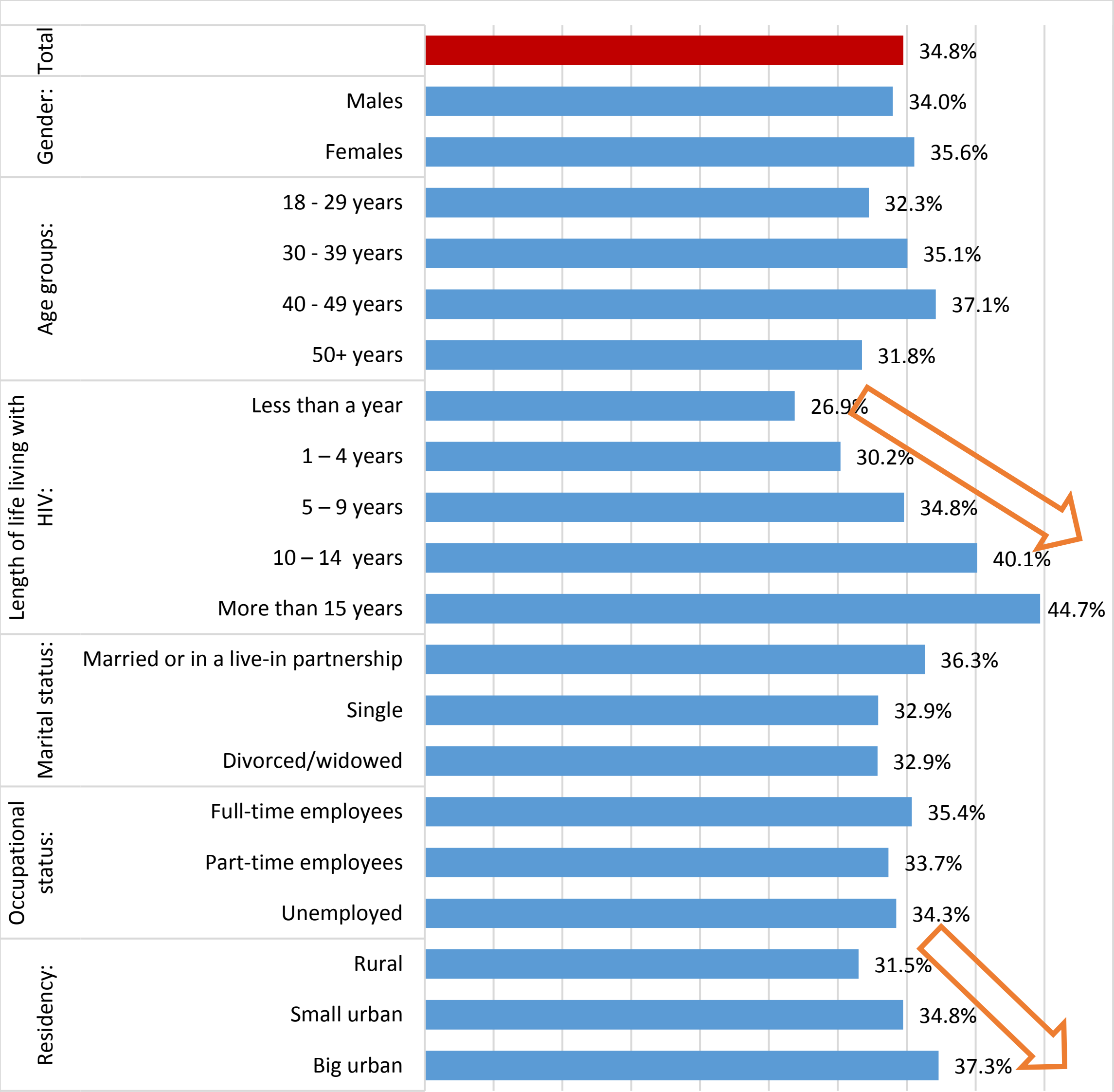
Figure 33. Privacy of medical documentation



An indicator that directly affects, and through which consideration is given to respecting the rights of PLWH and to the frequency of their violation, is related to the extent to which the social environment knows the status of PLWH. Thereby, the frequency of violation of rights recorded during the study is strongly diminished because most PLWH hide their status. The rate of disclosure of HIV+ status presented in **Figure 34** indicates the rate of respondents whose status is known at least for one of the categories of people listed in **Figure 31**, regardless of the way it was communicated (personally, by a third party, voluntarily or unconditionally). Therefore, according to the study results, in the case of two-thirds of respondents, their HIV status is kept in complete anonymity, and only 34.8% indicated that their status is known to at least one of these categories.

The disclosure rate is increased with the increase of the length of life living with HIV, as well as being directly related to the size of the place of residence - higher in bigger urban areas and lower in rural areas.

Figure 34. Disclosure rate of HIV+ status[14]



Constraints that cause PLWH to disclose their status to other people are not very common. Only around 6% of respondents were ever forced to disclose their status by other PLWHIV and around 4% by non-PLWH.

