2024

People Living with HIV Stigma Index 2.0

Country of Georgia

Study report

2024

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Key Terms and Concepts

Consent	Voluntary agreement or permission.
Discrimination	Discrimination involves treating someone in a different and unjust, unfair or prejudicial manner, often on the basis of their belonging, or being perceived to belong, to a particular group. It is often viewed as the end result of the process of stigmatization.
Informed consent	Voluntary agreement or permission that is given with full knowledge of what is involved (e.g. risks and benefits).
Internalized stigma	The way a person living with HIV feels about themselves and specifically if they feel a sense of shame about being HIV-positive. Internalized stigma can lead to low self-esteem, a sense of worthlessness and depression. It can also result in a person living with HIV withdrawing from social and intimate contact, or excluding themselves from accessing services and opportunities out of a fear of having their status revealed or being discriminated against because of their HIV-positive status.
HIV support group	A group of HIV-positive people who meet to give each other support, given that they share a common experience. The group may also be involved in HIV-related advocacy work.
Key Populations	Key populations are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV.
Law/legislation	A set of rules or norms of conduct which define how people must behave. Law is normally administered through a system of courts, in which lawyers argue cases before judges.
MSM	This is a term that refers to the behavior of men who have sex with other men.
Sex worker	The term sex worker is used to describe a person who engages in sexual activity for payment.
Shame	A feeling of dishonor, disgrace, or condemnation. To be ashamed of oneself refers to one having this feeling of shame.
Stigma index	The People Living with HIV (PLHIV) Stigma Index is a community-led study using a standardized tool to gather evidence on how stigma and discrimination impact the lives of people living with HIV. The PLHIV Stigma Index was developed to be used by and for people living with HIV and was created to reflect and support their greater involvement. PLHIV networks are empowered to lead the whole implementation of the PLHIV Stigma Index study.
Stigma	Rooted in the historical practice of branding morally flawed individuals, is a mark of disgrace that devalues and discredits a person. In the context of HIV, stigma often compounds existing biases related to gender, sexuality, and race. This stigma disproportionately affects individuals engaging in marginalized behaviors, such as sex work or drug use. It not only impacts those with HIV but also extends to their associates, perpetuating discrimination within households and communities.
Transgender	Transgender is an umbrella term to refer to people whose gender identity differs from the sex they were assigned at birth.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AIDS Center	Infectious Diseases, AIDS and Clinical Immunology Research Center in Georgia
ART	Antiretroviral Treatment
BBSS	Bio-Behavior Surveillance Studies
HCV	Hepatitis C virus
HIV	Human Immunodeficiency virus
KPs	Key populations
LCR	Limited Chain Referral
MNP	Minimum Number of People
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organization
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RPRV	Real People Real Vision
STI	Sexually transmitted infections
SW	Sex Workers
TB	Tuberculosis
TG	Transgender People
VBS	Venue-Based Sampling
WSW	Women Who Have Sex with Women

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Executive Summary

Background: The global HIV landscape remains a significant public health challenge, with an estimated 39.0 million people living with HIV by the end of 2022. Despite global efforts and UNAIDS' ambitious 95-95-95 targets, Eastern Europe and Central Asia are experiencing a concerning trend of rising HIV infections and AIDS-related deaths. In this region, key populations (KPs) and their sexual partners account for the majority of new infections, and the data reveals that only 62% of people living with HIV knew their status in 2022. Georgia, although categorized as a low HIV prevalence country, faces concentrated epidemics among MSM, TG, and PWID, with evidence of ongoing transmission and late diagnoses.

In Georgia, despite advancements in HIV service delivery transitioning towards a people-centered and integrated approach, HIV-associated stigma and discrimination persist as formidable barriers to the effective management of the epidemic. This includes discrimination in healthcare and workplace settings, internalized stigma, stigma within families and communities, and its detrimental impact on individual's willingness to get tested and adhere to antiretroviral treatment. Notably, the absence of comprehensive studies on HIV-related stigma in Georgia underscores a critical knowledge gap. Existing qualitative research highlights negative attitudes towards PLHIV, especially among KPs, revealing a potential intersectional stigma due to their multiple risk behaviors. The PLHIV Stigma Index 2.0 study, a pioneering initiative, was conducted in Georgia to systematically assess and address the diverse dimensions of stigma and discrimination affecting PLHIV. The findings from this study serve as a foundational resource for evidence-based advocacy, policy formulation, and the development of comprehensive programs to dismantle HIV-related stigma and discrimination in the country, ultimately contributing to the enhanced success of HIV prevention, treatment, care, and support initiatives.

Aim and Objectives: The primary goal of the study was to assess and comprehend the extent and characteristics of stigma and discrimination encountered by PLHIV including those from KPs in Georgia. Specific objectives included gathering information on the experiences of PLHIV with HIV-related stigma and discrimination in diverse settings such as the workplace, healthcare facilities, and within families, while considering the local cultural context. Additionally, the study aimed **to** examine the factors influencing access to HIV testing, treatment, and related services. Another objective was to establish a baseline for HIV-related stigma, facilitating comparisons over time and across different countries. Ultimately, the study sought to provide an empirical foundation to inform policy and advocacy recommendations geared towards reducing HIV-related stigma and discrimination in the region.

Methodology: The study employed a cross-sectional design based on the standardized PLHIV Stigma Index 2.0 methodology, adapting it to the local context and available resources in Georgia. Implemented by the PLHIV community-based organization "Real People Real Vision", the study prioritized the inclusion of PLHIV from diverse groups, with a steering committee comprising community representatives ensuring effective implementation. Using a venue-based sampling approach for 75% of the sample and a limited chain referral sampling approach for the remaining 25%, the study recruited PLHIV, including those from key populations, from institutions like the Infectious Diseases, AIDS and Clinical Immunology Research Center, and NGOs providing HIV prevention services. The sampling strategy defined a total of 750 participants, considering the gender distribution reflective of the national HIV prevalence and accounting for refusal rates. Ethical considerations were paramount, with approval from the National Center for Disease Control and Public Health of Georgia IRB, and informed consent and confidentiality measures were rigorously maintained. The data collection tool was the People Living with HIV Stigma Index 2.0

questionnaire, covering multiple dimensions such as disclosure, experiences of stigma and discrimination, interaction with health authorities, human rights, and personal experiences.

Results: The main characteristics of the respondents: the demographic characteristics of the study participants, encompassing age and gender, align closely with the profile of people living with HIV (PLHIV) in Georgia. This alignment underscores the adherence to predefined quotas during the respondent recruitment process, affirming the representativeness of the collected data for PLHIV aged 18 and older. With a robust sample size of 753 PLHIV (500 (67.3%) male and 243 (32.7%) female; 10 participants did not answer question about sex assigned at birth), the study aimed for inclusivity by ensuring the participation of diverse key populations, including 25.4% (n=191) people who use drugs (PWUD), 14.7% (n=111) sex workers (SW), 8.6% (n=65) men who have sex with men (MSM), and 4.1% (n=31) transgender individuals (TG). Notably, 10.5% of all key populations exhibited intersecting representation, navigating dual or multiple stigmas. Examining socioeconomic aspects, a substantial proportion of the surveyed PLHIV fell within the 30-49 age range, predominantly holding secondary or vocational education. Employment challenges persisted, with over a third of PLHIV reporting unemployment. Alarmingly, despite employment, nearly 80% of the participants faced difficulties meeting their basic needs consistently throughout the 12 months preceding the survey.

Approximately a quarter of participants indicated that no one in their social environment was aware of their HIV status, revealing a substantial prevalence of nondisclosure. Unauthorized disclosures were more prevalent when shared with different groups outside their immediate circles. Additionally, the majority of respondents reported positive experiences when disclosing to close individuals, however, over half stated negative experiences when sharing their status with unfamiliar individuals. A noteworthy finding is that disclosing HIV status did not become easier over time for more than half of the participants.

Key findings indicate that over 80% of respondents reported not encountering stigma or discrimination due to their HIV status. However, concerning experiences included discriminatory remarks or gossip from both family members (9.9%) and others (14.2%); 7.1% of respondents faced verbal abuse related to their HIV status, with 3.1% indicating discrimination against their spouse/partner/child. Overall, 5.4% of participants reported such experiences in the last 12 months, and 19.8% reported incidents beyond that timeframe.

In terms of internalized stigma, a significant majority of participants expressed difficulty related to telling (91.2%) and hiding (87.1%) their HIV status. Self-discriminatory decisions, ranging from 5.0% to 13.2%, were reported, with the highest proportion (13.2%) linked to avoiding seeking medical care. Notably, 23.0% of participants engaged in at least one self-discriminatory action in the last 12 months.

Among respondents, 30.7% reported being tested without their knowledge and discovering the results afterward, while only 1.7% indicated being forced into an HIV test without consent. Nearly 80% mentioned a testing interval of six months or less from considering it, while 10.1% delayed testing for six months or more. Treatment initiation varied, with 12.3% starting on the same day of diagnosis, 45.8% within a month, and 6.2% delaying for over two years. A substantial majority (96.0%) were currently on or had received antiretroviral therapy. Stigma and discrimination were more prevalent at non-HIV facilities (31.2%) compared to HIV treatment institutions (10.4%). Notably, stigma and discrimination linked to belonging to a specific key population group were more pronounced.

Conclusions: The Stigma Index 2.0 study in Georgia underscores a notable prevalence of internalized stigma among PLHIV, contributing to frequent non-disclosure of their status. Furthermore, there is a substantial burden of intersectional stigma and discrimination faced by PLHIV who simultaneously belong to key population groups. These study findings should be regarded as a baseline for understanding the current landscape of stigma and discrimination, providing a foundation for future comparisons.

Recommendations: The study's findings suggest a set of recommendations aimed at addressing and overcoming the challenges of stigma and discrimination in Georgia: **Access to Healthcare:** To foster a stigma-free healthcare environment, healthcare professionals should undergo training with a gender-conscious and inter-seasonal approach, promoting non-judgmental care. A qualitative study on barriers to HIV treatment uptake among key affected groups is recommended. Additionally, awareness campaigns within healthcare settings and the strengthening of community-based centers providing HIV services are essential. **Internalized Stigma:** Addressing internalized stigma, especially within key populations, requires targeted interventions and the implementation of mental health support programs. National media campaigns combating stigma are recommended. **Access to Justice:** Removing discriminatory articles in the Law on HIV/AIDS is crucial, alongside establishing legal education programs for PLHIV. Strengthening mechanisms to address human rights violations and creating a supportive legal environment is essential. In addition, it is recommended focusing on police training on HIV-related issues. **Capacity Building and Stakeholder Engagement:** Collaboration between government agencies, NGOs, and community-based organizations is vital to create comprehensive support systems. Engaging educational institutions in shaping attitudes through HIV awareness programs and collaborating with media outlets for responsible reporting is recommended. **Disclosure Concerns:** Strategies supporting HIV status disclosure, community-based workshops, and peer support programs are crucial. Providing family and partner counseling services can facilitate open and supportive discussions around HIV status disclosure within intimate relationships. **Develop an Advocacy Plan:** Collaboratively formulating and executing an advocacy strategy is recommended, emphasizing the leadership of PLHIV throughout the process. Advocating for gender-transformative programs, shelters/social houses, and minimizing restrictions on private health insurance is crucial. **Use Collected Data for Further Study:** Continuous monitoring and evaluation of interventions using collected data, further research on stigma intersectionality, and sharing study findings with policymakers and healthcare professionals are essential for evidence-based interventions and policies.

1. Introduction

1.1. Overview of HIV Epidemics (global, regional, and country facts)

Globally, there were an estimated 39.0 million [33.1 million–45.7 million] people living with human immunodeficiency virus (HIV) at the end of 2022, out of which 1.3 million [1 million–1.7 million] became newly infected and 630 000 [480 000–880 000] people died from HIV-related causes in 2022[1]. In 2022, globally, the median HIV prevalence among adults aged 15 to 49 was 0.7%, however, it was higher among key populations [KPs] (2.5% among sex workers, 7.7% among gay men and other men who have sex with men (MSM), 5.0% among people who inject drugs (PWID), 10.3% among transgender people (TG) and 1.4% among people in prisons)[2]. UNAIDS sets 95-95-95 targets for the global response to HIV (95% of people living with HIV (PLHIV) know their status, 95% of diagnosed PLHIV are on treatment and 95% of PLHIV on treatment achieve an undetectable viral load by 2025). In 2022, at the global level, 86% [73–98%] of people living with HIV knew their HIV status, 76% [65 – 89%] were accessing antiretroviral therapy, and 71% [60 – 83%] of were virally suppressed[3].

Data for Eastern Europe and Central Asia (EECA) indicates that the region is failing to control its HIV epidemic, with new HIV infections and AIDS-related deaths both continuing to rise. The annual number of new HIV infections increased by an estimated 49% and AIDS related deaths increased by 46% from 2010 to 2022[4]. KPs and their sexual partners accounted for virtually all new infections in the region[5]. Overall, 62% [56–68%] of people living with HIV knew their HIV status, 51% [46–56%] were receiving antiretroviral therapy, and 48% [43–53%] were virally suppressed in EECA region 2022[6].

Georgia remains a low HIV prevalence country with concentrated epidemics in KPs, mainly among MSM, TG and PWID. Despite low HIV prevalence (0.3%) in the general population and signs of a decreasing trend of new HIV diagnoses, evidence of high HIV levels in MSM and TG people, rates of recent HIV transmission in the MSM population and young population indicate ongoing transmission and risk of potential worsening of the HIV epidemic in KPs and their sexual partners[7,8]. Even though KPs constitute small proportion of Georgian population, they face increased risks of acquiring HIV infection, partly due to discrimination and social exclusion. Late diagnosis remains a significant challenge in Georgia with 55% of newly diagnosed HIV cases presented with CD4 levels of less than 200 and 34% with less than 350 in 2021[9]. Widespread stigma and discrimination towards PLHIV and KPs could be among the reasons for late presentation. In 2022, at the country level, 84% [78 – 89%] of people living with HIV knew their HIV status, 72% [67 – 76%] were accessing antiretroviral therapy, and 66% [61 – 70%] of were virally suppressed[10]. Existing data shows that the gap in HIV testing is even considerably higher among KPs - e.g., only 17% of MSM living with HIV were diagnosed in 2018[11]. The latter could also be attributed to intersectional stigma towards HIV and KPs, which is obviously common in the country.

As of July 12, 2023, a total of 10,104 HIV/AIDS cases have been registered in the Infectious Diseases, AIDS & Clinical Immunology Research Center, including 7,548 (75%) men and 2,556 (25%) women; most patients were within the age group of 29-40; 4,985 patients developed AIDS and 2,156 patients have died[12].

In Georgia, HIV is mainly concentrated among MSM and TG. Bio-Behavior Surveillance Studies (BBSS) conducted in different years (excluding TG) show that HIV prevalence among KPs is higher compared to the general population (Table 1).

Table 1. HIV prevalence among KPs, BBSS data, %

KP	HIV Prevalence (%)				
City				2021	2022
PWID (All)	2.2	2.2	2.3	N/A	0.9
Tbilisi	1.9	2	1.2	N/A	0.5
Batumi	2.9	4.4	5.1	N/A	1.1
Zugdidi	5.6	4.8	1.8	N/A	2.5
Telavi	0.4	1.2	2	N/A	0.7
Kutaisi	2.3	2.6	3.3	N/A	0
Gori	1.1	2.4	3.4	N/A	1.5
Rustavi	N/A	0.9	0.9	N/A	0.4
MSM (All)	20.7	N/A	N/A	N/A	N/A
Tbilisi	N/A	25.1	21.5	N/A	N/A
Batumi	N/A	22.3	15.6	N/A	N/A
Kutaisi	N/A	N/A	9.6	N/A	N/A
SW	0.7	N/A	N/A	N/A	N/A
Tbilisi	0.6	0.6	1.5	N/A	N/A
Batumi	0.8	0.8	0	N/A	N/A
Transgender	N/A	N/A	N/A	23.8[13]	N/A

1.2. HIV Stigma and Discrimination

HIV stigma is negative attitudes and beliefs about PLHIV, while discrimination is the behavior that result from those attitudes or beliefs[14]. Despite decades of scientific advances in prevention and treatment, as well as widespread awareness-raising efforts, irrational fears of HIV infection and negative attitudes towards PLHIV are a persistent barrier to addressing the epidemic[15]. PLHIV and KPs are often subject to discrimination in healthcare, workplace, and other settings.

The growing body of literature suggests that stigma and discrimination in healthcare settings are widespread across the world, and it deters many members of KPs from learning their HIV status or accessing life-saving prevention and treatment services[16]. HIV stigma and discrimination in workplace settings are also common, reflected in high rates of insecure employment, unemployment and lack of career advancement opportunities among PLHIV, as well as discriminatory attitudes from employers and coworkers, etc.[17,18] In addition, PLHIV often face internalized stigma and isolation within their own families and communities due to negative judgment and rejection.[19] As a result of stigma and discrimination people often refuse to get tested for HIV, have denied access to HIV prevention and treatment services and their ability to stay adherent to antiretroviral treatment (ART) gets affected.

In Georgia, the organization of HIV service delivery has evolved from a vertical system inherited from the Soviet era to a more people-centered and integrated approach over the past decade. The National Centre for Disease Control and Public Health (NCDC) manages vertical state programs for HIV, collaborating closely with the National AIDS Centre, and acting as the principal recipient of Global Fund programs. The Georgia HIV/AIDS National Strategic Plans, renewed every three years (with the latest covering 2023-2025), guide the national response, ensuring alignment with other national programs and global policies. State-supported HIV programs include surveillance, testing, treatment, in-patient care, and psychosocial support, while NGO-led prevention and harm-reduction programs, largely funded by external donors like the Global Fund, target key populations.

HIV-associated stigma and discrimination scale study has never been conducted in Georgia. Published data on causes and degrees of stigma and discrimination in Georgia are also limited. Qualitative study conducted in 2020 among Georgian youth revealed that expectation of negative attitude towards PLHIV and the stigma associated with HIV was one of the main barriers to the uptake of HIV testing.[20] Another qualitative research conducted in 2020 attempted to identify barriers of the healthcare system from the perspective of service recipient KPs and from the perspective of service providers. The latter mostly stated, "there are no barriers in the system", claiming that medical institutions they represent are free from stigma, however KPs described medical providers as indifferent and unethical.[21] Since KPs in Georgia are at a considerably higher risk for HIV infection, have significantly lower access to health services, face human rights violations, social and economic marginalization and criminalization, they might be subject to intersectional stigma and discrimination (due to intersectionality that they are often members of more than one KP group).

Georgia's response to HIV reflects a historical evolution from a vertical system inherited from the Soviet era to a contemporary, integrated, and people-centric approach. Over the last decade, the government has prioritized decentralization and comprehensive service delivery for HIV, TB, and viral hepatitis. Integration efforts have strengthened at both policy and service levels, evidenced by joint screening initiatives and coordinated management of HIV/TB coinfection. The National Centre for Disease Control plays a pivotal role, managing vertical programs and collaborating closely with the National AIDS Centre and the National TB Program. Current state-supported HIV programs encompass surveillance, testing, treatment, and support, while NGOs, reliant on external donors, enhance prevention and harm-reduction services, particularly for key populations. The nation's response, guided by strategic plans (the latest for the period of 2023-2025), reflects a commitment to integration, decentralization, and the continual improvement of services to combat HIV effectively. Although it should be noted that current HIV programs are weak at addressing HIV-related stigma and provide only fragmented interventions to support PLHIV and their families to deal with stigma and discrimination and strengthen the PLHIV communities. Research activities on HIV-related stigma are also scarce in Georgia resulting in gaps to inform evidence-based advocacy, policy, and programs/interventions development.

The PLHIV Stigma Index 2.0 is the only existing research and action initiative led by and for PLHIV that leverages a standardized questionnaire and methodology to gather evidence on stigma and discrimination affecting people living with HIV. The PLHIV Stigma Index monitors HIV-related stigma and discrimination in different life settings, with particular attention given to related stigmas affecting diverse populations of PLHIV including those from the key populations and provides evidence for advocacy to address key barriers to HIV-related treatment, prevention, care and support. Thus, it was relevant to conduct the PLHIV Stigma Index 2.0 study in Georgia, which was the first attempt to document how stigma and discrimination impact the lives of PLHIV, generate evidence for advocacy and stimulate policy and programmatic change to end HIV related stigma and discrimination in the country.

2. Aim and Objectives

The overall aim of the study was to identify the magnitude and nature of stigma and discrimination faced by PLHIV including those from KPs and develop policy and advocacy recommendations for reducing HIV-related stigma and discrimination in Georgia. The study had the following specific objectives:

- To collect information on HIV-related stigma and discrimination faced by PLHIV in different settings (workplace, healthcare, family and others) considering local cultural context;
- To study the factors affecting access to HIV testing, treatment and other services;
- To provide a baseline of HIV-related stigma – for comparison across time and across countries, and
- To provide an evidence basis for policies and programs change.

3. Methodology

The study was based on the PLHIV Stigma Index 2.0 standardized methodology and took into consideration the country context and available resources. It is important to note that the PLHIV Stigma Index research has been designed and is implemented specifically by and for PLHIV, thus the main implementer was the PLHIV community-based organization in Georgia – "Real People Real Vision" (RPRV), represented by PLHIV of both genders. Furthermore, a steering committee comprised of various community representatives was formed with the goal of ensuring that the study was properly implemented, and the information gained was used to advocate for improved policies, programs, and practices.

3.1. Study design

Cross-sectional study design was used for the research. The quantitative data was collected through interviewing PLHIV using the standardized PLHIV Stigma Index 2.0 questionnaire.

3.2. Study Participants

The population of the study was PLHIV, including PLHIV with a key population background (PWUD, SW, MSM, and transgender people living with HIV). Study participants were recruited from two main types of institutions: the Infectious Diseases, AIDS and Clinical Immunology Research Center in Georgia (AIDS Center) and NGOs providing HIV prevention services to KPs in selected regions of Georgia.

The selection criteria included:

- Age 18 or above;
- Had known that they were living with HIV for at least 12 months;
- Was mentally sound and capable of providing consent to participate;
- Provided signed informed consent to participate in the study and understand all elements of the study;
- Spoke Georgian language.

Exclusion criteria included:

- Independently not understanding questions in Georgian;
- Physical and/or mental disabilities affecting their participation in the study (difficulties to understand the questions and respond and other limitations)- a person with neurological and / or mental illnesses that limit communication with the interviewer;
- A person who refused to sign an informed consent to participate in the study;

- Representative of KPs not living with HIV;
- PLHIV who had already participated in the study.

3.3. Sampling

1. Number of participants

Based on the latest estimate data (Spectrum 2021, UNAIDS) the number of PLHIV in Georgia is 8,500.

The total number of participants planned for this study was **750 PLHIV** (around 25% would be women, consistent with the overall gender ratio of PLHIV in the country). For defining the study sample size, we used the sample size calculator developed for the People Living with HIV Stigma Index 2.0. The latter used the following parameters: (1) Estimated prevalence of avoidance of healthcare by PLHIV and (2) Target precision. Since there was no such data available on the estimated prevalence of avoidance of healthcare by PLHIV in Georgia, as recommended in the guidance note of the online calculator, we used the average of available regional estimate of 13% (22.65% in Tajikistan, 10% in Kazakhstan, 9% in Lithuania, 12% in Ukraine and 11.1% in Moldova). Taking a target precision of 5% and confidence level of 95% and using PLHIV Stigma Index calculator: https://hall.shinyapps.io/PLHIV_Stigma_Sample_Size_Calculator/ we calculated the minimum number of people (MNP) (n=696) for the study. Considering our previous studies conducted among HIV key populations in Georgia where refusal rate was no more than 10%, we added those who might refuse to participate to the MNP (n=696) and got a planned sample size of 750 participants.

2. Distribution of the sample of study participants by regions of Georgia

To select the regions for the study, we first looked at the available data on geographical distribution of PLHIV registered at the AIDS center and receiving treatment by the end of 2021 (Table 2).

Table 2. Number of PLHIV by geographic area in 2021, n, %

Year		Tbilisi	AR Adjara (Baumi)	Imereti (Kutaisi)	Samegrelo-Zemo Svaneti (Zugdidi)	Abkhazia (Sokhumi)	Total
2021	N	3661	634	423	398	630	5746
	%	63.7%	11.0%	7.4%	6.9%	11.0%	100%

Source: AIDS Centre, 2022

To cover both east and west parts of the country and include the regions with the highest, mid-level and lowest HIV prevalence, we selected all above-mentioned regions, including the capital but with exemption of the Autonomous Republic of Abkhazia (occupied region). We used the regions as subnational administrative units (SNUs) for the sampling plan. Total of 5116 registered cases come from these regions and account for almost 61% of estimated number of PLHIV in Georgia. The survey was conducted in 4 regions of Georgia and the numbers of participants were proportionally distributed according to the proportion of registered PLHIV in a particular region (Table 3).

Table 3. Distribution of the sample of study participants by regions of Georgia, n, %

Subnational Administrative Unit (SNU)	Total # of PLHIV registered	% of PLHIV out of total number registered in selected SNUs	Allocated Sample Size for selected SNU
Tbilisi	3661	72%	540
Samegrelo-Zemo Svaneti	398	8%	60
Adjara	634	13%	98
Imereti	423	7%	52
Total	5116	100%	750

The selection of participants for the study was carried out in two ways: Venue-based sampling (VBS) and Limited chain referral (LCR) sampling approaches. With the VBS, it was planned to recruit about 75% of the total sample and the remaining 25% were selected through LCR.

For VBS, participants were first stratified by gender and then randomly selected from the PLHIV database at AIDS Center (the gender distribution corresponded to the HIV prevalence in the country (75% men and 25% women). As for the PLHIV from KP groups (at least 25% of the entire sample), they were recruited through LCR at NGOs/CBOs delivering HIV prevention services to KPs in the selected regions. The regions and the number of participants for the study were determined and agreed upon in consultation with representatives of the respective communities (Table 4).

Table 4. Distribution of the sample of participants by the method of selection of respondents, including key population groups by regions

Regions	Number of study participants	Selection methods				
			LCR			
		VBS	PWUD	SW	MSM	Transgender people
Tbilisi	540	438	29	24	29	20
Samegrelo-Zemo Svaneti	60	32	9	9	10	0
Adjara	98	73	5	5	10	5
Imereti	52	24	9	9	10	0
Total	**750**	**567**	**52**	**47**	**59**	**25**

It should be noted that over the course of the study, the sample distribution was checked regularly, and adjustments made to ensure all groups were well represented in the final sample.

3.4. Data Collection

3.4.1. Recruitment of Study Participants

In the case of **VBS approach** (75% of the entire sample) participants were randomly selected from the electronic database of PLHIV at AIDS center. A designated staff from the AIDS center (recruiter) was trained in selecting the participants for the study. The entire database was stratified according to the gender and then participants were randomly selected from each stratum. Inclusion and exclusion criteria were considered accordingly. The recruiter then contacted each participant, explained the aim and objectives of the study and after obtaining oral consent ensured their contact with interviews. Interviewers then contacted potential participants (based on the pre-agreement obtained by recruiter), together selected, and agreed on the venue, date and time for the meeting and conducted face-to-face interview accordingly.

Recruitment of participants through **LCR approach** (25% of the entire sample) took place at NGO/CBO partner organizations working with KPs and was applied to recruit PLHIV from key populations. At the first stage, NGOs/CBOs invited beneficiaries from among people living with HIV to participate in the study, then they invited people living with HIV from their community to participate in the study. PLHIV who participated in the study received three coupons and were asked to share them with people they knew were living with HIV and who were expected to be available for interviews during the study period. Coupons included the phone number of the Field Study Coordinator and the coupon identification number but did not list the selection criteria or purpose of the study. If interested, the potential participants reached out to the study coordinator, who then checked the eligibility criteria of these potential participants and decided on their inclusion in the study.

3.4.2. Data Collection Tool

The People Living with HIV Stigma Index 2.0 standard questionnaire was the main tool for collecting data for this study. The questionnaire consisted of eight sections devoted to the following questions:

1. Section A: About You - Questions about the respondent and their family.
2. Section B: Disclosure of Status - Questions about the respondent's experience with disclosing their HIV status.
3. Section C: Your Experience of Stigma and Discrimination - Questions about the respondent's experience with stigma and discrimination related to their HIV status.
4. Section D: Subjective stigma and resilience - Questions about how respondents feel about themselves in relation to their HIV status.
5. Section E: Interaction with health authorities - Questions about the respondent's experience with health services and the associated stigma and discrimination based on their HIV status. Questions include: HIV testing, care and treatment; general health; experience in receiving services; sexual and reproductive health.
6. Section F: Human Rights and Implementation of Change - Questions about the respondent's experience with human rights violations related to their HIV status.
7. Section G: Stigma and Discrimination for Non-HIV Reasons - Questions about stigma and discrimination of the respondent related to reasons other than HIV status. This includes items on the following topics:
    a. Men who have sex with men, gay / homosexual
    b. Transgender people.
    c. People who have (had) sex in exchange for money or goods, or who identify as sex workers.
    d. People who (have) use(d) drugs
8. Section H: Personal Experiences of Stigma / Discrimination.

This study used a paper-based questionnaire for data collection.

3.4.3. Interviewing

The study team ensured arrangements for suitable venue (ensuring social distancing considering the COVID-19 epidemiological situation in the country, ensuring the respondents felt comfortable, safe, non-stigmatized and non-judgmental, ensuring privacy, without interruptions or disturbances during the process of the interview) in which the interviews were conducted.

The interviewers selected for the study were people living with HIV who received appropriate training to conduct interviews with people living with HIV, including people living with HIV from key populations. Overall, 15 interviewers (10 from regions and 5 from Tbilisi) were trained in data collection during the intensive three-day face-to-face training. The interviewers were diverse in gender, age, and key population groups.

4. Ethical Considerations

Ethical Review Board: The study protocol for this research underwent review and was approved on October 25, 2022, by the National Center for Disease Control and Public Health of Georgia IRB (certificate IRB0000215).

Process for obtaining Informed consent: Participants were provided with information about the research aim and study procedures and had the opportunity to ask questions as part of the informed consent process. Interviewers used the standard information sheet (Annex 1) to guide the explanation process. In addition, the participants were informed that at any time during the interview they had the right to refuse to fill in a particular question or set of questions or to quit the interview. All respondents were informed that their participation was voluntary and that their responses would remain confidential. No individual data was identified during data analysis or reporting. Study results present aggregated data and do not contain any directly or indirectly identifiable information on study participants. Participants were also assured that their participation or refusal to participate would in no way affect the services they received. Informed consent (Annex 2) was obtained from all research participants.

Confidentiality: Study team ensured that the data collected under this study was kept confidential through the following arrangements: (1) a staff confidentiality agreement (Annex 3) was obtained from all personnel participating in the study ; (2) interviewers and data entry specialist were trained and pledged that any information provided by the participants would not be discussed with others outside of the study team; (3) records were identified by Study ID, not Participant ID; (4) questionnaires and informed consent forms were identified using a unique identifier; (5) participants were interviewed in private interview rooms; (6) no individual participant was identified during data analysis or reporting; (7) the completed paper-based questionnaires were securely stored in a locked file cabinet at the RPRV office.

5. Data Analysis

Descriptive statistics and stratified analyses were conducted based on the entire sample of PLHIV as well as PLHIV among KPs (by number of years living with the HIV status, gender, age and key population group). A limited number of participants identified as belonging to the groups of women who have sex with women and bisexual individuals. Due to the relatively small representation within the sample, these groups were not subjected to separate analysis and, consequently, are not featured in Section 7 of the report. The study used descriptive statistics to understand the characteristics of participants. All analyses were performed using the SAS statistical software.

6. Results

Despite initially aiming for a targeted number of 750 participants, the interviewers reached and interviewed 765 individuals for this study. One of the inclusion criteria for study participation was knowing HIV status for at least 12 months. There were 12 participants who indicated that they knew their status for less than 1 year, thus they were excluded from the analysis. Overall, 753 participants were included in the final analysis. Table 5 below presents the distribution of completed questionnaires by SNU.

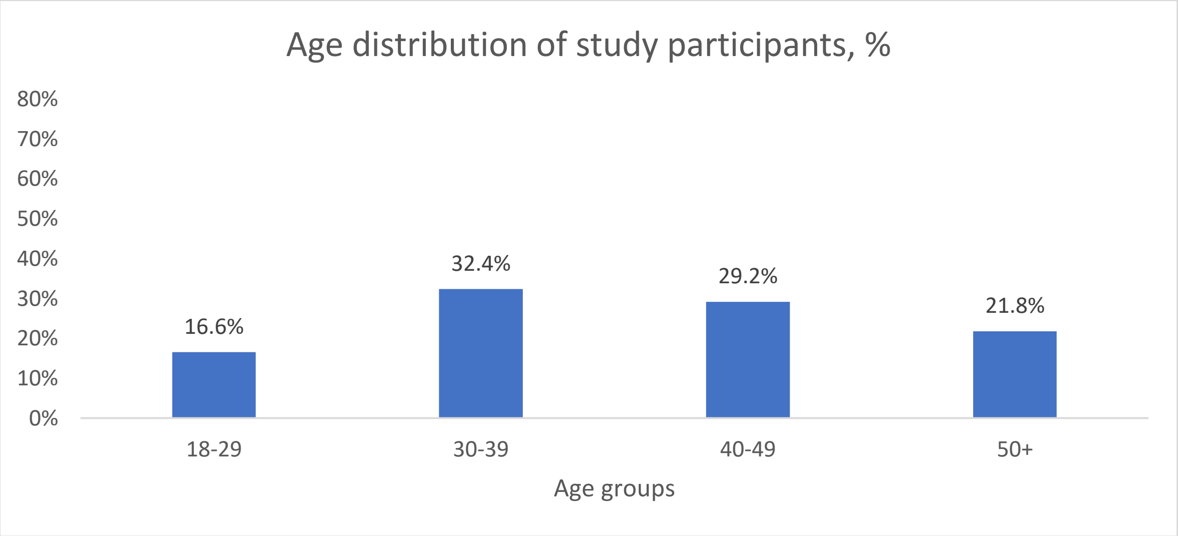
Table 5. Distribution of completed questionnaire by Subnational Administrative Units (SNU), n and %, N=753

Subnational Administrative Unit (SNU)	n	%
Tbilisi	541	71.8
Samegrelo-Zemo Svaneti	32	4.2
Adjara	80	10.6
Imereti	100	13.3
Total	753	100

6.1. Social and demographic characteristics

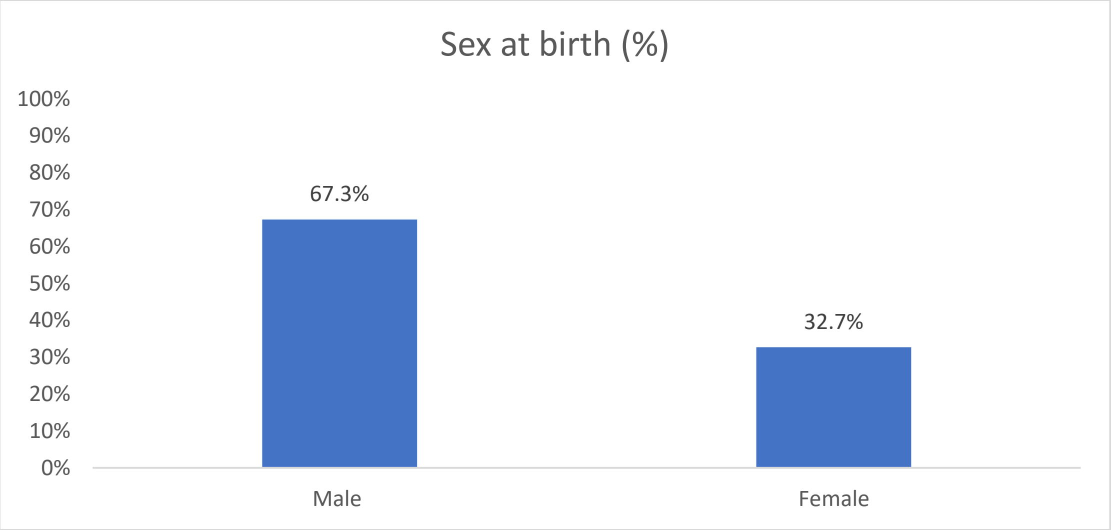
All but two participants provided information about their age. The two missing data were imputed by the average age of the entire sample. The mean age of the respondents who took part in the study was 40.6 (SD=10.8) years, with the youngest participant being 18 and the oldest 76 years old. Most participants were aged between 30 and 49 years old (Fig. 1).