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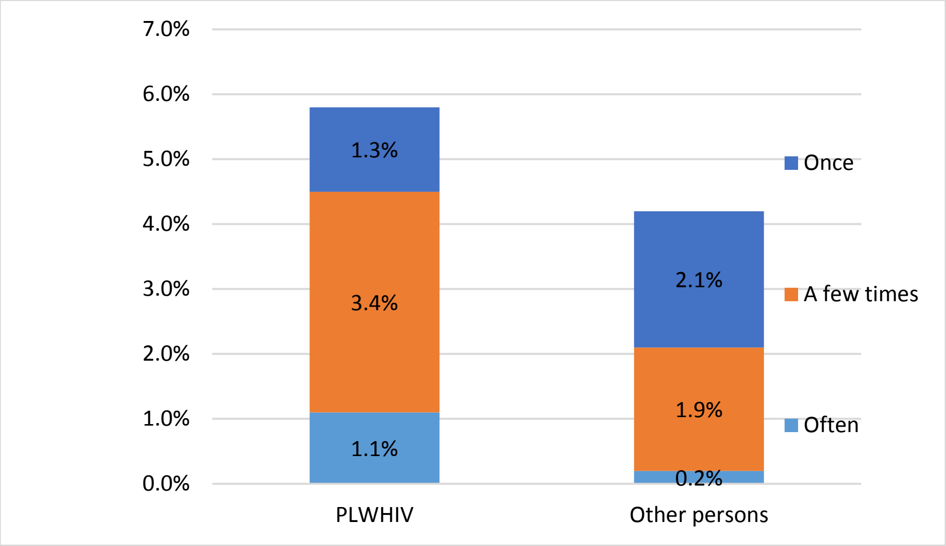
[14] Expresses the rate of the categories of people (see figure 31), to whom the respondent's HIV + status is known

Figure 35. Disclosure constraint of status

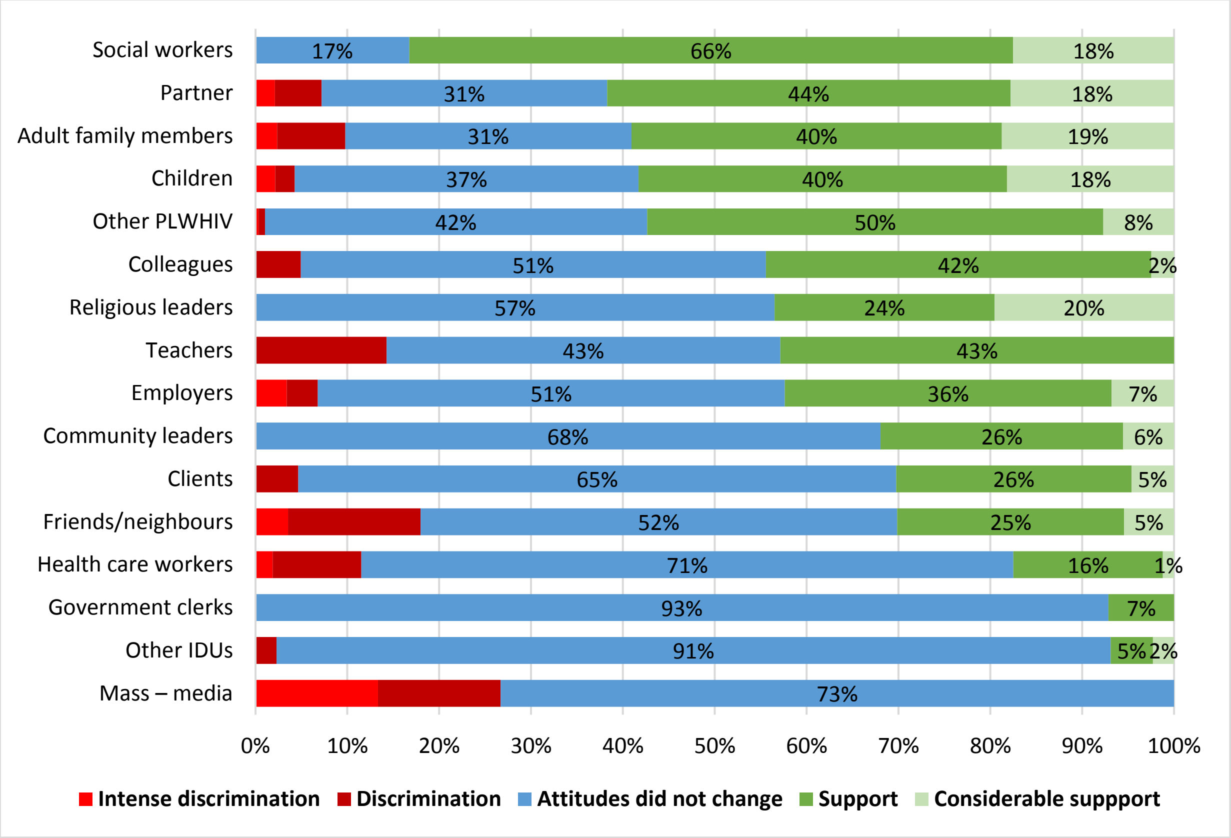


The social reaction in the case of disclosure of HIV+ status is mostly one of support, or at least without changes of attitudes. Most often, PLWH found support from social assistants. Likewise, in the majority of cases, family members (partner, other adults, and children) have reacted by providing support or at least have not changed their attitude.

Groups with moderate levels in this sense are the PLWH community, work colleagues, religious leaders, teachers and employers.

The highest rates of discriminatory reactions were reported from mass media representatives (around 27%), friends/neighbours (18%), teachers (17%) and workers in the medical system (11%).