Fig. 1. Age distribution of study participants, % N=753



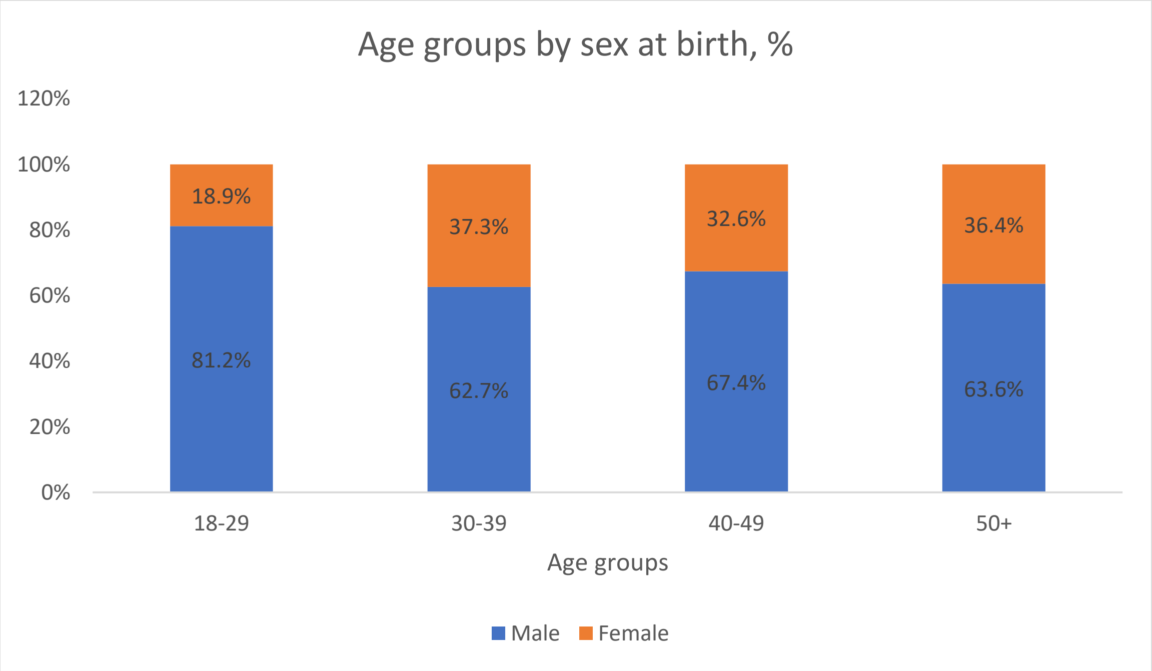
When asked about sex assigned at birth, 500 (67.3%) of respondents answered male and 243 (32.7%) female (Fig. 2). This distribution almost corresponds to the sex distribution of Georgian PLHIV which indicates the compliance with the set quotas during the recruitment of the respondents.

Fig. 2. Proportion of respondents by sex assigned at birth, %, N=743, Missing=10



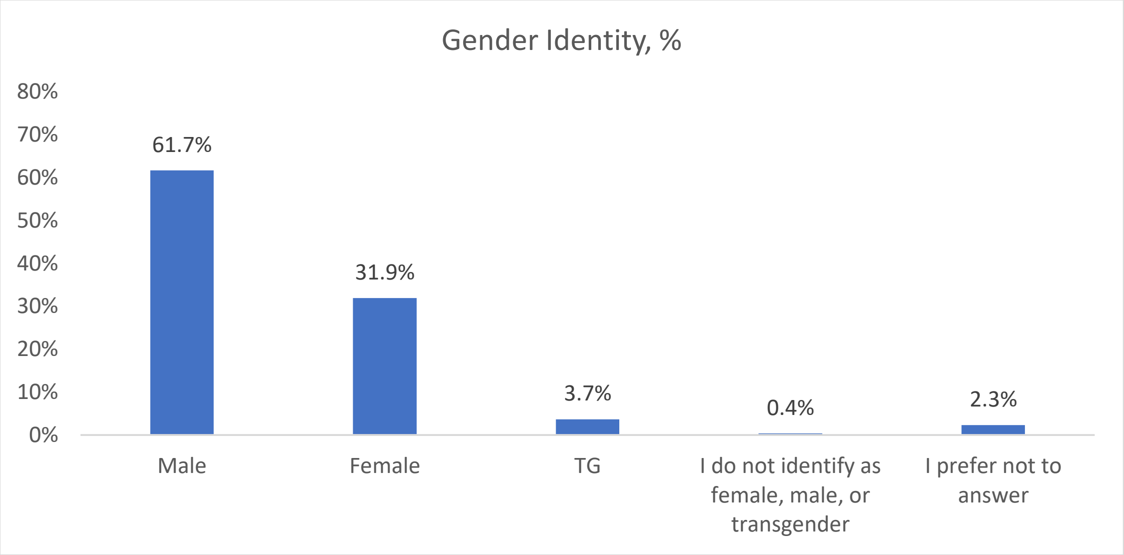
There were more men in 18-29 age group compared to females, while the opposite trend was seen for the 30-39 age group. Both sexes were represented almost the same for 40-49 and 50+ age groups (Fig. 3).

Fig. 3. Age groups by sex at birth, %, N=743, Missing=10



Participants were asked about their gender identity and the responses were distributed as follows: 353 (61.7%) identified themselves as male, 183 (31.9%) as female, 21 (3.7%) as transgender, 2 participants (0.4%) did not identify themselves as male, female or transgender and 13 (2.3%) preferred not to answer (Fig. 4).

Fig. 4. The proportion of respondents by gender identity, %, N=572, Missing=181



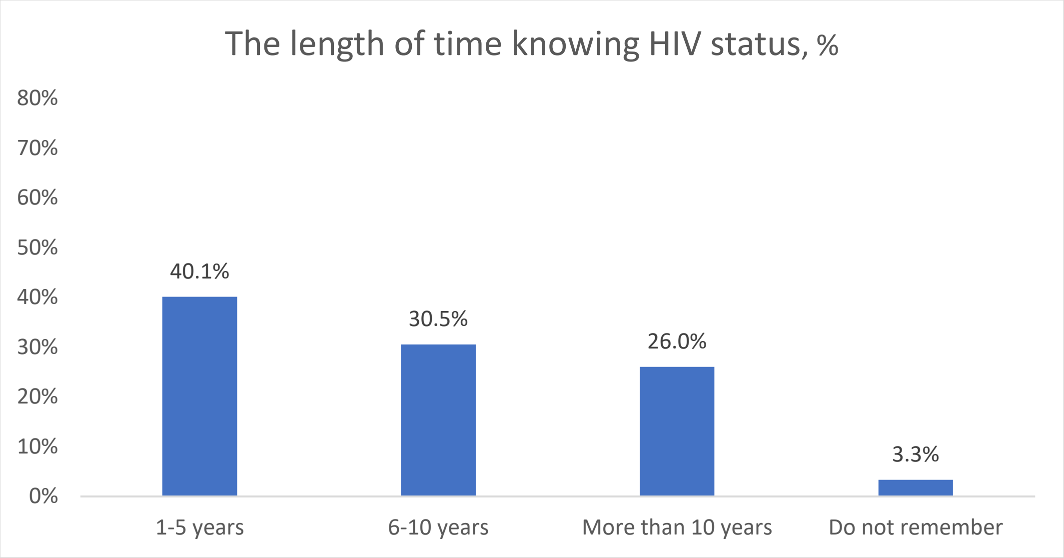
When looking at the age distribution by gender, it was possible to see that more men were presented in 18-29 age group, while there were more women aged 30-39 and the vast majority (n=18) of transgender people were within the 18-39 age group. See Table 6 below for more details.

Table 6. Age groups by Gender, %

AGE GROUPS	WOMEN (n=183)	MEN (n=353)	TRANSGENDER (n=21)	I do not identify as male, female, TG (n=2)	Prefer not to answer (n=13)
	%	%	%	%	%
18-29	8.2% (15)	18.7% (66)	42.9% (9)	50% (1)	30.8% (4)
30-39	41.5% (76)	29.7% (105)	42.9% (9)	0% (0)	46.2% (6)
40-49	28.4% (52)	28.3% (100)	14.3% (3)	50% (1)	23.1% (3)
50+	21.9% (40)	23.2% (82)	0% (0)	0% (0)	0% (0)
Total	100% (183)	100% (353)	100% (21)	100% (2)	100% (13)

The average time that respondents had known their HIV positive status was 7 years and the maximum time a respondent knew his HIV status was 35 years. Respondents ranged from individuals who had HIV for a brief period (one year) to those who were diagnosed more than ten years ago. (Fig. 5).

Fig. 5. The proportion of study participants by length of time knowing HIV status, %, N=750, Missing=3



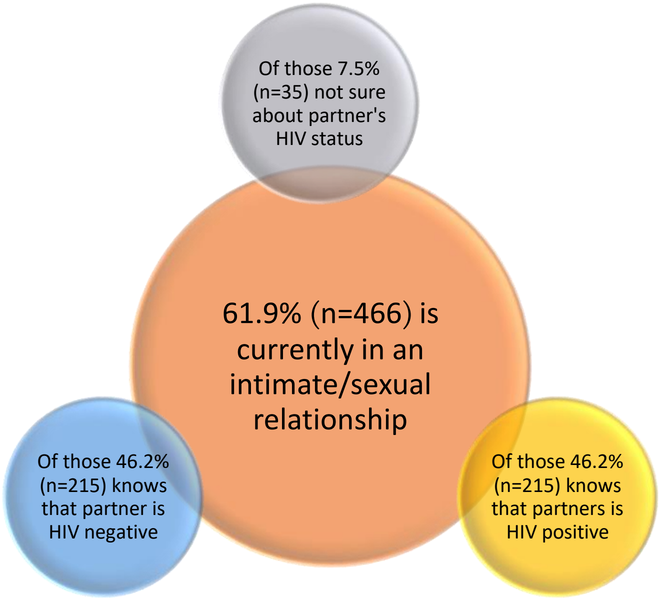
There were no significant differences in genders and knowledge of the status between males and females, whereas 50% of transgender (10 out of 20) people were aware of their status for 1-5 years (Table 7).

Table 7. Awareness about the status, by gender, %

Awareness about status (years)	**WOMEN (n=183)**	**MEN (n=351)**	**TRANSGENDER (n=20)**	**I do not identify as male, female, TG (n=2)**	**Prefer not to answer (n=13)**
	% (n)	% (n)	% (n)	% (n)	% (n)
1-5 years	32.8% (60)	37.1% (130)	50.0% (10)	50.0% (1)	46.1% (6)
6-10 years	31.2% (57)	31.9% (112)	25.0% (5)	50.0% (1)	30.8% (4)
More than 10 years	35.0% (64)	25.6% (90)	15.0% (3)	0% (0)	7.7% (1)
Do not remember	1.0% (2)	5.4% (19)	10.0% (2)	0% (0)	15.4% (2)
Total	100% (183)	100% (351)	100% (20)	100% (2)	100% (13)

More than half of the respondents (n=466; 61.9%) said they were in an intimate/sexual relationship (married or unmarried) at the time of the survey. Those in an intimate/sexual relationship were asked about the HIV status of their partner(s), of whom 1 respondent did not answer the question, while the proportions of those with partners living with HIV and those with HIV-negative partners were equal (Fig. 6).

Fig. 6. Respondents' sexual relationships and HIV status of their partners, %, N=466



When disaggregating data by sex at birth and key population groups, the total numbers may vary due to respondents not providing responses to all questions and the presence of missing data. Consequently, in bivariate outputs, we observe different totals. To ensure more precise interpretation, the accurate number of total responses has been specified in each analysis in the tables onward below.

According to the table below, sex workers (65.8%) and TG (67.7%) were more engaged in intimate/sexual relationships at the time of the interviews than the other groups. For further details, please see Table 8 below.

Table 8. Currently in intimate/sexual relationships, by sex at birth and key populations, n and %

Item	**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
	WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%
Yes	156	64.2	305	61.0	28	43.1	73	65.8	21	67.7	114	59.7
No	87	35.8	195	39.0	37	56.9	38	34.2	10	32.3	77	40.3
Total	243	100	500	100	65	100	111	100	31	100	191	100

Almost half of the respondents (n=341; 47.0%) reported that they do not have children. Among those who indicated that they have children, the majority reported 1 (n=160; 22.0%) or 2 (n=154; 21.2%) children. Having 3 or more children was reported by 71 (9.7%) participants. Among the study participants, more than 70% of women and more than 40% of men had at least one child living with them that they were taking care of. Among the KP groups 90% (n=27/30) of TG, 87.5% (n=56/64) of MSM, 58.3% (n=63/108) of SW and 48.9% (n=91/186) of PWUD reported that they did not have children. See Table 9 below for more details:

Table 9. Number of children living together, by sex at birth and key populations, n and %

	Total PLHIV	**PLHIV**	**MSM**	**SW**	**TG**	**PWUD**

Number			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
0	341	47.0	63	26.6	270	56.3	56	87.5	63	58.3	27	90.0	91	48.9
1	160	22.0	78	32.9	82	17.1	6	9.3	21	19.4	0	0	36	19.4
2	154	21.2	69	29.1	85	17.7	1	1.6	13	12.0	3	10.0	38	20.4
3	45	6.2	18	7.6	27	5.6	1	1.6	9	8.3	0	0	14	7.5
4	17	2.3	6	2.5	10	2.1	0	0	1	0.9	0	0	4	2.2
5	5	0.7	2	0.8	3	0.6	0	0	1	0.9	0	0	2	1.1
6	3	0.4	1	0.4	2	0.4	0	0	0	0	0	0	1	0.5
7	1	0.1	0	0	1	0.2	0	0	0	0	0	0	0	0
Total	726	100	237	100	480	100	64	100	108	100	30	100	186	100

Participants were asked to report on their highest level of formal education. Having no formal education was reported by 9 (1.2%) participants, 16 (2.1%) had primary education, 323 (43.2%) secondary, 139 (18.5%) vocational and 261 (34.9%) university education. More women had higher education compared to men and among KP groups more than half of the MSM reported having university education (Table 10).

Table 10. Education level by sex at birth and key populations, n and %

Item	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
No formal Education	9	1.2	2	0.8	6	1.2	1	1.5	2	1.8	2	6.4	7	3.7
Primary	16	2.1	5	2.1	11	2.2	1	1.5	3	2.7	1	3.2	4	2.1
Secondary	323	43.2	82	34.2	238	47.8	19	29.2	52	47.3	11	35.5	111	58.7
Vocational	139	18.5	54	22.5	84	16.9	8	12.3	24	21.8	9	29.0	37	19.6
University	261	34.9	97	40.4	159	31.9	36	55.4	29	26.4	8	25.8	30	15.9
Total	748	100	240	100	498	100	65	100	110	100	31	100	189	100

Most respondents (n=454; 60.5%) reported having some type of paid job, while 26 (3.5%) received a pension or were retired, and more than a third (n=270; 36.0%) were unemployed. When looking into the KP groups, almost every second PWUD reported being unemployed, while MSM were more likely to be engaged in full-time work than other representatives of KPs (Table 11).

Table 11. Employment by sex at birth and key populations, n and %

Item	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
In full-time work (as an employee)	217	28.9	85	34.9	130	26.2	25	38.4	21	18.9	8	25.8	26	13.6
In part-time (as an employee)	56	7.5	22	9.1	33	6.6	6	9.2	13	11.7	4	12.9	14	7.3
Working full-time, but not as an employee (self-employed or	75	10.0	13	5.4	60	12.1	10	15.4	6	5.4	1	3.2	21	11.0

paid work for others)														
Doing casual or informal part time work (self-employed or paid work for others)	106	14.1	26	10.7	80	16.1	6	9.2	33	29.7	9	29.0	34	17.8
Retired/on pension	26	3.5	12	4.9	14	2.8	0	0	0	0	0	0	9	4.7
Unemployed	270	36.0	85	34.9	180	36.2	18	27.7	38	34.2	9	29.0	87	45.5
Total	750	100	243	100	497	100	65	100	111	100	31	100	191	100

Participants were asked to report about their inability of meeting their basic needs (e.g., food, shelter, clothing) during the last 12 months. Majority (n=458; 61.4%) of the respondents were not able to meet their needs some of the time. Among the KP groups almost third of the PWUD reported being unable to meet their basic needs most of the time (Table 12).

Table 12. Participants' ability to meet their basic needs during the last 12 months, by sex at birth and key populations, n and %

Item	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
In the last 12 months, how often have you been unable to meet basic needs (e.g., food, shelter, or clothing)?														
Never	157	21.1	42	17.5	114	23.0	21	32.8	18	16.7	9	29.0	25	13.4
Some of the time	458	61.4	156	65.0	294	59.4	32	50.0	79	73.1	18	58.1	113	60.4
Most of the time	130	17.5	42	17.5	87	17.6	11	17.2	11	10.2	4	12.9	49	26.2
Total	745	100	240	100	495	100	64	100	108	100	31	100	187	100

Participants were also asked if they were or had been a racial, ethnic, or religious minority, a person with a disability, a refugee or asylum seeker, a migrant worker, an internally displaced person (IDP), or incarcerated. The majority of respondents (n=589; 78.2%) stated that they did not belong to any of the socially vulnerable groups. Table 13 shows the distribution of responses.

Table 13. Belonging to socially vulnerable groups, n and %

	n	**%**
Belong to or have been a member of a racial, ethnic, or religious minority (N=752)	19	2.5
Member of an indigenous/aboriginal group (N=750)	6	0.8
Person living with a disability (vision, hearing, mobility, intellectual/developmental) of any kind (other than HIV) (N=752)	53	7.1
Refugee or asylum seeker (N=751)	27	3.6
Migrant worker (N=750)	33	4.4

Internally displaced person (N=752)	40	5.3
Was in prison/incarcerated (N=750)	17	2.2

In addition, 105 (14.1%) respondents reported being a member of an HIV support group. Women living with HIV were more likely to be part of HIV support groups than men (Table 14).

Table 14. Membership in HIV support groups by sex at birth and key populations, n and %

Item	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Are you a member of HIV support group?														
Yes	105	14.1	50	20.7	55	11.1	10	15.4	17	15.3	8	25.8	26	13.8
No	641	85.9	191	79.3	441	88.9	55	84.6	94	84.7	23	74.2	162	86.2
Total	746	100	241	100	496	100	65	100	111	100	31	100	188	100

6.2. HIV Status Disclosure

The HIV status disclosure section asked questions about individuals or groups of individuals who were aware of respondents' HIV status and if the status disclosure was unauthorized. Over 60% (n=435) of the respondents noted that they disclosed their status to the sexual partner (hisband/wife/partner) and almost 10% (42 out of 435) of these respondents also mentioned that their status disclose happened without their consent. Almost a quarter (n=153; 24.7%) of the respondents noted that their children knew their status and unauthorised disclose had happened in 15.5% (24 out of 153) for these cases. Family members and friends were aware of the respondents' status in 58.8% (n=425) and 43.4% (n=312), respectively. Disclosure problems were more severe outside the families (less than 10% telling their status to different groups of people). Unauthorized disclosure was more frequent among the different groups of people outside their close networks, including neighbors, employers, co-workers, teachers/school administrators, classmates, local leaders, and authority figures (Table 15).