Figure 36. Perceived reactions to HIV disclosure [15]



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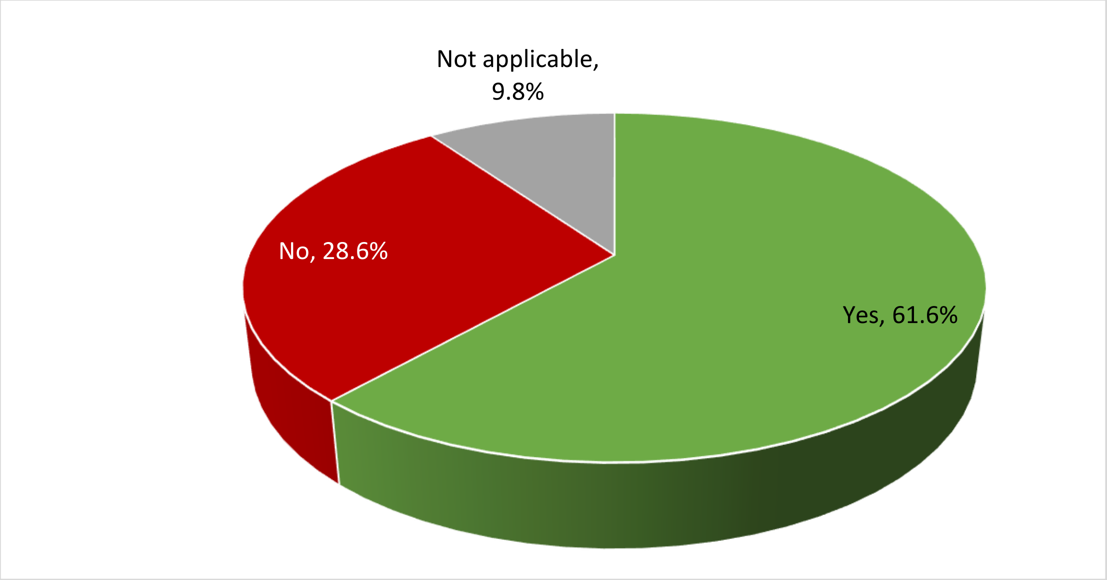
[15] Recalculated at 100% after excluding "not applicable"

In the same time, the majority of respondents (61.6%) reported that the disclosure of HIV+ status has helped them or has been beneficial.

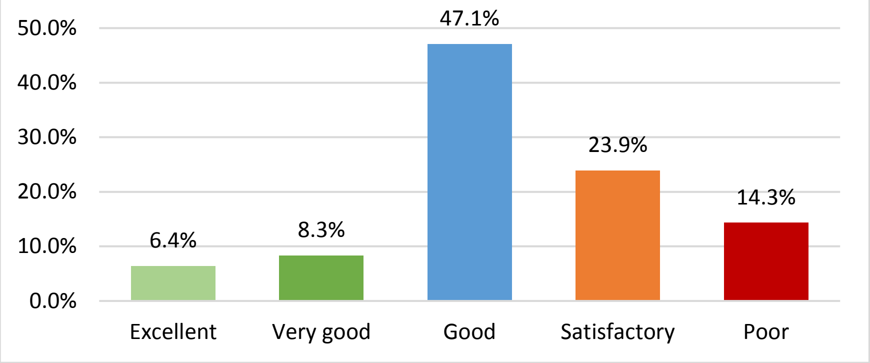
Figure 37. Benefits after disclosure of HIV+ status



Health status and treatment

14.3% of respondents have described their health status as "poor". Differences were not reported in regards to the gender of the respondent, however major discrepancies were found in regards to age. Thereby, 9.0% of young people (18-29 years) described their health as "poor" as did more than 19% among those 40 years and more. The highest rate was reported among those living with HIV for more than 15 years (29.8%).

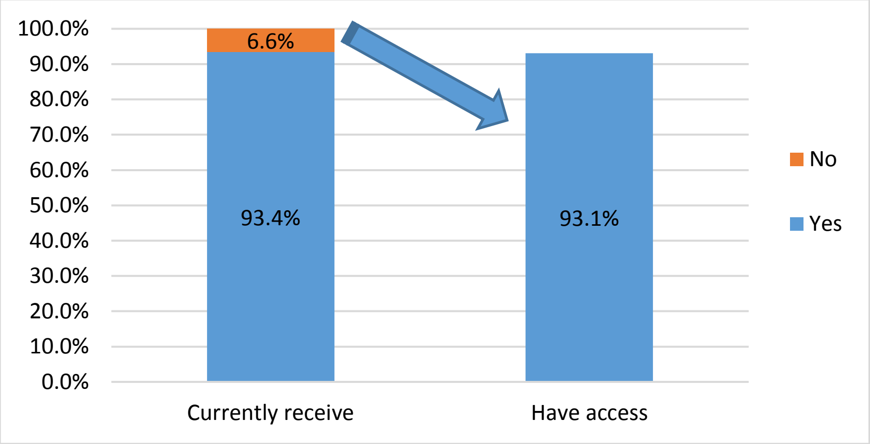
Figure 38. Descriptions of current health



More than nine out of ten respondents (93.4%) were undergoing ARV treatment at the time of the survey. At the same time, 6.6% of respondents were not undergoing ARV treatment, especially among those living with HIV for more than 15 years (10.5%).

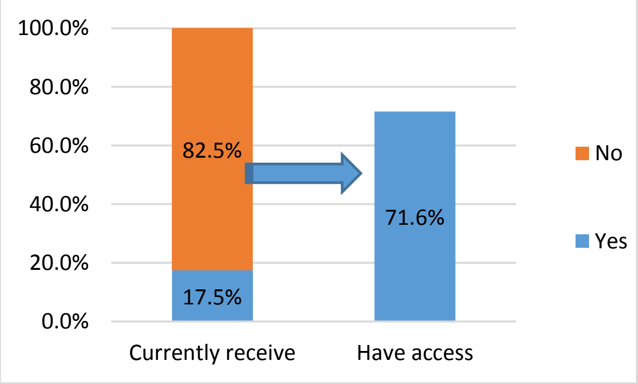
The large majority of those not undergoing treatment claimed to have access to ARV (93.1%), reported having access to these medications and not taking them for reasons other than restricted access.

Figure 39. Access to ARV treatment



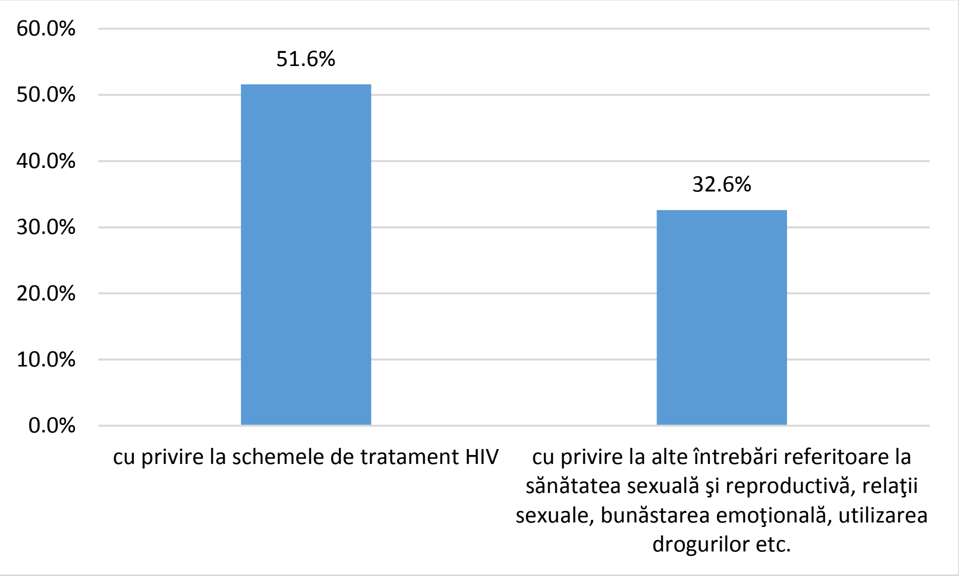
On the other side, only 17.5% of those living with HIV at the time of the survey were undergoing treatment by administering medications for the prophylaxis or treatment of opportunistic, while 71.6% reported having access to these medications even if they were not currently taking it.

Figure 40. Access to medication for prevention and treatment of opportunistic infections, last 12 months



The permanent connection between patients and medical workers is one of the conditions for the proper deployment of health care and the efficiency of treatments. During the last 12 months, each second respondents (51.6%) discussed HIV treatment options with a healthcare professional, while 32.6% discussed other subjects, such as sexual and reproductive health, sexual relations, emotional well-being, drug use etc.

Figure 41. Percentage of respondents who have sustained constructive discussions with medical workers in regards to treatment, last 12 months

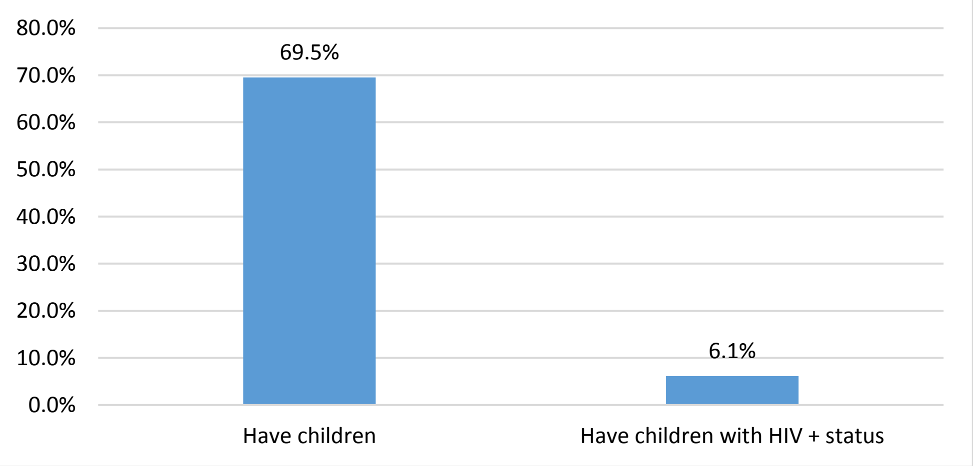


Having children

The realization of the right to give birth to children is addressed in the case of PLWHIV by a series of potential risks and violations, because of the low level of information of the population regarding the infection, the ways of transmission, the methods of protection etc. One of the widespread stereotypes instigates the idea of the immorality of the decision taken by PLWHIV to give birth to children, which is associated with the very high risk that the child could be born with HIV+ status.