Table 15. Do the following people or groups of people know your HIV status? n and %

Groups	**No % (n)**	**Y % (n) s**	**If "Yes", was your status ever disclosed to this person/group without your consent? % (n)**
Your husband/wife/partner(s) (N=698)	37.7% (263)	62.3% (435)	9.7% (42)
Your children (N=619)	75.3% (466)	24.7% (153)	15.5% (24)
Other family members (N=723)	41.2% (298)	58.8% (425)	15.6% (66)
Your friends (N=718)	56.6% (406)	43.4% (312)	18.6% (58)
Your neighbors (N=700)	90.1% (631)	9.9% (69)	37.7% (26)
Your employer(s) (N=678)	93.8% (636)	6.2% (42)	35.7% (15)
Your co-workers (N=674)	93.2% (628)	6.8% (46)	28.3% (13)
Your teacher(s)/school administrator(s) (N=594)	97.0% (576)	3.0% (18)	66.7% (12)
Your classmates (N=596)	97.1% (579)	2.9% (17)	62.5% (10)
Local leaders (N=666)	97.6% (650)	2.4% (16)	68.8% (11)

Authority figures (e.g., police, judges, prosecutors, law enforcement, etc.) (N=673)	95.8% (645)	4.2% (28)	46.4% (13)

Participants were also asked about their experiences with status disclosure. Eighty percent of all respondents agreed (n=322; 44.2%) or partially agreed (n=261; 35.8%) that disclosing their HIV status to close people (e.g., partner, family, close friends) was a positive experience and that they (close people) were supportive when they first learnt of their HIV status. In comparison more than half (n=388; 59.7%) of the respondents stated that disclosing HIV status to people who they don't know very well had been a negative experience and they (not close people) were not supportive (n=366; 55.3%) during disclosure. Also, more than half of all respondents (n=411; 56.2%) stated that it was not easier for them to disclose their HIV status over time. Almost third of SW (n=38; 34.9%) and TG (n=11; 35.5%) noted that disclosing HIV status among their close environment was not a positive experience and 66.2% (n=55) of SW and 65% (n=13) of TG had bad experience while disclosing status to people who they don't know very well. More details are given in Table 16.

Table 16. Participants' experience in disclosing HIV status, by sex at birth and key populations, n and %

Statement: In general, disclosing your HIV status to people you are close to (e.g., partner, family, close friends) has been a positive experience.														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Agree	322	44.2	98	41.7	222	45.9	32	51.6	32	29.3	9	29.0	68	36.8
Somewhat agree	261	35.8	82	34.9	174	36.0	16	25.8	39	35.8	11	35.5	74	40.0
Disagree	146	20.0	55	23.4	88	18.1	14	22.6	38	34.9	11	35.5	43	23.2
Total	729	100	235	100	484	100	62	100	109	100	31	100	185	100
Statement: In general, people you are close to were supportive when they first learned about your HIV status.														
Agree	331	46.0	100	43.5	229	47.7	40	63.5	37	35.2	11	35.5	71	38.4
Somewhat agree	231	32.1	65	28.3	162	33.8	14	22.2	35	33.3	7	22.6	70	37.8
Disagree	158	21.9	65	28.3	89	18.5	9	14.3	33	31.4	13	41.9	44	23.8
Total	720	100	230	100	480	100	63	100	105	100	31	100	185	100
Statement: In general, disclosing your HIV status to people you don't know very well has been a positive experience.														
Agree	76	11.7	20	9.2	56	13.2	9	17.7	10	12.1	3	15.0	26	14.7
Somewhat agree	186	28.6	53	24.4	131	30.9	17	33.3	18	21.7	4	20.0	42	23.7
Disagree	388	59.7	144	66.4	237	55.9	25	49.0	55	66.2	13	65.0	109	61.6
Total	650	100	217	100	424	100	51	100	83	100	20	100	177	100
Statement: In general, people you don't know very well were supportive when they first learned about your HIV status.														
Agree	103	15.6	29	13.2	72	16.6	8	15.7	26	28.0	3	15.0	27	15.4
Somewhat agree	193	29.1	52	23.6	138	31.9	19	37.3	24	25.8	4	20.0	47	26.8
Disagree	366	55.3	139	63.2	223	51.5	24	47.0	43	46.2	13	65.0	101	57.8
Total	662	100	220	100	433	100	51	100	93	100	20	100	175	100
In general, disclosing your HIV status has become easier over time.														
Agree	135	18.5	31	13.2	102	20.9	16	24.6	17	15.6	5	16.1	57	30.8

Somewhat agree	185	25.3	51	21.8	130	26.7	21	32.3	46	42.2	10	32.3	30	16.2
Disagree	411	56.2	152	65.0	255	52.4	28	43.1	46	42.2	16	51.6	98	53.0
Total	731	100	234	100	487	100	65	100	109	100	31	100	185	100

6.3. Experience of Stigma and Discrimination

Participants' experiences with stigma and discrimination were examined in terms of scenarios encountered inside their families, near social surroundings (relatives, partners, friends, etc.), as well as at work or other institutional sites. More than 80% of the respondents indicated that they had not encountered stigma or discrimination because of their HIV status. The most prevalent negative experience mentioned by the respondents was discriminatory remarks or gossiping about their HIV status from their family members (n=71, 9.9%) and people other than their family members (n=102, 14.2%) that happened both within the last 12 months and earlier than in the last year. 7.1% (n=52) of respondents (including 1.5% in the last year, n=11) had ever had the experience of verbal abuse (e.g., yelled, scolded, or was otherwise verbally abusive) because of their HIV status. 3.1% (n=22) of the respondents indicated that situations of discrimination had ever happened against their spouse/partner/child due to their HIV status. Women living with HIV, TG and people who use drugs more often reported experiences of stigma and discrimination. Details on stigma and discrimination experiences by groups are provided in Table 17.

Table 17. The experience of stigma and discrimination due to HIV status, by sex at birth and key populations, n and %

Have you ever been excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status?														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes, Within the last 12 months	6	0.8	3	1.3	3	0.6	0	0	0	0	0	0	2	1.1
Yes, but not in the last 12 months	16	2.2	6	2.6	10	2.1	2	3.3	2	1.9	1	3.4	7	3.8
No	691	97.0	217	96.1	464	97.3	59	96.7	106	98.1	28	96.6	175	95.1
Total	713	100	226	100	477	100	61	100	108	100	29	100	184	100
Have you ever been excluded from religious activities or places of worship because of your HIV status?														
Yes, Within the last 12 months	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yes, but not in the last 12 months	14	2.0	4	1.7	10	2.1	1	1.6	3	2.8	1	4.0	5	2.7
No	695	98.0	224	98.3	461	97.9	60	98.4	103	97.2	24	96.0	179	97.3
Total	709	100	228	100	471	100	61	100	106	100	25	100	184	100
Have you ever been excluded from family activities because of your HIV status?														
Yes, Within the last 12 months	5	0.7	3	1.3	2	0.4	0	0	0	0	0	0	2	1.1

Yes, but not in the last 12 months	22	3.1	10	4.4	12	2.5	0	0	4	3.9	1	4.4	8	4.3
No	686	96.2	217	94.3	459	97.1	61	100	100	96.1	22	95.6	176	94.6
Total	713	100	230	100	473	100	61	100	104	100	23	100	186	100
Have you ever been aware of family members making discriminatory remarks or gossiping about you because of your HIV status?														
Yes, Within the last 12 months	11	1.5	5	2.2	6	1.3	0	0	0	0	0	0	2	1.1
Yes, but not in the last 12 months	60	8.4	23	10.0	36	7.6	4	6.4	13	12.4	4	17.4	13	7.0
No	641	90.1	201	87.8	431	91.1	58	93.6	92	87.6	19	82.6	171	91.9
Total	712	100	229	100	473	100	62	100	105	100	23	100	186	100
Have you ever been aware of other people (other than family members) making discriminatory remarks or gossiping about you because of your HIV status?														
Yes, Within the last 12 months	18	2.5	5	2.2	13	2.7	2	3.2	5	4.5	4	13.3	3	1.6
Yes, but not in the last 12 months	84	11.7	34	14.9	50	10.5	9	14.3	11	9.9	5	16.7	19	10.4
No	615	85.8	190	82.9	415	86.8	52	82.5	95	85.6	21	70.0	162	88.0
Total	717	100	229	100	478	100	63	100	111	100	30	100	184	100
Has someone ever verbally harassed you (e.g., yelled, scolded, or was otherwise verbally abusive) because of your HIV status?														
Yes, Within the last 12 months	11	1.5	3	1.3	8	1.7	2	3.1	5	4.5	2	6.5	4	2.2
Yes, but not in the last 12 months	41	5.6	15	6.5	25	5.2	7	10.9	9	8.1	4	12.9	9	4.8
No	674	92.9	214	92.2	451	93.1	55	86.0	97	87.4	25	80.6	173	93.0
Total	726	100	232	100	484	100	64	100	111	100	31	100	186	100
Has someone ever blackmailed you because of your HIV status?														
Yes, Within the last 12 months	4	0.6	2	0.9	2	0.4	1	1.6	1	0.9	0	0	0	0
Yes, but not in the last 12 months	18	2.5	8	3.5	10	2.1	4	6.3	8	7.3	3	9.7	2	1.1
No	700	96.9	219	95.6	471	97.5	59	92.1	101	91.8	28	90.3	184	98.9
Total	722	100	229	100	483	100	64	100	110	100	31	100	186	100
Has someone ever physically harassed or hurt you (e.g., pushed, hit, or was otherwise physically abusive) because of your HIV status?														
Yes, Within the last 12 months	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Yes, but not in the last 12 months	11	1.5	3	1.3	8	1.7	5	7.9	7	6.4	3	10.0	3	1.6
No	712	98.5	227	98.7	475	98.3	58	92.1	103	93.6	27	90.0	182	98.4
Total	723	100	230	100	483	100	63	100	110	100	30	100	185	100
Have you ever been refused employment or lost a source of income or job because of your HIV status?														
Yes, Within the last 12 months	8	1.1	4	1.7	4	0.9	2	3.2	1	1.0	0	0	1	0.5
Yes, but not in the last 12 months	31	4.3	10	4.3	20	4.2	2	3.2	4	3.9	1	5.0	12	6.5
No	674	94.6	217	94.0	448	94.9	59	93.6	97	95.1	19	95.0	173	93.0
Total	713	100	231	100	472	100	63	100	102	100	20	100	186	100
Has your job description or the nature of your job ever been changed, or have you ever been denied a promotion, because of your HIV status?														
Yes, Within the last 12 months	6	0.8	3	1.3	3	0.6	1	1.6	0	0	0	0	0	0
Yes, but not in the last 12 months	16	2.3	7	3.1	9	1.9	1	1.6	0	0	0	0	5	2.7
No	688	96.9	219	95.6	459	97.5	61	96.8	102	100	21	100	180	97.3
Total	710	100	229	100	471	100	63	100	102	100	21	100	185	100
Has your wife/husband, partner(s) or child(ren) ever experienced discrimination because of your HIV status?														
Yes, Within the last 12 months	6	0.8	1	0.4	5	1.1	2	3.3	2	1.9	1	3.7	1	0.5
Yes, but not in the last 12 months	16	2.3	8	3.5	8	1.7	0	0	0	0	0	0	4	2.2
No	689	96.9	218	96.1	461	97.2	58	96.7	106	98.1	26	96.3	179	97.3
Total	711	100	227	100	474	100	60	100	108	100	27	100	184	100

Overall, of 753 participants, 5.4% (n=41) reported at least one stigma and discrimination experience in the last 12 months, and 19.8% (n=149), reported at least one stigma and discrimination experience beyond the last 12 months.

6.4. Internalized Stigma and Resilience

Study respondents were asked to indicate personal and socio-psychological changes that occurred in their lives because of their HIV status during the last 12 months. Almost 40% (n=297) of the respondents stated that their HIV status has negatively affected their self-confidence. Almost every third respondent mentioned problems with self-respect (n=201; 27.2%) and inability to cope with stress (n=198; 26.9%). Within KP groups negative effect on the self-confidence, as well as difficulties in coping with stress was highest among SW. Negative effect on self-respect was highest among MSM. Over fifth of the participants talked about reduction/disappearance of desire to have children (n=177; 24.9%) and their negatively affected ability to find love (n=160; 22.0%), and unfavorable changes in personal and professional development (n=158; 21.6%) (Table. 18).

A portion of the respondents (11.3%-31.7%) also said that their HIV status had a beneficial impact on certain areas of their psychological well-being and connections with others. Positive changes in their ability to cope with stress (n=233; 31.7%), having close and secure relationships with others (n=223; 30.3%), and respect for other people (n=157; 21.3%) were the most frequently mentioned (Table 18).

A significant proportion of respondents (41.4%-77.5%) said that their psychological well-being and relationships with the social environment had not been affected by their HIV status (neither positively nor negatively) (Table 18).

More details disaggregated by sex at birth and key populations are provided in Table 18.

Table 18. The impact of HIV status on various aspects of respondents' lives, by sex at birth and key populations, n and %

Options	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Statement: My self-confidence														
Has been positively affected by my HIV status	116	15.7	46	19.4	70	14.3	11	16.9	14	13.0	6	20.0	31	16.7
Has not been affected by my HIV status	324	44.0	98	41.4	220	44.9	32	49.2	57	52.7	17	56.7	114	61.3
Has been negatively affected by my HIV status	297	38.3	93	39.2	200	40.8	22	33.9	37	34.3	7	23.3	41	22.0
Total	737	100	237	100	490	100	65	100	108	100	30	100	186	100
Statement: My self-respect														
Has been positively affected by my HIV status	117	15.9	44	18.6	73	14.9	14	21.5	12	11.1	5	16.7	29	15.5
Has not been affected by my HIV status	419	56.9	124	52.5	286	58.3	34	52.3	89	82.4	23	76.7	133	71.1
Has been negatively affected by my HIV status	201	27.2	68	28.9	132	26.8	17	26.2	7	6.5	2	6.6	25	13.4
Total	737	100	236	100	491	100	65	100	108	100	30	100	187	100
Statement: My ability to respect others														
Has been positively affected by my HIV status	157	21.3	51	21.6	106	21.5	28	43.1	14	13.0	6	20.0	31	16.5
Has not been affected by my HIV status	523	70.9	164	69.5	349	70.9	36	55.4	83	76.8	20	66.7	145	77.1

Has been negatively affected by my HIV status	58	7.8	21	8.9	37	7.6	1	1.5	11	10.2	4	13.3	12	6.4
Total	738	100	236	100	492	100	65	100	108	100	30	100	188	100
Statement: My ability to cope with stress														
Has been positively affected by my HIV status	233	31.7	80	33.8	152	31.2	29	44.6	18	16.7	7	22.6	47	25.3
Has not been affected by my HIV status	304	41.4	89	37.6	209	42.8	26	40.0	51	47.2	18	58.1	111	59.7
Has been negatively affected by my HIV status	198	26.9	68	28.6	127	26.0	10	15.4	39	36.1	6	19.3	28	15.0
Total	735	100	237	100	488	100	65	100	108	100	31	100	186	100
Statement: My ability to have close and secure relationships with others														
Has been positively affected by my HIV status	223	30.3	71	29.8	151	31.0	31	48.4	16	14.8	5	16.7	43	23.0
Has not been affected by my HIV status	366	49.8	121	50.8	239	49.1	30	46.9	55	50.9	22	73.3	122	65.2
Has been negatively affected by my HIV status	146	19.9	46	19.4	97	19.9	3	4.7	37	34.3	3	10.0	22	11.8
Total	735	100	238	100	487	100	64	100	108	100	30	100	187	100
Statement: My ability to find love														
Has been positively affected by my HIV status	111	15.2	39	16.9	71	14.5	9	14.1	7	6.5	2	6.5	22	11.7
Has not been affected by my HIV status	458	62.8	147	63.6	304	62.3	37	57.8	78	72.9	23	74.2	126	67.0
Has been negatively affected by my HIV status	160	22.0	45	19.4	113	23.2	18	28.1	22	20.6	6	19.3	40	21.3
Total	729	100	231	100	488	100	64	100	107	100	31	100	188	100
Statement: My desire to have children														
Has been positively affected by my HIV status	89	12.5	34	15.0	54	11.4	1	1.7	3	2.9	0	0	17	9.1
Has not been affected by my HIV status	446	62.6	139	61.2	300	63.2	43	72.9	79	77.5	21	84.0	130	69.5
Has been negatively affected by my HIV status	177	24.9	54	23.8	121	25.4	15	25.4	20	19.6	4	16.0	40	21.4
Total	712	100	227	100	475	100	59	100	102	100	25	100	187	100
Statement: My ability to achieve personal and/or professional goals														
Has been positively affected by my HIV status	116	15.9	38	16.4	77	15.8	9	14.1	7	6.6	1	3.3	17	9.0

Has not been affected by my HIV status	456	62.5	140	60.3	308	63.1	48	75.0	74	69.8	23	76.7	135	71.8
Has been negatively affected by my HIV status	158	21.6	54	23.3	103	21.1	7	10.9	25	23.6	6	20.0	36	19.2
Total	730	100	232	100	488	100	64	100	106	100	30	100	188	100
Statement: My ability to contribute to my community														
Has been positively affected by my HIV status	133	18.2	48	20.5	84	17.3	14	21.5	8	7.6	1	3.6	17	9.1
Has not been affected by my HIV status	459	63.0	140	59.8	310	63.9	48	73.9	74	69.8	22	78.6	136	73.1
Has been negatively affected by my HIV status	137	18.8	46	19.7	91	18.8	3	4.6	24	22.6	5	17.8	33	17.8
Total	729	100	234	100	485	100	65	100	106	100	28	100	186	100
Statement: My ability to practice a religion/faith as I want to														
Has been positively affected by my HIV status	82	11.3	32	13.7	50	10.4	4	6.6	2	1.9	2	7.7	19	10.2
Has not been affected by my HIV status	561	77.5	177	75.6	374	77.9	50	81.9	88	84.6	22	84.6	150	80.7
Has been negatively affected by my HIV status	81	11.2	25	10.7	56	11.7	7	11.5	14	13.5	2	7.7	17	9.1
Total	724	100	234	100	480	100	61	100	104	100	26	100	186	100

Overall, of 753 participants; 54.8% (n=413) reported that at least one aspect of their lives had been negatively affected by their HIV status, while 45.1% (n=340) noted that at least one aspect of their lives had been positively affected. In general, the respondents' answers of "no changes" dominated.

The respondents were also asked to indicate whether their HIV status had a better, similar, or worse impact on various aspects of their lives (as listed in above Table 18) before 12 months ago. In total 742 participants responded to this question. The majority of respondents (n=510; 68.7%) stated that the situation has not changed, 23.1% (n=171) of respondents indicated relative worsening (meaning that the situation was better before), while only 8.2% (n=61) talked about improvement (meaning that the situation was worse before) (Table 19).