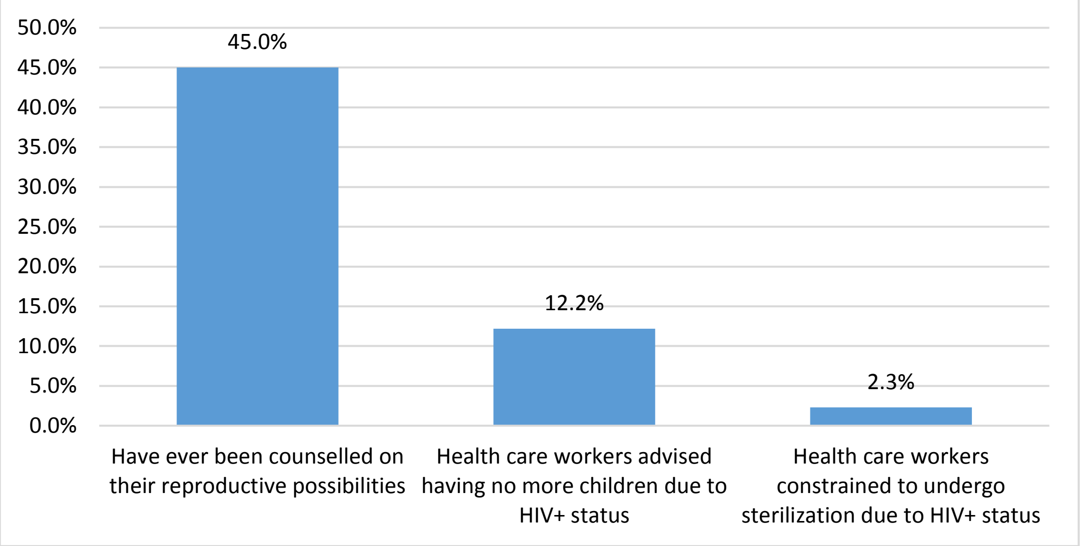
Study data reveals that 69.5% of respondents have children, of which only 6.1% (under 10% of all cases) have children with HIV+ status. It is noteworthy that these cases are more frequent among relatively young persons– 13.2% among those of 18-29 years old and 8.2% among those of 30-39 years old. Likewise, the rate varies in regards to the place of residence, 9.0% of respondents have children with HIV+ status in rural areas, 6.3% in small urban areas and 2.5% in big urban areas.

Figure 42. Respondents with children, including with HIV+ status



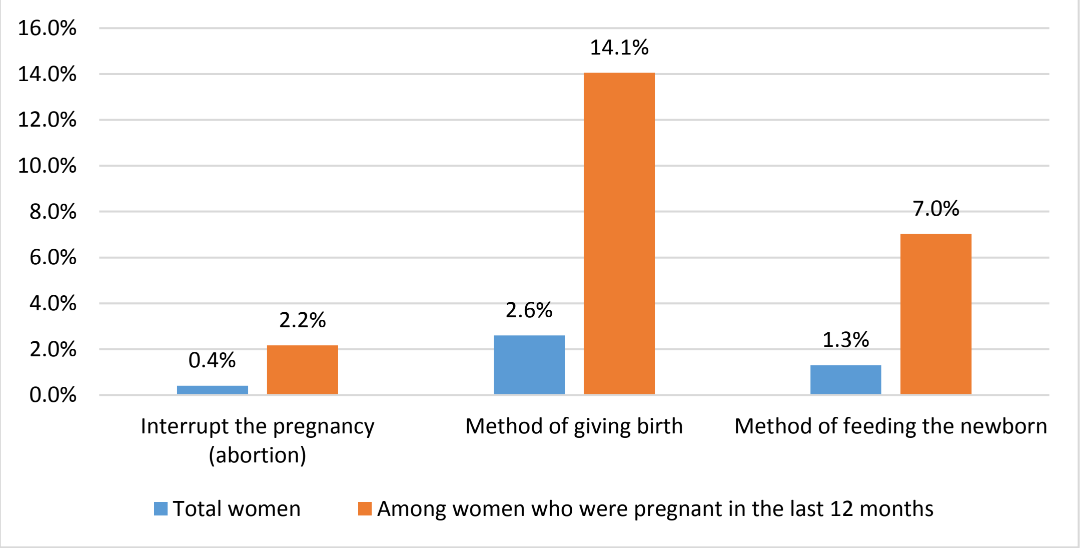
On one hand, a lack of counselling or information services for PLWH on reproductive possibilities in conditions of HIV+ status is noted, with only 45.0% of respondents been ever counselled in this sense during their living with HIV. On the other hand, the study raises signals that the medical workers themselves contribute to the abandonment of the conception of children by PLWH due to their status. Thereby, 12.2% of respondents reported at least once, being advised not to have children, while 2.3% were constrained to submit to sterilization for the same reason. Obviously in this sense, women are more often targeted (19.0% were advised not to have children compared to 5.5% among men), younger people, during their maximum reproductive period. At the same time, the phenomenon seems to diminish through time, being attested in lower levels in the case of recently diagnosed persons, in comparison with people with a longer length of life living with HIV. For example, among those living with HIV for less than a year, 5.0% were suggested to give up having children and there were no cases of constraint to undergo sterilization, while among those living with HIV for more than 15 years, these percentages are 26.3% and 7.0% respectively.

Figure 43. Counselling on reproductive options, and advised not to have a child since diagnosis



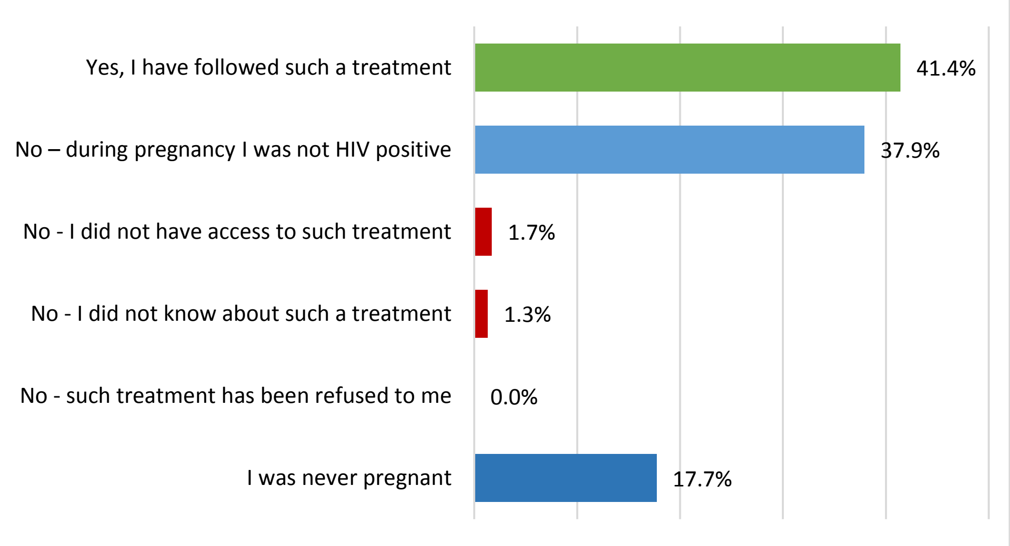
Trends of coercion on the behalf of medical workers on women living with HIV are found as well, regarding pregnancy, birth and feeding of the child in the conditions of living with HIV. Among the interviewed women who were pregnant in the last 12 months, 2.2% claimed to be constrained by medical workers to interrupt their pregnancy, 14.1% of them were subject to some form of coercion in the sense of the decision on the method of giving birth and 7.0% regarding the method of feeding the child.

Figure 44. Women counselling by medical workers in regards to pregnancy, birth and lactation, last 12 months



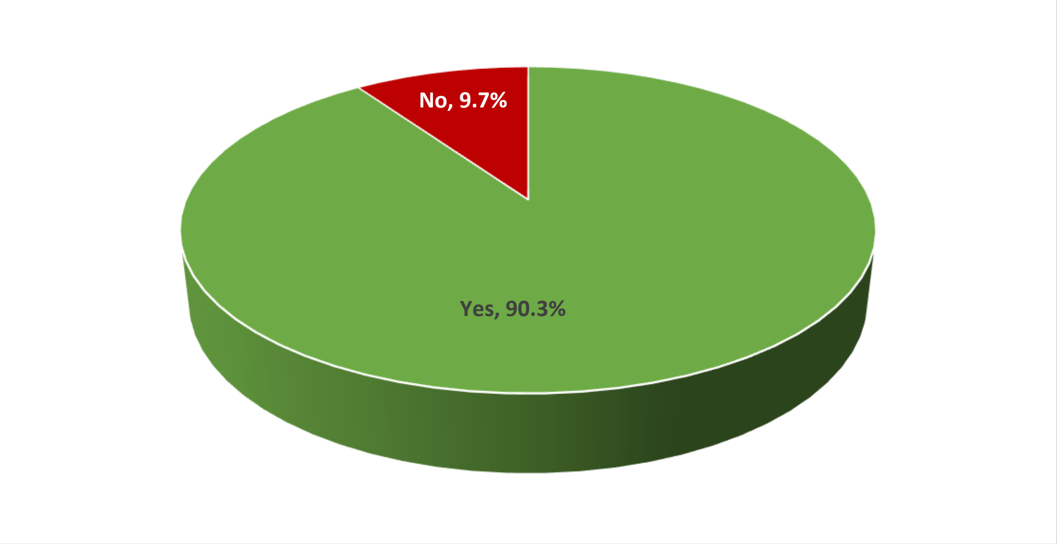
At the same time, a considerable level of access and administration to ARV therapy is reported during pregnancy. Only 3 % of women living with HIV did not benefit from therapy during pregnancy because they had no access or did not know of such treatment at that time.

Figure 45. Access to ARV treatment



Among all women who were pregnant, nine out of ten (90.3%) were informed about healthy pregnancy and maternity as part of the mother-to-child HIV transmission prophylaxis program. In this context, the modest percentage of respondents who claimed that they have ever been consulted about their reproductive possibilities (figure 43) in relation to the indicator from figure 46 implies a very low level of coverage of men living with HIV with information services and counsellors about the birth of children under the conditions of HIV + status.