Table 19. The effect of participants' HIV status on the various aspects of their life (as listed in Table 18) before 12 months, n and %, N=742

	n	%
Better	171	23.1
About the same	510	68.7
Worse	61	8.2
Total	742	100

The participants were asked about certain decisions related to HIV status made in the last year, where positive answers indicated self-discriminatory actions. The percentage of self-discriminatory decisions varied from 5.0% to 13.2%, with the highest of 13.2% for avoidance of seeking medical care. Almost a quarter of MSM (n=16; 24.6%) stated that they had avoided going to a clinic or hospital when there was a need (Table 20).

Table 20. Decisions related to HIV status made in the last year, by sex at birth and key populations, n and %

I have chosen not to attend social gatherings														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes	37	5.0	12	5.1	24	4.9	5	7.8	5	4.5	3	9.7	8	4.3
No	697	95.0	224	94.9	464	95.1	59	92.2	105	95.5	28	90.3	179	95.7
Total	734	100	236	100	488	100	64	100	111	100	31	100	187	100
I avoided going to a clinic or hospital when I needed to														
Yes	97	13.2	33	14.0	63	12.9	16	24.6	11	9.9	5	16.1	18	9.7
No	638	86.8	203	86.0	426	87.1	49	75.4	100	90.1	26	83.9	168	90.3
Total	735	100	236	100	489	100	65	100	111	100	31	100	186	100
I have chosen not to apply for a job(s)														
Yes	54	7.4	18	7.7	36	7.4	3	4.6	5	4.5	1	3.2	22	11.8
No	677	92.6	215	92.3	452	92.6	62	95.4	106	95.5	30	96.8	165	88.2
Total	731	100	233	100	488	100	65	100	111	100	31	100	187	100
I have chosen not to seek social support														
Yes	76	10.5	25	10.7	50	10.4	9	14.5	5	4.7	6	21.4	20	10.7
No	651	89.5	209	89.3	433	89.6	53	85.5	102	95.3	22	78.6	167	89.3
Total	727	100	234	100	483	100	62	100	107	100	28	100	187	100
I have isolated myself from family and/or friends														
Yes	38	5.2	16	6.8	22	4.5	7	10.8	7	6.3	2	6.5	8	4.3
No	696	94.8	219	93.2	467	95.5	58	89.2	104	93.7	29	93.5	180	95.7
Total	734	100	235	100	489	100	65	100	111	100	31	100	188	100
I decided not to have sex														
Yes	64	8.8	19	8.2	45	9.2	11	16.9	7	6.3	4	12.9	16	8.6
No	664	91.2	212	91.8	442	90.8	54	83.1	104	93.7	27	87.1	171	91.4
Total	728	100	231	100	487	100	65	100	111	100	31	100	187	100

Overall, of 753 participants, 23.0% (n=173) had made at least one self-discrimination action during the last 12 months.

Respondents were asked if they agreed or disagreed with a series of statements (as listed in Table 21), with agreement suggesting internalized stigma. Difficulty telling (n=686; 91.2%) and hiding (n=655; 87.1%) HIV status from others were the most prevalent responses, which complies with the findings about disclosure concerns as described in section 2 of this report. Feelings like being guilty, ashamed, or worthless due to HIV status was highest among PWUD. More men reported being guilty about being HIV positive, while more women talked about being ashamed due to their status (Table 21).

Table 21. Internalized stigmatization of PLHIV, by sex at birth and key populations, n and %

It is difficult to tell people that I am HIV positive						
Options	**Total PLHIV**	**PLHIV**	**MSM**	**SW**	**TG**	**PWUD**

			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes	686	91.2	223	92.2	453	90.6	59	90.8	106	95.5	28	90.3	171	89.5
No	66	8.8	19	7.8	47	9.4	6	9.2	5	4.5	3	9.7	20	10.5
Total	752	100	242	100	500	100	65	100	111	100	31	100	191	100
Being HIV positive makes me feel dirty														
Yes	94	12.5	26	10.7	68	13.6	7	10.8	10	9.0	2	6.5	40	20.9
No	658	87.5	216	89.3	432	86.4	58	89.2	101	91.0	29	93.5	151	79.1
Total	752	100	242	100	500	100	65	100	111	100	31	100	191	100
I feel guilty that I am HIV positive														
Yes	301	40.0	67	27.7	229	45.8	20	30.8	54	48.6	8	25.8	109	57.1
No	451	60.0	175	72.3	271	54.2	45	69.2	57	51.4	23	74.2	82	42.9
Total	752	100	242	100	500	100	65	100	111	100	31	100	191	100
I am ashamed that I am HIV positive														
Yes	271	36.1	103	42.6	164	32.9	19	29.2	26	23.4	5	16.1	77	40.5
No	479	63.9	139	57.4	334	67.1	46	70.8	85	76.6	26	83.9	113	59.5
Total	750	100	242	100	498	100	65	100	111	100	31	100	190	100
I sometimes feel worthless because I am HIV positive														
Yes	215	28.6	70	28.9	144	28.9	8	12.3	30	27.1	11	35.5	86	45.3
No	536	71.4	172	71.1	355	71.1	57	87.7	81	72.9	20	64.5	104	54.7
Total	751	100	242	100	499	100	65	100	111	100	31	100	190	100
I hide my HIV status from others														
Yes	655	87.1	213	88.0	433	86.6	59	90.8	98	88.3	28	90.3	157	82.2
No	97	12.9	29	12.0	67	13.4	6	9.2	13	11.7	3	9.7	34	17.8
Total	752	100	242	100	500	100	65	100	111	100	31	100	191	100

6.5. Interactions with healthcare services

This section asked questions about participants' interaction with healthcare services and covered topics such as experiences of HIV testing, care and treatment, encounters and reasons for treatment interruptions, participants' general health status and comorbidities, service delivery practices and experience of stigma and discrimination at healthcare facilities, and healthcare providers' attitude in terms of participants' sexual and reproductive health.

6.5.1. HIV Testing, Care, and Treatment

Participants were asked about their choices to be tested for HIV. For the majority of respondents, testing for HIV was their own decision: 450 (60.1%) respondents decided to take the test consciously and voluntarily, and 48 (6.4%) did it under pressure from other people, although they themselves decided to take the test. Respondents reporting that they were tested without their knowledge and found out about it only after doing the test accounted for 230 (30.7%). Only 13 (1.7%) respondents indicated that they were forced to take an HIV test without their consent and 8 (1.1%) were born with HIV or acquired HIV in infancy/childhood and were not aware that they had been tested. There were slight differences by sex at birth in terms of voluntary testing (with more women [n=154; 63.3%] testing voluntarily than men [289; 58.3%]) and testing voluntarily, but under pressure from others (with more men [n=39; 7.9%] testing voluntarily, but under pressure than women [n=9; 3.7%]). Almost half of PWUD reported being tested without their knowledge (n=91; 47.6%). More details are provided in Table 22 below.

Table 22. Respondents' self-determination on HIV testing, by sex at birth and key populations, n and %

Items	**Total PLHIV**	**PLHIV**	**MSM**	**SW**	**TG**	**PWUD**

			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes, it was my choice	450	60.1	154	63.3	289	58.3	50	78.1	75	67.6	22	71.0	87	45.5
Yes, but I was pressured by others	48	6.4	9	3.7	39	7.9	7	10.9	11	9.9	3	9.7	8	4.2
No, I was tested without my knowledge and only found out after the test had been done	230	30.7	76	31.3	152	30.6	6	9.4	25	22.5	6	19.4	91	47.6
No, I was forced to take an HIV test without my consent	13	1.7	4	1.6	9	1.8	1	1.6	0	0	0	0	4	2.1
No, I was born with HIV or acquired HIV in infancy/childhood and was not aware I had been tested	8	1.1	0	0	7	1.4	0	0	0	0	0	0	1	0.5
Total	749	100	243	100	496	100	64	100	111	100	31	100	191	100

The respondents who indicated that they were tested for HIV by their choice whether voluntarily or under pressure from other people (N=498), were asked: (1) to list main reasons for testing, (2) to indicate the time between they first thought to get an HIV test and the time they first took an HIV test and (3) to tell if the positive test result made them hesitant to take the test due to fears about how other people (e.g., your family, friends, employer, or community) would respond.

Being referred for testing by a healthcare provider or as part of other health care (including blood donation, pre-surgery investigation, antenatal care, PrEP, TB, HCV, STI care) was the most frequent reason for HIV testing (n=130; 26.3%), followed by feeling sick and being suspected of HIV-related cause (n=128; 25.9%). Perception of being at risk for HIV was the reason for testing for 111 (22.4%) participants. Other reasons were specified by 43 (8.7%) respondents, out of which the majority tested because their partners/wife/husband was diagnosed with HIV. More women and TG from KP groups reported being tested based on the providers' recommendation. Testing due to risk perception was highest among TG and PWUD, while feeling sick was more often noted by SW. Not surprisingly, representatives of KPs were more often tested within community-based programs compared to those from the general population. Testing due to curiosity was highest among MSM population (Table 23).

Table 23. Reasons for HIV testing, by sex at birth and key populations, n and %, N=495, missing=3

Items	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
A provider recommended it, or as part of other health care (e.g., antenatal, medical male circumcision, STI	130	26.3	49	30.2	81	24.8	12	21.0	16	18.6	7	28.0	19	20.0

testing/treatment, PrEP)														
I believed I was at risk for HIV	111	22.4	39	24.1	69	21.2	11	19.3	23	26.7	8	32.0	31	32.6
I felt sick and I/someone close to me thought it might be HIV related	128	25.9	35	21.6	93	28.5	5	8.8	23	26.7	1	4.0	23	24.2
As part of or because of a community-based program	40	8.1	4	2.4	34	10.4	10	17.5	10	11.6	4	16.0	10	10.5
It was mandatory (e.g., for employment, visa/citizenship, incarceration, marriage, to access antenatal care)	4	0.8	3	1.8	1	0.3	0	0	1	1.2	0	0	1	1.1
I just wanted to know	39	7.9	8	4.9	30	9.2	16	28.1	11	12.8	5	20.0	8	8.4
Other reasons	43	8.7	24	14.8	18	5.5	3	5.3	2	2.3	0	0	3	3.2
Total	495	100	162	100	326	100	57	100	86	100	25	100	95	100

Almost 80% (n=383) of participants stated that the time interval between the moment when they first thought about taking test and the moment when they took it was 6 months or less, while 10.1% (n=50) of PLHIV delayed the testing for 6 months or more. Men and PWUD more often reported delaying testing (Table 24). Also, the proportion of those who tested within 6 months after their first thought about it was the highest among participants in the 18-29 age group (n=67; 85.7%)

Table 24. The time interval between the moment when the respondents first thought about taking tests and the moment when they took them, by sex at birth and key populations, n and %

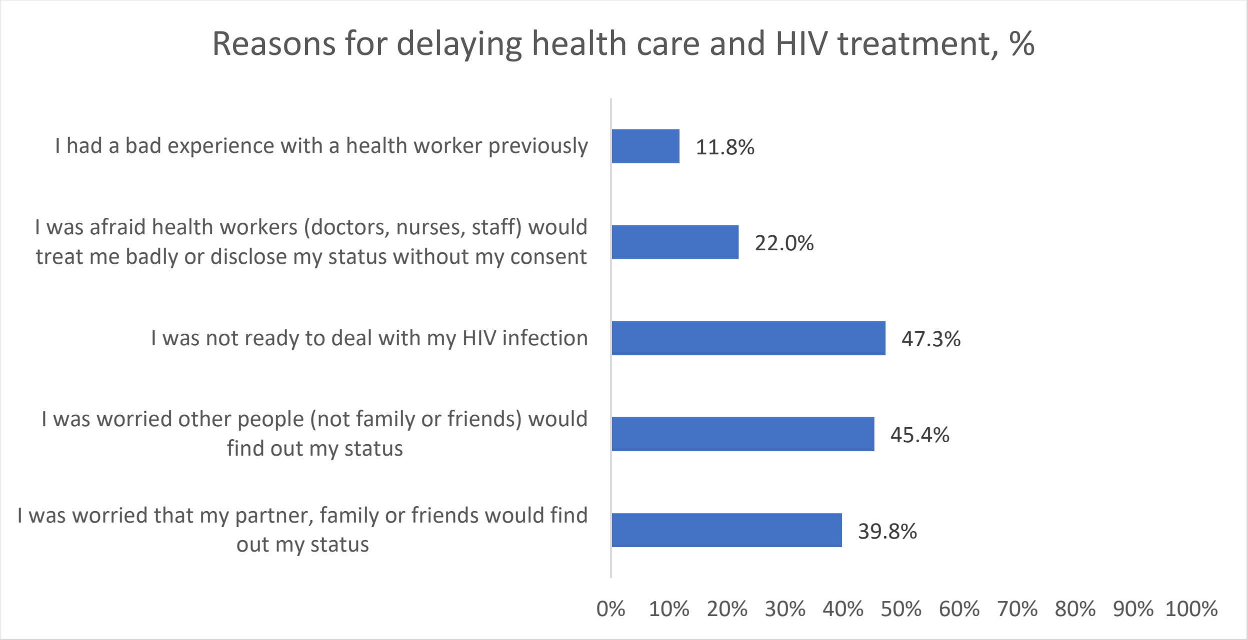
Items	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
6 months or less	383	77.7	128	80.5	251	76.8	46	79.3	71	82.6	22	88.0	56	58.3
More than 6 months to 2 years	44	8.9	9	5.6	34	10.4	2	3.5	5	5.8	1	4.0	16	16.7
More than 2 years	6	1.2	3	1.9	3	0.9	1	1.7	1	1.2	1	4.0	2	2.1
I don’t know/can’t remember	60	12.2	19	12.0	39	11.9	9	15.5	9	10.5	1	4.0	22	22.9
Total	493	100	159	100	327	100	58	100	86	100	25	100	96	100

More than a third of those who claimed they were tested for HIV by their choice (n=178/485; 36.7%; missing=13) said they were concerned of other people's reactions (friends, family members, employers, or acquaintances) to possible positive HIV test results, which drove them to postpone HIV testing.

The vast majority (n=722; 96.0%) of respondents indicated that they were taking antiretroviral therapy or had ever been on ART. Among them 593 (82.1%) chose to start treatment as soon as they were told the benefits and offered ART. 89 respondents (12.3%) indicated that when treatment was offered to them, they took the decision to wait and started at a later time and 10 (1.4%) felt pressured or forced to start treatment by health care staff. 30 (4.2%) indicated other reasons for the delay, where they mainly stated about their health condition. There were only 30 (4.0%) participants in our sample who had never received ART or were currently not receiving ART.

All respondents were asked to talk about the reasons that made them hesitate, delay, or prevent them from initiating care or treatment for HIV. More than half of the participants (415; 55.1%) reported delaying the start of health care and treatment for HIV due to at least one reason for hesitancy/delay. The reasons for the delay were as follows: 47.3% (n=351; N=742) stated that they were not ready to deal with their HIV infection; worries that people from their close social contacts (partner, family, or friends) and other contacts would find out about their HIV status was mentioned by 39.8% (n=296; N=743) and 45.4% (n=337; N=743) respectively; assumption of healthcare providers unfavorable attitude or potential breach of confidentiality was the reason for delayed HIV treatment and care seeking stated by 22.0% (n=163; N=741) of participants and 11.8% (n=88; N=741) indicated that they had a bad experience with health care provider previously, which prevented them from starting HIV treatment and care (Fig. 7).

Fig. 7. The distribution of the reasons for delaying initiation of health care and HIV treatment, %



All respondents who were taking antiretroviral therapy or had ever been on ART, were asked to indicate the time interval between HIV diagnosis and treatment initiation. Only 89 (12.3%) of participants initiated treatment on the same day of the diagnosis, while almost half of them (331; 45.8%) started the treatment within one month of the diagnosis. Only 6.2% (n=45) of the respondents had delayed treatment initiation for more than 2 years. Same day initiation of ART was higher among men and MSM (Table 25). In addition, among those who delayed treatment initiation for more than 2 years after diagnosis, more than half (n=23/45; 51.1%) were from the 40-49 years age group.

Table 25. The time interval between HIV diagnosis and treatment initiation, by sex at birth and key populations, n and %

Items	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%

Immediately – or the same day I was diagnosed	89	12.3	24	10.1	63	13.3	13	20.3	9	8.4	4	14.3	18	10.4
>1 day to 1 month (30 days) after being diagnosed	331	45.8	108	45.4	221	46.6	29	45.3	45	42.1	11	39.3	50	28.9
>1 month to 6 months after being diagnosed	122	16.9	39	16.4	81	17.1	13	20.3	29	27.1	5	17.9	33	19.1
>6 months to 2 years after being diagnosed	79	10.9	29	12.2	48	10.1	1	1.6	5	4.7	1	3.6	33	19.1
>2 years after being diagnosed	45	6.2	19	7.9	26	5.5	3	4.7	6	5.6	3	10.7	16	9.3
I can't remember	56	7.8	19	7.9	36	7.6	5	7.8	13	12.2	4	14.3	23	13.3
Total	722	100	238	100	475	100	64	100	107	100	28	100	173	100

Over the past 12 months, 144 (20.2%) study respondents missed a dose of ARV drugs due to fear that someone would learn about their HIV status. More men than women reported missing the dose due to disclosure concerns. Within key population groups, individuals identified as TG, MSM and SW exhibited a higher percentage of fear of disclosure leading to non-adherence to ARV, as indicated by a greater frequency of missed doses (Table 26).

Table 26. Missed a dose of ARV due to fear that someone would learn about their HIV status in the past 12 months by sex at birth and key populations, n and %

Items	**Total PLHIV (N=713)**		**PLHIV**				**MSM (N=64)**		**SW (N=105)**		**TG (N=28)**		**PWUD (N=171)**	
			WOMEN (N=233)		**MEN (N=471)**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Missed a dose of ARV due to fear that someone would learn about their HIV status in the past 12 months	144	20.2	39	16.7	103	21.9	18	28.1	27	25.7	11	39.3	34	19.9

Respondents who indicated that they were taking antiretroviral therapy or had ever been on ART were asked to provide information about their most recent viral load test conducted in the last 12 months. Having undetectable viral load was mentioned by 573 (79.4%) participants, while 67 (9.3%) were not virally suppressed. When looking into the different population groups, the proportion of those with self-reported undetectable viral load was the lowest for PWUD (n=128; 74.0%). In addition, detectible viral load was the highest (n=28/67; 41.8%) among PLHIV over 50 years old and those assigned male at birth (n=43/67; 64.2%) (Table 27).