Figure 46. Counselling in regards to I healthy pregnancy and maternity as part of the program for the prophylaxis of HIV transmission from mother to child



MSM specific to stigma and discrimination

Around 10 % of the PLWHIV sample, carried out on the right bank, are people that belong to the MSM group (n=47). This cannot serve as an indicator of the MSM share among PLWH, because in the design of the sample it was decided to carry out an additional number of interviews in this group in order to provide the possibility of separate analysis of the stigma and discrimination of the persons belonging to both groups (PLWH and MSM). Below we present the issues that differentiate MSM living with HIV from the PLWHIV community in general.

The MSM group, inside the PLWH community, is distinguished by a higher level of study (38.3% with university studies versus 14.3% at the general level) and a much lower level of unemployment (10.6% to 36.0%).

There are a number of types of stigma, the incidence of which among MSM is higher than compared to the rest of the PLWH community.

MSM are more often exposed to gossip (48.9% vs. 35.8% in the PLWH community in general), more often insulted, prosecuted, or verbally threatened (29.8% vs. 16.0%). In cases where the respondent was subject to stigma for reasons other than HIV status, 34.0% was the reason for gender and identity manifestation.

The data also suggest that MSM living with HIV are experiencing sexual resilience more often than other PLWHIVs, 19.0% claim that sexual intercourse for HIV status has been refused over the last 12 months (relative to 6.5% per sample) and 66.0% would have feared that someone would not want to have sex because of the respondent's HIV status (compared to 32.2% per sample).

Conclusions

Characteristics of the targeted group

- The population living with HIV in the Republic of Moldova presents a series of specific characteristics, compared to the general population. Among PLWH, the share of single people is double among those aged 30-49 years. Likewise, the infection has is concentrated in big urban areas. At the same time, PLWH usually have a lower level of education, the share of holders of higher education degrees is twice as low as of the general population.
- More than half of the respondents are unemployed or at least do not have full employment.
- Every sixth person living with HIV has a degree of disability on other diseases than HIV, while the most common diseases associated with the PLWHIV group are viral hepatitis B and C, tuberculosis, neurological problems and cirrhosis.
- Every second PLWH belongs to at least one of the key populations, associated with a higher risk of infection – migrants, PWID, former detainees, MSM.
- PLWH households are significantly smaller than those of the general population, with an average of 2.0 people, compared to 2.9 in the general population.

Experience of stigma and discrimination

- Four out of ten PLWH report experiences of discriminatory treatments in the last 12 months. Most often, these are in the form of gossip and insults.
- Exposure to discriminatory treatments of the PLWH is also aggravated by multiple memberships to risk groups, especially for PWIDs.
- PLWH confront themselves as well with rejection within the couple or even within the PLWH community, as well as overcoming the discrimination caused by their HIV + status over their family members.

Access to work, health and education services

- One out of ten respondents reported that he/she required to change their place of living or faced difficulties to rent a home, and among these cases, 10.7% of them were caused by the respondent's HIV status. Likewise, every tenth respondent lost his or her job or other income sources, of which 5.1% of these cases were caused by their HIV status.
- In total, 6.1% of respondents have reported that during the last 12 months they have faced at least one of the situations of restriction in achieving basic rights, based on their HIV+ status. Women, young people and the unemployed are the categories with a higher incidence of such treatments.

Internal Stigma

- Internal stigma as phenomena is more widespread than social, external stigma. Practically, every PLWH is self-stigmatizing in some form. Most often, this has the form of guilt assignment, feelings of shame, decreased self-esteem, and suicidal tendencies, manifested by 6.6% respondents.
- The forms of internal stigmatization are different in the cases of specific socio-demographic groups. Trends toward suicide manifest the newly diagnosed and the single persons.
- The HIV infection also shapes the self-imposition of restrictions, primarily renouncing marriage and childbirth, sexual intercourse or giving up health services.

Rights, laws and policies

- One out of four PLWH claims to know about the 2016 UN Declaration of Commitment on HIV and more than half have heard about the National Law on prevention and control of HIV/AIDS. However, to have read or discussed them, have claimed only 12.5% and 30.5% respectively.

Association of civic groups of PLWH

- The notoriety level of organizations/ groups of the civil society that offer services for PLWH is a high one, as eight out of ten respondents say that they know where to address for them.
- Every fourth respondent claims to be part of a group/network of PLWH, especially women and elder persons.

Experience of testing, disclosure, treatment and having children

- The circumstances of diagnosis are very varied. Most often, the tests on which the HIV+ status was established were realized at the indication of suspected HIV-associated symptoms, during pregnancy or after the diagnosis with HIV+ status of the partner or household members.
- In the majority of cases, the test, on which the HIV+ status was established, has been done voluntarily, at the respondents' decision. The share of voluntary testing is higher among PLWH whose status was recently established, which implies improvements over time in this chapter. Similar tendencies are found in regards to providing counselling for testing.

Disclosure and confidentiality

- Partners, social workers, other PLWH and adult household members are the people whom the respondents personally communicated their HIV status.
- In total, four out of ten PLWH have experienced that their status has been communicated to someone without their consent. Medical workers, friends/neighbours are the groups among which the HIV status is often communicated by third parties without consent.
- In the case of two-thirds of respondents, their HIV status is kept in complete anonymity.

Health status and treatment

- 14.3% of respondents have described their health status as "poor".
- At the time of the study, 93.4% benefited from ARV therapy, and 93.1% of those who did not benefit claimed they had access to this treatment.
- Only 17.5% of those living with HIV at the time of the survey were undergoing treatment by administering medications for the prophylaxis or treatment of opportunistic, while 71.6% reported having access to these medications even if they were not currently taking it.