Table 27. Self-reported viral load by sex at birth and key populations, n and %

Items	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes	573	79.4	198	83.2	367	77.3	49	76.6	93	86.9	23	82.1	128	74.0

No – I have not had a viral load test in the last 12 months	17	2.3	5	2.1	12	2.5	3	4.7	3	2.8	2	7.1	5	2.9
No – I had a viral load test and am waiting for the results	50	6.9	10	4.2	40	8.4	5	7.8	4	3.7	0	0	19	11.0
No – The virus was detectable/I am not virally suppressed	67	9.3	23	9.7	43	9.1	5	7.8	4	3.7	3	10.7	17	9.8
No – I have never had a viral load test	2	0.3	0	0	2	0.4	0	0	0	0	0	0	2	1.2
I don't know what viral load or viral suppression are	13	1.8	2	0.8	11	2.3	2	3.1	3	2.8	0	0	2	1.2
Total	722	100	238	100	475	100	64	100	107	100	28	100	173	100

6.5.2. Treatment Interruptions

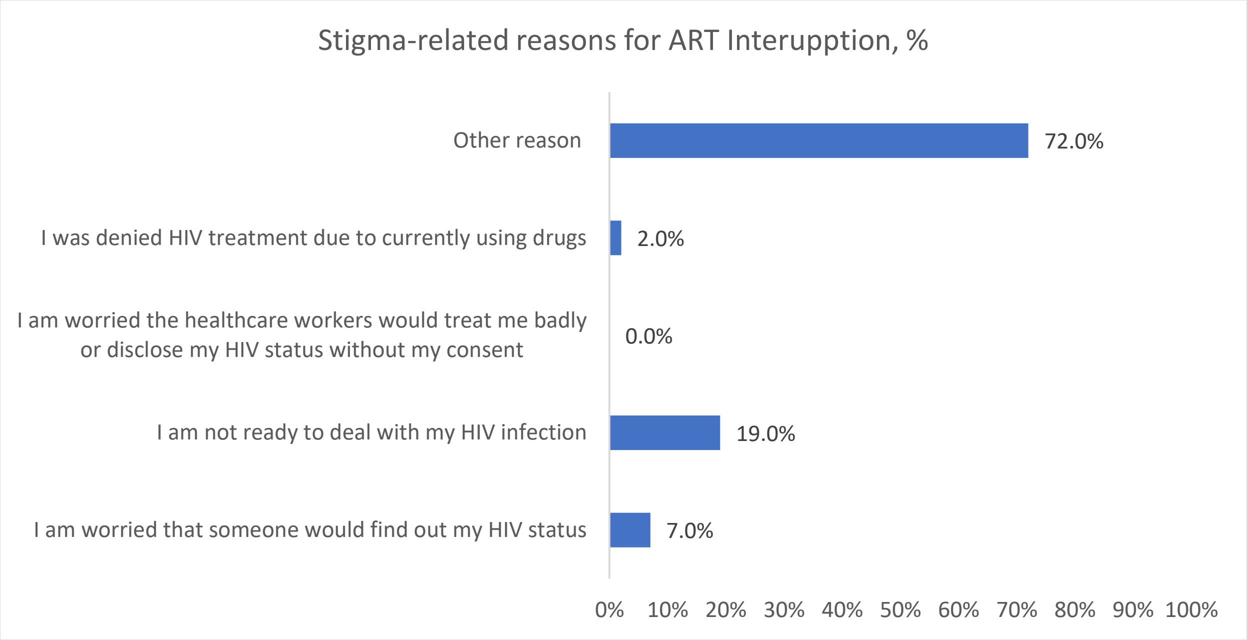
Among those who had ever started ART, 489 (67.6%) participants stated that they had never interrupted treatment, respectively 168 (23.2%) had ever interrupted ART and 66 (9.1%) could not provide information for this question. Encounters of treatment interruption was higher among men, MSM, TG and SWs. Results for treatment interruption by separate KP groups are summarized in Table. 28.

Table 28. Treatment interruption by sex at birth and key populations, n and %

Items	**Total PLHIV (n=723)**		**PLHIV**				**MSM (n=64)**		**SW (n=107)**		**TG (n=28)**		**PWUD (n=175)**	
			WOMEN (n=238)		**MEN (n=476)**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Ever interrupted ART	168	23.2	45	18.9	122	25.6	25	39.1	38	35.5	10	35.7	45	25.7

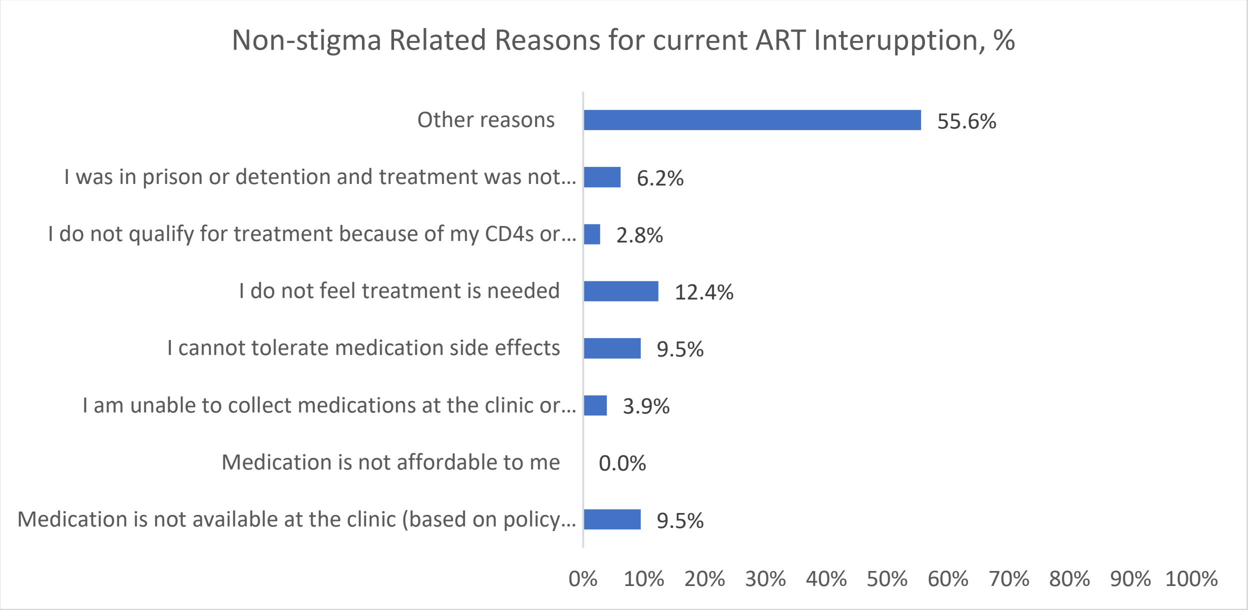
Participants with treatment interruption experience for any period of time in the last 12 months were asked to state if it happened due to certain stigma-related and non-stigma related reasons. Among the stigma-related reasons, 19.0% (n=19) of the respondents stated that they were not ready to deal with HIV infection as a reason for ART interruption. The majority (n=72; 72.0%) of respondents chose the "other reasons" option, but responses listed there were mostly non-stigma related, such as alcohol use, being out of the city/country, stress, etc. (Fig. 8).

Fig. 8. Stigma-related reasons for ART interruption, %, N=100, (missing=35; N/A=33)



The main non-stigma-related reason why these respondents did not currently receive HIV treatment, according to them, was that they did not think treatment was needed (n=22; 12.4%), non-availability of medication at the clinic (n=17; 9.5%), side effects of ARV drugs (n=17; 9.5%), being in prison (n=11; 6.2%), etc. Again, the majority (n=99; 55.6%) of respondents talked about other non-stigma related reasons for treatment interruptions, such as drug/alcohol use and being out of the city/country (Fig. 9).

Fig. 9. Non-stigma related reasons for current ART interruption, %, N=178



Respondents were also asked to indicate reasons for postponing, delaying or being prevented from restarting treatment after treatment interruption. The most frequent answers included not being ready for dealing with HIV infection (n=47; 36.7%) and being worried about status disclosure among close people (partner, family, or friends) and other people (n=19; 14.8% and n=23; 18.0% respectively). Another 7.8% (n=10) of the respondents also talked about their previous unfavorable experience with health care workers. Also, the fear that health care workers would disclose their status was mentioned as one of the reasons for treatment restarting hesitancy by 5.6% (n=7) of the participants (Table. 29).

Table 29. The reasons for the hesitancy restarting treatment, n and %

Items	Yes n (%)	No n (%)	Total
I was worried that my partner, family or friends would find out my status	19 (14.8%)	109 (85.2%)	128 (missing=40)
I was worried other people (not family or friends) would find out my status	23 (18.0%)	105 (82.0%)	128 (missing=40)
I was not ready to deal with my HIV infection	47 (36.7%)	81 (63.3%)	128 (missing=40)
I was afraid health workers (doctors, nurses, staff) would treat me badly or disclose my status without my consent	7 (5.6%)	119 (94.4%)	126 (missing=42)
I had a bad experience with a health worker previously	10 (7.8%)	118 (92.2%)	128 (missing=40)

6.5.3. General Health Status

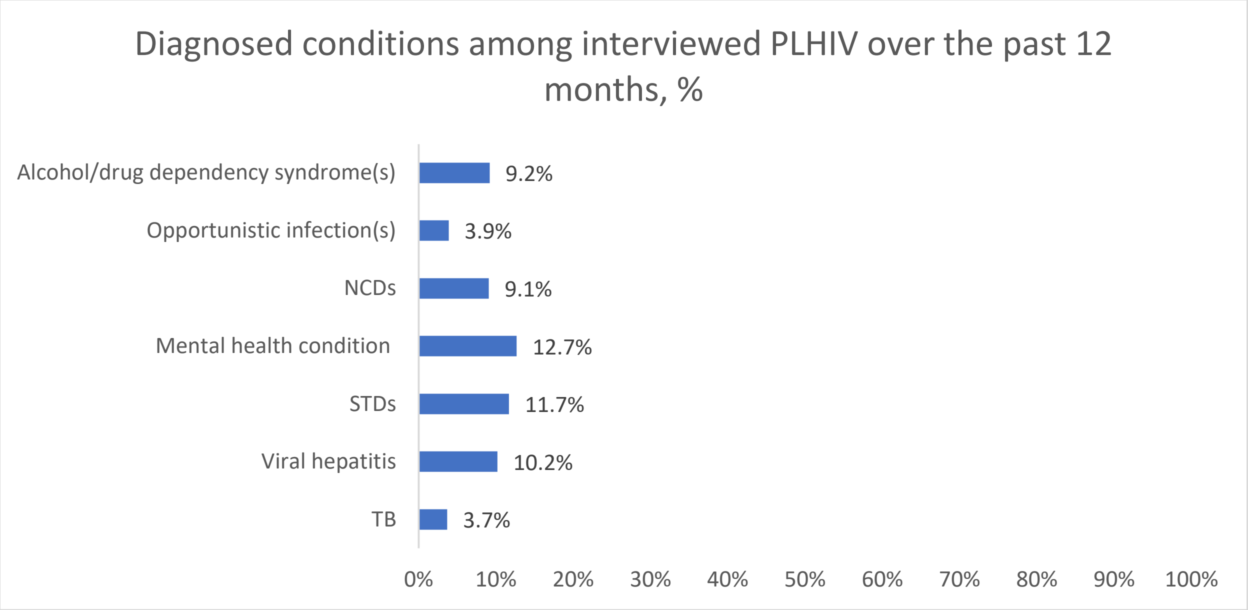
Slightly more than half of the respondents (390; 52.0%) evaluated their health as good, while 43.6% (n=327) defined their health as fair. Only 4.4% (n=33) of respondents rated their health status as poor. Perceived poor health status was more pronounced for men, and within KP groups this indicator was highest for PWUD. (Table 30).

Table 30. General health status by sex at birth and key populations, n and %

Items	Total PLHIV		PLHIV				MSM		SW		TG		PWUD	
			WOMEN		MEN									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Poor	33	4.4	7	2.9	26	5.2	2	3.1	3	2.7	0	0	20	10.5
Good	390	52.0	135	55.8	251	50.4	40	61.5	54	49.1	13	43.3	87	45.5
Fair	327	43.6	100	41.3	221	44.4	23	35.4	53	48.2	17	56.7	84	44.0
Total	750	100	242	100	498	100	65	100	110	100	30	100	191	100

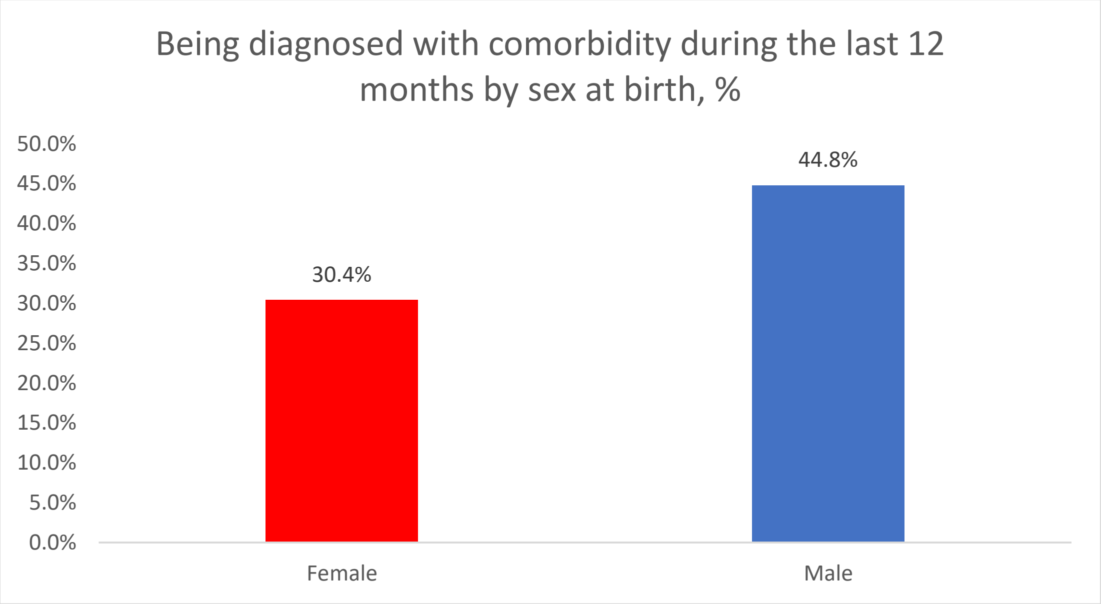
Respondents also reported other conditions diagnosed in the last 12 months. Mental health disorders (n=95; 12.7%) and sexually transmitted infections (n=88; 11.7%) were the most reported among the respondents, followed by viral hepatitis (n=77; 10.2%), the syndrome of alcohol or drug addiction (n=69; 9.2%), non-communicable diseases (n=68; 9.1%), opportunistic infections (n=29; 3.9%) and TB (n=28; 3.7%). 56.4% (228) of respondents answered that they were offered treatment for their conditions diagnosed in the past 12 months (Fig. 10).

Fig. 10. Diagnosed conditions among interviewed PLHIV over the past 12 months, %, N=750



The proportion of respondents who indicated being diagnosed with at least one comorbidity during the last 12 months was 39.7% (n=298). Among them, male PLHIV (n=224; 44.8%) had higher prevalence of being diagnosed with comorbidity compared to female PLHIV (n=74; 30.4%) (Fig. 11).

Fig. 11. Being diagnosed with at least one comorbidity during the last 12 months by sex at birth, %



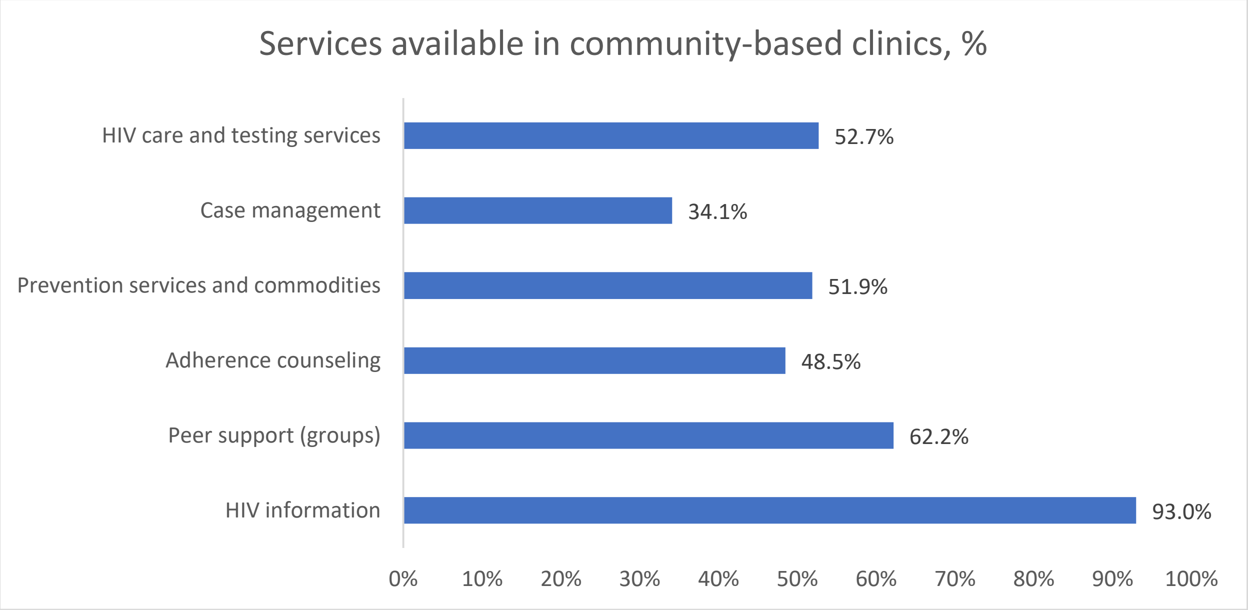
6.5.4. Service Delivery Experiences

The study participants were asked to list the institutions where they get their regular HIV care and treatment services. The largest proportion of PLHIV (714/752; 94.9%) stated that they receive HIV care and treatment services at public healthcare facilities (which is AIDS Center). Only 27 (3.6%) respondents said that they were not currently receiving HIV care or treatment. 8 (1.1%) respondents indicated private clinic, hospital, or doctor, 2 (0.3%) – multiple places and 1 (0.1%) NGO clinic or facility.