Having children

- Seven out of ten respondents have children, while 6.1% have children with HIV+ status.
- A lack of counselling or information services for PLWHIV on reproductive possibilities in conditions of HIV+ status is noted, with only 45.0% of respondents been ever counselled in this sense during their living with HIV.
- There are also cases when medical workers try to impose a decision to give up pregnancy and birth (12.2% were suggested to while 2.3% were even constrained).
- Trends of coercion on the behalf of medical workers on women living with HIV are found as well, regarding pregnancy, birth and feeding of the child in the conditions of living with HIV.

Recommendations

Following the findings of the study, a number of recommendations are required for decision-makers, actors involved in providing services to PLWH, Civic Groups of PLWH, etc.

The incidence of discrimination and stigma against PLWH is actually diminished due to the preservation of HIV + status in secret, which may lead to erroneous perception that PLWH are more often discriminated against by the narrow social circle (partners, close relatives, PLWH community) than by the broader society.

Policies for the protection and realization of PLWH rights must take into account the complexity of PLWH vulnerability to stigma and discrimination, in addition to the HIV status. PLWH, as compared to the general population report:

- a much higher level of unemployment,
- incapacity to work due to disability,
- lower level of education and professional training,
- to belong to key populations associated with increased risk of discrimination such as MSM, PWID, former detainees.

The most serious consequences of self-stigma, such as suicide, occur in the immediate aftermath of diagnosis, which must be considered in the post-test assistance.

Although there are positive trends in eliminating testing without the consent of a person, the determination of PLWH to abandon pregnancy or their determination to refrain from the birth of a child remains to be addressed seriously and efforts should be made to combat such approaches, by medical professionals.

HIV + status is strongly associated with childbirth-giving renouncing tendencies, self-imposed by PLWH. In this regard, efforts are needed to inform PLWH about the birth of a healthy child in HIV + status, as well as providing assistance / support, especially during pregnancy.

Although the study has found a high level of notoriety and involvement of PLWH in the work of associative groups of PLWH, there is a reasonable suspicion that these levels are over-estimated, taking into account the data collection mechanism. In this context, militant civil society organizations to ensure the rights of PLWH and social services in the field must continue to work towards widening the circle of beneficiaries.

Specific recommendations:

Government

- Strengthen the legal framework that protects the rights of people living with HIV and specifically address stigma and discrimination related to HIV.

- Strengthen active participation of people living with HIV in the development of laws, policies and community service and support.

- Supporting the growth and mobilization of widespread social and community consciousness as part of efforts to eradicate stigma and discrimination of people living with HIV and key populations, including by educating and removing HIV-related myths and stereotypes.

- Prioritize stigma and reduce HIV and key populations-related discrimination in national planning, funding, and programs, including support for increased implementation of these programs.

- Framing of HIV-related stigma and discrimination indicators as part of national HIV / AIDS monitoring and evaluation systems to monitor and assess progress over time.

National Program for Prevention and Control of HIV / AIDS and STIs

- Given that there is a low but consistent level of denial of the rights of people living with HIV in the health system, it is necessary to:
  - review and continuously adapt pre and in-service training curricula to enhance the capacity of health service providers to offer tolerant and non-discriminatory services to people living with HIV;
  - revise and update, where necessary, the protocols to ensure that they are rights-based and include initial training for health workers as well as training courses for healthcare providers, managers and staff from other health facilities;
  - strengthen surveillance mechanisms to promote non-judicial / tolerant and non-discriminatory practices towards people living with HIV.

- Considering that there is a certain level of denial of the sexual and reproductive rights of people living with HIV and especially a high level of self-limiting of PLWH to this end, coherent information actions and appropriate options for sexual and reproductive health are needed for people living with HIV.
- Supporting links between sexual and reproductive and HIV rights, including integrating these services into HIV programs.
- Supporting the active participation of people living with HIV in the elaboration of laws, policies in the delivery of community services and support.
- Increasing the capacity of support groups and other local organizations to provide adequate counselling and other support for people living with HIV and key populations.

UN agencies and development partners Moldova

- Dissemination of the results of this study to the Government, the National Program on Prevention and Control of HIV / AIDS and STIs, Civil Society and Donors.

- Advocating for the rights of all people living with HIV, including key populations, and supporting / challenging violations of rights.

- Provide support to:

- educational activities with people living with HIV on health, dignity and prevention.

- encourage and strengthen the capacity of people living with HIV to be actively involved in the development and implementation of projects and programs to combat stigma and discrimination and to provide support and assistance to people living with HIV individually and through support groups and other local organizations.

- advocating for the inclusion of people living with HIV in policy-making bodies and in drafting relevant legislation.

- Support into increasing the capacities of support groups and other local organizations to provide adequate counselling and other support for people living with HIV, including key populations, especially drug users, current or former prisoners, men who have sex with men etc.

Civil society organizations

- Advocating for the rights of all people living with HIV, including key populations.
- Increasing the capacity of support groups and other local organizations to provide adequate counselling and other support for people living with HIV and key populations.
- Support active participation of people living with HIV in the development of laws, policies and guidelines; and in the provision of community-based services and support.
- Enhancing the coverage of the HIV-living population of supported programs and services.