Among those receiving regular HIV care and treatment, 302 (41.7%) respondents stated that they were aware of community-based centers that provide HIV service, while 123 (17.0%) participants noted that they access those services there and 179 (24.7%) did not access such services there. More than half (422; 58.3%) of the respondents indicated that they did not know (n=354; 48.9%) or have not heard (n=68; 9.4%) of such community centers. Awareness of community-based centers was the highest among the participants from the 30-39 age group (n=115; 38.1%). The highest proportion of PLHIV who know about community-based centers was among MSM (n=38; 58.4%), followed TG (n=15; 48.4%), SW (n=46; 41.4%) and PWUD (n=78; 40.8). Men (n=202; 40.4%) and women (n=96; 40.0%) had almost the same knowledge about community-based centers.

Those who were aware of community-based centers indicated a reasonably high degree of awareness about the specific services available in such facilities (Fig. 12).

Fig. 12. Services available in community-based centers, %, N=241, Missing=61



When asked about stigma and discrimination experienced in the past 12 months from health facility staff because of their status at an HIV-specific health care institution, 34 (4.7%) participants noted that medical staff disclosed their HIV status without the consent of the respondent and 33 (4.5%) participants mentioned that they had faced cases when medical staff avoided physical contact with them. Both cases were more pronounced among MSM. Some other cases of stigma and discrimination at an HIV-specific health care institution included: being advised not to have sex because of HIV (24; 3.3%) and more than half of these participants were from MSM group, being talked badly about or gossiped about (22; 3.0%), verbal abuse (15; 2.1%) and denial of health services (12; 1.6%). There were 3 (0.4%) participants who mentioned that they had been physically abused by health facility staff at an HIV-specific health care institution in the last 12 months. (Table 31). The proportion of respondents who had sought HIV specific health care in the past year and experienced at least one manifestation of stigma and discrimination was 10.4%.

Table 31. Experiences of stigma and discrimination due to HIV status from medical staff at HIV-specific health care facility, in the last 12 months, by sex at birth and key populations, n and %

Denial of health services because of your HIV status														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes	12	1.6	3	1.3	9	1.8	1	1.6	2	1.8	0	0	7	3.9
No	719	98.4	236	98.7	474	98.1	62	98.4	107	98.2	28	100	171	96.1
Total	731	100	239	100	483	100	63	100	109	100	28	100	178	100
Being advised not to have sex because of your HIV status														
Yes	24	3.3	2	0.8	22	95.5	13	20.6	7	6.5	0	0	5	2.8
No	706	96.7	236	99.2	461	4.5	50	79.4	102	93.5	28	100	173	97.2
Total	730	100	238	100	483	100	63	100	109	100	28	100	178	100
Being talked badly about or gossiped about because of your HIV status														
Yes	22	3.0	5	2.1	17	3.5	7	11.1	2	1.9	0	0	11	6.2
No	707	97.0	233	97.9	264	96.5	56	88.9	106	98.1	28	100	167	93.8
Total	729	100	238	100	482	100	63	100	108	100	28	100	178	100
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status														
Yes	15	2.1	3	1.3	12	2.5	3	4.8	1	0.9	0	0	10	5.6
No	713	97.9	234	98.7	470	97.5	59	95.2	107	99.1	28	100	168	94.4
Total	728	100	237	100	482	100	62	100	108	100	28	100	178	100
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status														
Yes	3	0.4	1	0.4	2	0.4	0	0	0	0	0	0	2	1.1
No	727	99.6	237	99.6	481	99.6	63	100	109	100	28	100	176	98.9
Total	730	100	238	100	483	100	63	100	109	100	28	100	178	100
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status														
Yes	33	4.5	9	3.8	23	4.8	7	11.1	5	4.7	1	3.5	7	3.9
No	697	95.5	229	96.2	460	95.2	56	88.9	104	95.3	27	96.5	171	96.1
Total	730	100	238	100	483	100	63	100	109	100	28	100	178	100
Telling other people about your HIV status without your consent														
Yes	34	4.7	13	5.4	21	4.4	6	9.5	3	2.8	1	3.5	13	7.3
No	695	95.3	225	94.6	461	95.6	57	90.5	106	97.2	27	96.5	164	92.7
Total	729	100	238	100	482	100	63	100	109	100	28	100	177	100

The third of the PLHIV interviewed (n=275; 36.7%) said that in the last 12 months they had sought healthcare for different non-HIV related health needs. Women slightly more often sought non-HIV related health care than men (n=97; 40.3% compared to n=176; 35.3%). Within separate KP group TG (n=17; 54.8%) more often stated that they had sought healthcare for different non-HIV related health needs, followed by MSM (n=31; 47.7%), SW (n=34, 30.6%) and PWUD (n=57; 30.0%).

The level of stigma and discrimination at non-HIV facilities outweighed the level of stigma and discrimination in HIV treatment institutions. The proportion of respondents who had sought health care for non-HIV related reasons in the past year and experienced at least one manifestation of stigma and discrimination was 31.2%.

When asked about stigma and discrimination experienced in the previous 12 months from health facility staff because of their HIV status at a non-HIV-specific health care institution, 63 (23.8%) participants reported cases in which medical staff avoided physical contact with them, 31 (11.9%) respondents noted that their HIV status was disclosed without their consent. Other instances of stigma and discrimination at a non-HIV-specific healthcare facility included: being gossiped about (29; 10.9%), being advised not to have sex because of HIV (12; 4.5%), denial of dental care (11; 4.1%), denial of health services (9; 3.4%) and verbal abuse (7; 2.6%). One (0.4%) individual reported being physically abused. Again, experiences of stigma and discrimination at non-HIV specific health care facilities were more often stated by MSM (Table 32).

Table 32. Experiences of stigma and discrimination due to HIV status from medical staff at non-HIV-specific health care facility, in the last 12 months, by sex at birth and key populations, n and %

Denial of health services because of your HIV status														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes	9	3.4	2	2.1	7	4.1	3	10.0	2	5.9	0	0	3	5.3
No	257	96.6	92	97.9	163	95.9	27	90.0	32	94.1	17	100	54	94.7
Total	266	100	94	100	170	100	30	100	34	100	17	100	57	100
Denial of dental care because of your HIV status														
Yes	11	4.1	3	3.2	8	4.7	4	13.3	2	5.9	0	0	2	3.5
No	255	95.9	91	96.8	162	95.3	26	86.7	32	94.1	17	100	55	96.5
Total	266	100	94	100	170	100	30	100	34	100	17	100	57	100
Being advised not to have sex because of your HIV status														
Yes	12	4.5	4	4.3	8	4.7	4	13.3	3	8.8	0	0	1	1.7
No	254	95.5	90	95.7	162	95.3	26	87.7	31	91.2	17	100	56	98.3
Total	266	100	94	100	170	100	30	100	34	100	17	100	57	100
Being talked badly about or gossiped about because of your HIV status														
Yes	29	10.9	11	11.7	18	10.5	4	13.3	3	8.8	0	0	7	12.3
No	237	89.1	83	83.3	152	89.5	26	86.7	31	91.2	17	100	50	87.7
Total	266	100	94	100	170	100	30	100	34	100	17	100	57	100
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status														
Yes	7	2.6	2	2.3	5	2.9	1	3.3	0	0	0	0	3	5.3
No	259	97.4	92	97.9	165	97.1	29	96.7	34	100	17	100	54	94.7
Total	266	100	94	100	170	100	30	100	34	100	17	100	57	100
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status														
Yes	1	0.4	1	1.1	0	0	0	0	0	0	0	0	0	0
No	265	99.3	93	98.9	170	100	30	100	34	100	17	100	57	100
Total	266	100	94	100	170	100	30	100	34	100	17	100	57	100
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status														
Yes	63	23.8	23	24.5	40	23.7	7	23.3	5	14.7	1	5.9	6	10.5
No	201	76.2	71	75.5	128	76.3	23	76.7	29	85.3	16	94.1	51	89.5
Total	264	100	94	100	168	100	30	100	34	100	17	100	57	100
Telling other people about your HIV status without your consent														
Yes	31	11.9	14	15.2	17	10.1	3	10.0	3	8.8	0	0	7	12.3
No	232	88.1	78	94.8	152	89.9	27	90.0	31	91.2	17	100	50	87.7
Total	263	100	92	100	169	100	30	100	34	100	17	100	57	100

The majority of all PLHIV interviewed (n=541; 71.9%) said that they usually do not disclose their HIV status when receiving healthcare services not related to HIV outside HIV clinic. Men slightly more often did not disclose their status when they went outside the HIV clinic for general (non-HIV related) health services, than women (n=362; 72.4% compared to n=170; 70.0%). Within separate KP groups, non-disclosure status when they went outside the HIV clinic was highest among SW (n=88, 79.3%), then TG (n=24; 77.4%), followed by MSM (n=49; 75.4%), and PWUD (n=127; 66.5%) (Table 33).

Table 33. HIV status disclosure when receiving healthcare services not related to HIV outside HIV clinic, by sex at birth and key populations, n and %

HIV status disclosure when receiving healthcare services not related to HIV outside HIV clinic														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Yes	212	28.1	73	30.0	138	27.6	16	24.6	23	20.7	7	22.6	64	33.5
No	541	71.9	170	70.0	362	72.4	49	75.4	88	79.3	24	77.4	127	66.5
Total	753	100	243	100	500	100	65	100	111	100	31	100	191	100

Participants were asked to comment about the confidentiality of their medical records relating to their HIV status. Most of them (n=454; 60.4%) noted that they are sure the information about their HIV status is kept confidential and will not be shared without their written informed consent, over third of the respondents (n=262; 34.9%) were not sure about this, and 35 (4.7%) participants believed that their medical records are not kept confidential.

6.5.5. Sexual and Reproductive Health

Sexual and reproductive health questions were first separately asked to all participants and then to females only. Questions for the entire sample included health care professionals' stigmatizing/discriminatory behavior towards the participants, solely because of their HIV status in the last 12 months. Only a very small proportion of respondents indicated that during the last 12 months they had received advice from the healthcare professional not to mother/father a child (n=7; 1.0%) and to use a specific method of contraception to get ART (n=4; 0.6%) (Table 34).

Table 34. Health care professionals' behavior towards the participants during the last 12 months, n and %

	Yes **n (%)**	**No** **n (%)**	**Prefer not to answer** **n (%)**	**Total** **n (%)**
Advised you not to mother/father a child	7 (1.0%)	639 (97.0%)	13 (2.0%)	659 (100%)
Pressured or incentivized you to get sterilized	0 (0%)	645 (97.9%)	14 (2.1%)	659 (100%)
Sterilized you without your knowledge or consent	0 (0%)	(98.0%)	13 (2.0%)	656 (100%)
Denied your contraception/family planning services	0 (0%)	6 (98.0%)	13 (2.0%)	655 (100%)
Told you that you had to use (a specific method of) contraception to get your HIV (antiretroviral) treatment	4 (0.6%)	628 (97.5%)	12 (1.9%)	644 (100%)

Questions for females also included healthcare professionals' stigmatizing/discriminatory behavior towards the participants, solely because of your HIV status both during the last 12 months and earlier. One woman (0.5%) noted that healthcare professional advised her to terminate pregnancy because of her HIV status during the last 12 months. Other encounters of stigmatizing/discriminatory behaviors from health care professionals (Table 35) were mentioned by female PLHIV that had happened before the last 12 months.

Table 35. Health care professionals' behavior towards the female participants during the last 12 months, n and %

	Yes n (%)	Yes, but not within the last 12 months n (%)	No n (%)	Prefer not to answer n (%)	Total n (%)
Advised you to terminate a pregnancy	1 (0.5%)	7 (3.5%)	184 (92.9%)	6 (3.1%)	198 (100%)
Pressured you to use a specific type of contraceptive method	0 (0%)	5 (2.5%)	188 (95.4%)	4 (2.1%)	197 (100%)
Pressured you to use a particular method of giving birth/delivery option	0 (0%)	9 (4.6%)	181 (92.8%)	5 (2.6%)	195 (100%)
Pressured you to use a particular infant feeding practice	0 (0%)	13 (6.7%)	178 (91.3%)	4 (2.0%)	195 (100%)
Pressured you to take HIV (antiretroviral) treatment during pregnancy	0 (0%)	10 (5.2%)	178 (92.2%)	5 (2.6%)	193 (100%)

6.6. Human Rights and Affecting Change

Respondents were questioned about any violations of their rights as PLHIV they had experienced in the previous year or earlier. According to the study findings, cases of human rights abuse were not common. The vast majority (91.7%-98.1%) of respondents stated that they had not experienced any of the breaches listed in Table 36. Being forced to take an HIV test or disclosure of HIV status as a precondition for receiving health care services was the most frequently noted violation experienced by study participants both within the past 12 months and earlier (3.2% and 3.4% respectively). Data for separate groups are presented in Table 36.

Table 36. Violations of the rights of people living with HIV within the past 12 months and earlier, by sex at birth and key populations, n and %

I was forced to get tested for HIV or disclose my status in order to obtain a visa or to apply for residency/citizenship in a country														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**TG**		**PWUD**	
			WOMEN		**MEN**									
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
No	686	97.9	237	98.7	441	97.4	63	100	110	100	29	100	149	97.4
Yes, within the last 12 months.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yes, but not within the last 12 months.	4	0.6	2	0.8	2	0.4	0	0	0	0	0	0	1	0.6
Prefer not to answer	11	1.6	1	0.4	10	2.2	0	0	0	0	0	0	3	2.0
Total	701	100	240	100	453	100	63	100	110	100	29	100	153	100
I was forced to get tested for HIV or disclose my status in order to apply for a job or get a pension plan														
No	680	96.8	233	96.7	439	96.7	63	98.5	110	100	30	100	148	96.7
Yes, within the last 12 months.	4	0.7	3	1.2	1	0.2	0	0	0	0	0	0	0	0
Yes, but not within the last 12 months.	7	0.9	3	1.2	4	0.9	1	1.5	0	0	0	0	2	1.3
Prefer not to answer	11	1.6	1	0.8	10	2.2	0	0	0	0	0	0	3	2.0
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was forced to get tested for HIV or disclose my status in order to attend an educational institution or get a scholarship														

No	687	98.0	237	98.7	442	97.6	63	98.5	109	99.1	30	100	149	98.0
Yes, within the last 12 months.	1	0.1	0	0	1	0.2	0	0	1	0.9	0	0	0	0
Yes, but not within the last 12 months.	2	0.2	2	0.8	0	0	1	1.5	0	0	0	0	0	0
Prefer not to answer	12	1.7	1	0.4	10	2.2	0	0	0	0	0	0	3	2.0
Total	701	100	240	100	453	100	64	100	110	100	30	100	152	100
I was forced to get tested for HIV or disclose my status in order to get health care services														
No	644	91.7	225	93.7	411	90.5	55	85.9	96	87.3	26	86.7	146	95.4
Yes, within the last 12 months.	22	3.2	6	2.5	16	3.5	2	3.1	12	10.9	1	3.3	0	0
Yes, but not within the last 12 months.	24	3.4	7	2.9	17	3.7	7	10.9	2	1.8	3	10.0	5	3.3
Prefer not to answer	12	1.7	2	0.8	10	2.2	0	0	0	0	0	0	2	1.3
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was forced to get tested for HIV or disclose my status in order to get medical insurance														
No	677	96.6	231	96.2	438	96.7	62	97.0	109	99.1	30	100	148	97.3
Yes, within the last 12 months.	1	0.1	0	0	1	0.2	0	0	1	0.9	0	0	0	0
Yes, but not within the last 12 months.	7	1.0	5	2.1	2	0.4	1	1.5	0	0	0	0	0	0
Prefer not to answer	16	2.3	4	1.6	12	2.7	1	1.5	0	0	0	0	4	2.6
Total	701	100	240	100	453	100	64	100	110	100	30	100	152	100
I was arrested or taken to court on a charge related to my HIV status														
No	686	97.6	233	97.1	445	98.0	64	100	110	100	30	100	150	98.0
Yes, within the last 12 months.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yes, but not within the last 12 months.	2	0.2	2	0.8	0	0	0	0	0	0	0	0	0	0
Prefer not to answer	14	2.1	5	2.1	9	2.0	0	0	0	0	0	0	3	2.0
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was detained or quarantined because of my HIV status														
No	686	97.6	236	98.4	442	97.4	64	100	110	100	30	100	147	96.0
Yes, within the last 12 months.	1	0.2	0	0	1	0.2	0	0	0	0	0	0	1	0.6
Yes, but not within the last 12 months.	4	0.6	2	0.8	2	0.4	0	0	0	0	0	0	2	1.4
Prefer not to answer	11	1.6	2	0.8	9	2.0	0	0	0	0	0	0	3	2.0
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was denied a visa or permission to enter another country because of my HIV status														
No	687	97.8	237	98.7	442	97.4	64	100	110	100	30	100	148	96.7
Yes, within the last 12 months.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yes, but not within the last 12 months.	3	0.4	2	0.8	1	0.2	0	0	0	0	0	0	1	0.6

Prefer not to answer	12	1.8	1	0.4	11	2.4	0	0	0	0	0	0	4	2.6
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was denied residency or permission to stay in another country because of my HIV status														
No	682	97.2	232	96.7	442	97.4	64	100	110	100	30	100	148	96.7
Yes, within the last 12 months.	1	0.1	1	0.4	0	0	0	0	0	0	0	0	0	0
Yes, but not within the last 12 months.	4	0.6	2	0.8	2	0.4	0	0	0	0	0	0	2	1.3
Prefer not to answer	15	2.1	5	2.1	10	2.2	0	0	0	0	0	0	3	2.0
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was forced to disclose my HIV status publicly or my status was publicly disclosed without my consent														
No	674	96.1	232	96.7	434	95.7	60	93.7	107	97.3	28	93.3	144	94.1
Yes, within the last 12 months.	2	0.3	1	0.4	1	0.2	1	1.6	1	0.9	0	0	0	0
Yes, but not within the last 12 months.	14	2.0	5	2.1	9	1.9	3	4.7	2	1.8	2	6.7	6	3.9
Prefer not to answer	12	1.6	2	0.8	10	1.2	0	0	0	0	0	0	3	2.0
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was forced to have sex when I did not want to														
No	686	97.8	234	97.8	444	97.8	63	98.4	107	97.3	28	93.3	152	99.3
Yes, within the last 12 months.	4	0.5	1	0.4	3	0.7	1	1.6	3	2.7	0	0	0	0
Yes, but not within the last 12 months.	2	0.2	2	2.1	0	0	0	0	0	0	2	6.7	0	0
Prefer not to answer	10	1.4	3	0.8	7	1.5	0	0	0	0	0	0	1	0.7
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
I was denied access to a domestic violence shelter														
No	689	98.1	235	97.9	446	98.3	64	100	110	100	30	100	151	98.7
Yes, within the last 12 months.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yes, but not within the last 12 months.	3	0.4	3	1.3	0	0	0	0	0	0	0	0	0	0
Prefer not to answer	10	1.5	2	0.8	8	1.7	0	0	0	0	0	0	2	1.3
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100
My partner(s) prevented me from accessing (public/private/community-led) health services														
No	686	97.7	236	98.4	442	97.4	64	100	109	99.1	29	96.8	151	98.7
Yes, within the last 12 months.	1	0.1	0	0	1	0.2	0	0	1	0.9	1	3.2	0	0
Yes, but not within the last 12 months.	2	0.3	2	0.8	0	0	0	0	0	0	0	0	0	0
Prefer not to answer	13	1.9	2	0.8	11	2.4	0	0	0	0	0	0	2	1.3
Total	702	100	240	100	454	100	64	100	110	100	30	100	153	100

Overall, the proportion of PLHIV who faced at least one of the violations of their rights during the last year was 3.7%(n=28) and 5.3%(n=40) for the earlier period.

According to the study results, of those who were subjected to infringement of their rights in the previous year, only 25.0% of respondents (7 people) stated they attempted to defend themselves and took certain protective steps: contacted a lawyer (4 people), spoke publicly about the matter (2 people) and requested documents from the medical institution (1 individual). Concerning the outcomes of these actions, three out of the seven respondents indicated that they were able to achieve a favorable result, three stated that the problem was not solved and one problem solving was still underway at the time of the study.

Respondents who indicated that they did not try to do anything about their matter with rights abused experienced during the last 12 months, were asked to state the main reason for such behavior. The most frequently mentioned reasons included being worried that taking action would lead to their HIV status disclosure (17.7%) and incompetence in the legal system - they didn't know where to go or what to do (12.4%). Among other reasons (54.9%; n=62) the most frequent answer was that they didn’t have the willpower to defend violated rights (Table 37).

Table 37. Reasons that prevented respondents from defending violated rights, n and %, N=113

	n	%
I did not know where to go/how to take action	14	12.4
I had insufficient financial resources to take action	1	0.9
The process of addressing the problem appeared too complicated	1	0.9
I felt intimidated or scared to take action	2	1.8
I was worried taking action might lead people to learn about my HIV status	20	17.7
I was worried taking action might lead people to learn that I am a man having sex with men/transgender person/person who sells sex/person who uses drugs	2	1.8
I was advised against taking action by someone else	3	2.6
I had no/little confidence that the outcome would be successful	5	4.4
There was a lack of evidence of the abuse	3	2.6
	62	54.9
	113	100

Participants were asked whether they knew about the existence of laws protecting PLHIV from discrimination in Georgia. According to the study results, nearly every second respondent (46.4%; n=325) said they were aware of legislation that protected PLHIV from discrimination, 44.6% (n=312) did not know about such laws, and the remaining 9.0% thought there were none. PLHIV female sex assigned at birth and PLHIV from KPs were more likely to be aware of such legislation. In addition, those with lower (those who answered having primary, secondary or vocational education) levels were more likely to note that there are no laws, or they were not aware of such compared to those with higher education level (those who answered having university education) (Table 38). Among those who stated that they knew about existing laws protecting PLHIV from discrimination over 50% were in the 30-49 years age group.

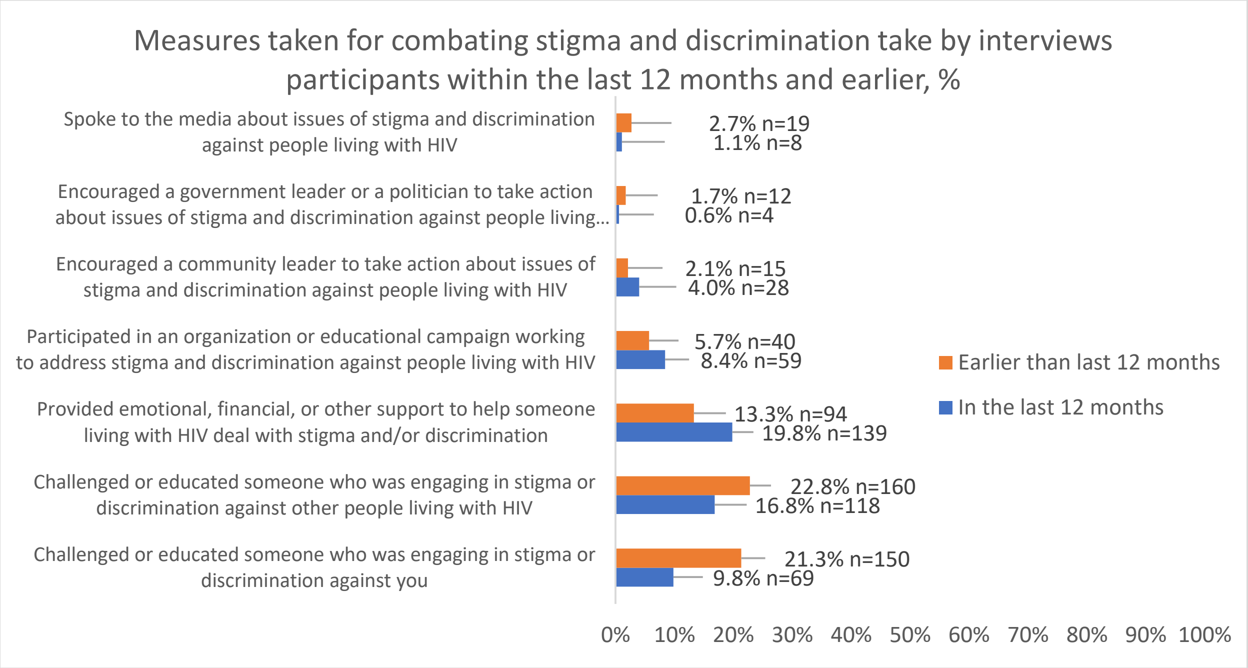
Table 38. Awareness of laws that protect PLHIV against discrimination, entire sample, by sex at birth, by PLHIV population groups and by education level, %

Do you know if there are any laws in your country to protect people living with HIV from discrimination?	**Entire sample N=700**	**Sex at Birth**		**PLHIV population groups**		**Education level**	
		Male N=451	*Female N=241*	*PLHIV, General population*	*PLHIV, All KPs N=229*	*Lower education N=436*	*Higher education N=254*

				N=471			
Yes, there are laws	46.4%	42.8%	51.5%	43.9%	51.5%	37.8%	59.9%
No, there are no laws	9.0%	10.6%	6.2%	8.7%	9.6%	11.7%	4.7%
I don’t know if there are laws	44.6%	46.6%	42.3%	47.4%	38.9%	50.5%	35.4%
	100	100	100	100	100	100	100

Participants were asked about the various measures they have taken for combating stigma and discrimination against PLHIV both within the last 12 months and earlier. Providing emotional, financial, or other support to help PLHIV deal with stigma and/or discrimination; challenging or educating those engaging in stigma or discrimination against other PLHIV and challenging or educating those engaging in stigma or discrimination against them were the most prevalent answers. Overall, respondents who had done at least any of the listed measures both in the last 12 months or earlier, was 24.6% and 27.9% respectively (Fig. 13).

Fig. 13. Measures taken for combating stigma and discrimination taken by interviews participants within the last 12 months and earlier, n and %



6.7. Stigma and Discrimination Experienced for Reasons Other than HIV Status

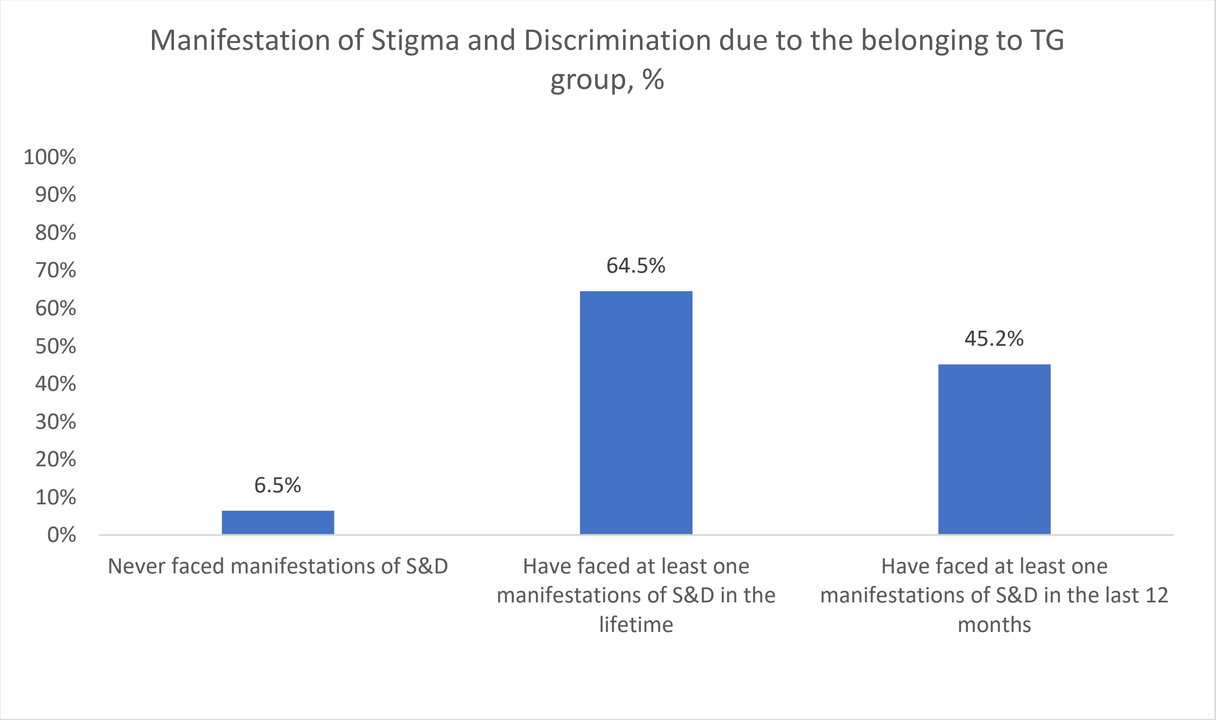
This section provides information about the stigmatization of people living with HIV who belong to key populations. The questionnaire initially asked questions to identify the respondent as a member of a specific key population category (TG, MSM, SW, PWUD), and then questions regarding their experiences with stigma and discrimination because of their membership in that group. In addition, participants were asked if their social surroundings were aware of their KP membership and their participation in community networks or support groups.

6.7.1. Transgender people

In the total sample the number of transgender people was 31 (4.1%). This number was calculated from the persons who identified as transgender in the questionnaire and who had mismatch in the gender and sex at birth variables.

Only 2 (6.5%) out of 31 TG stated that they had never faced manifestations of stigma and discrimination (including internalized stigma) because of their belonging to this social group. Instead, 20 (64.5%) out of 31 respondents had such an experience, including 14 (45.2%) reporting at least one of the manifestations of stigma within the last 12 months (Fig. 14).

Fig. 14. Manifestation of Stigma and Discrimination due to the belonging to TG group, %, N=31



The most common manifestations of stigma and discrimination within the past 12 months noted by the participants were verbal insults (n=13; 54.2%), followed by exclusion from family activities (n=8; 33.3%), discriminatory remarks by family members and physical harassments (both n=6; 25.0%), being blackmailed (n=4; 17.4%) and fear of seeking health services (n=4; 16.7%). Avoidance of seeking health services because of being worried about other people learning their gender identity was mentioned by 3 (12.5%) TG. Participants also recounted experiences of stigma and discrimination predating the last 12 months, with 50% (n=12) of transgender individuals reporting incidents of physical harassment, over 40% (n=10) citing discrimination from family members, and more than a third (n=8; 33.3%) disclosing instances of verbal harassment and feeing afraid to seek health services because of your gender identity. (Table 39).

Table 39. Stigma and Discrimination towards TG identity, n and %, N=24 (missing=7)

	Yes, within the last 12 months n (%)	**Yes, but not in the last 12 months n (%)**	**No n (%)**	**Prefer not to answer n (%)**
Have you ever felt excluded from family activities because of your gender identity?	8 (33.3%)	7 (29.2%)	8 (33.3%)	1 (4.2%)
Have you ever felt that family members have made discriminatory remarks or gossiped about you because of your gender identity?	6 (25.0%)	10 (41.7%)	7 (29.2%)	1 (4.2%)

Have you ever felt afraid to seek health services because of your gender identity?	4 (16.7%)	8 (33.3%)	12 (50.0%)	0 (0%)
Have you ever avoided seeking health services because you worried someone may learn of your gender identity?	3 (12.5%)	4 (16.7%)	17 (70.8%)	0 (0%)
Has someone ever verbally harassed you because of your gender identity?	13 (54.2%)	8 (33.3%)	2 (8.3%)	1 (4.2%)
Has someone ever blackmailed you because of your gender identity?	4 (17.4%)	6 (26.1%)	12 (52.2%)	1 (4.3%)
Has someone ever physically harassed or hurt you because of your gender identity?	6 (25.0%)	12 (50.0%)	6 (25.0%)	0 (0%)

The majority (n=23/24; 95.8%) of TG respondents said that at least someone from their social environment members knew about their belonging to this group, which includes others transgender people or people whose gender identity differs from the sex they were assigned at birth, family or other friends or other people in your community (Table 40).

Table 40. Awareness of the social environment about the belonging of respondents to the group of TG, n and %

In general, do the following people or groups of people know your gender identity (Transgender)?	**Yes n (%)**	**No n (%)**
Other transgender people or people whose gender identity differs from the sex they were assigned at birth (N=24; missing=7)	23 (95.8%)	1 (4.2%)
Family or other friends (N=24; missing=7)	21 (87.4%)	3 (12.5%)
Other people in your community (N=24; missing=7)	23 (95.8%)	1 (4.2%)

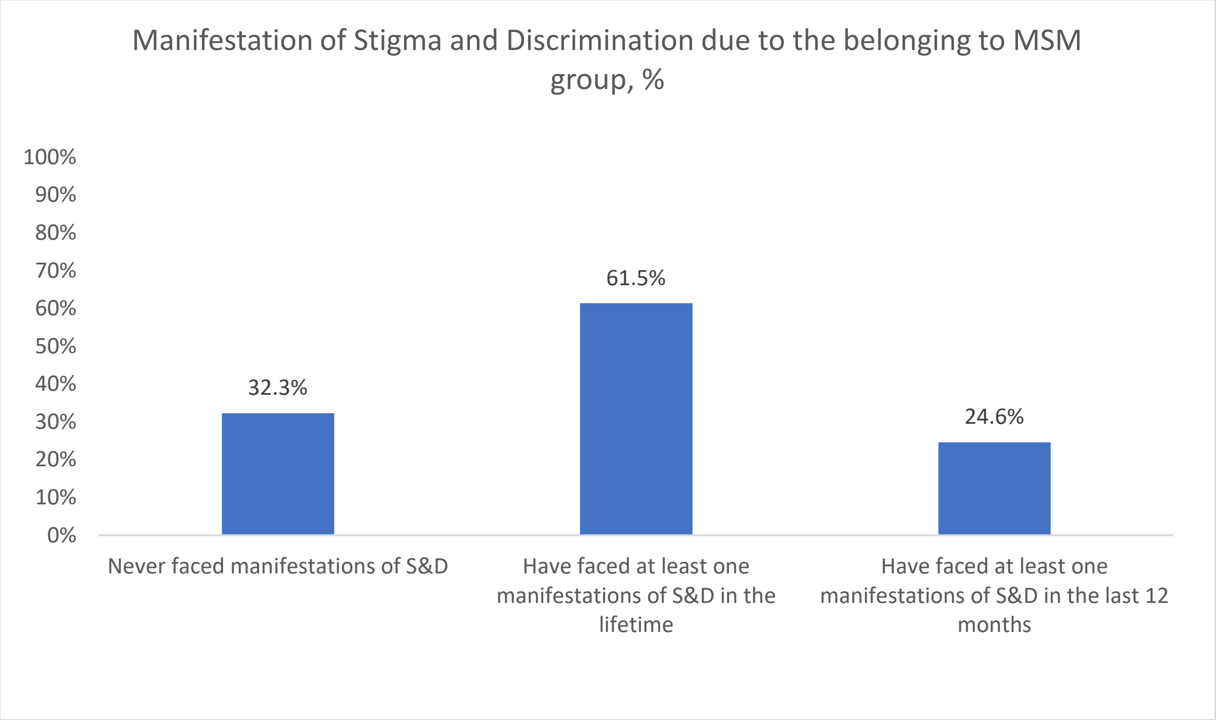
Out of the 22 participants who shared information about their affiliation with networks or support groups for individuals identifying as transgender people or people whose gender identity differs from the sex they were assigned at birth, 13 individuals (59.1%) reported being members of such groups or networks.

6.7.2. Men who have sex with men

In the total sample the number of MSM was 65 (8.6%). This number was calculated from the persons who indicated that they currently or had previously identified themselves as members of MSM/Gay/Homosexual and those who stated that they ever had sex with another man.

A little more than a third of MSM/gays who were interviewed (n=21; 32.3%) stated that they had never faced manifestations of stigma and discrimination (including internalized stigma) because of their belonging to this social group. Instead, 40 (61.5%) respondents had such an experience, including 16 (24.6%) of them reporting at least one of the manifestations of stigma in the 12 months preceding the survey (Fig. 15).

Fig. 15. Manifestation of Stigma and Discrimination due to the belonging to MSM group, %, N=65



The most common manifestations of stigma and discrimination within the past 12 months as noted by the study participants were verbal insults (12; 19.0%), fear of seeking and avoidance of healthcare services because of being worried about other people learning their gender identity (both 9; 14.3%) and exclusion from family activities (7; 11.3%). Instances of stigma and discrimination occurring in the period preceding the last 12 months were more frequently reported, ranging from 12.7% experiencing physical harassment to over 25% expressing concerns about seeking healthcare due to apprehensions about disclosing their MSM identity (Table 41).

Table 41. Stigma and Discrimination towards MSM identity, n and %

	Yes, within the last 12 months n (%)	**Yes, but not in the last 12 months n (%)**	**No n (%)**	**Prefer not to answer n (%)**
Have you ever felt excluded from family activities because you are gay/homosexual/MSM/have sex with men? (N=62; missing=3)	7 (11.3%)	13 (21.0%)	40 (64.5%)	2 (3.2%)
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are gay/homosexual/MSM/have sex with men? (N=63; missing=2)	4 (6.3%)	14 (22.2%)	42 (66.7%)	3 (4.8%)
Have you ever felt afraid to seek health services because you worried someone may learn you are gay/homosexual/MSM/have sex with men? (N=63; missing=2)	9 (14.3%)	16 (25.4%)	37 (58.7%)	1 (1.6%)
Have you ever avoided seeking health services because you worried someone	9 (14.3%)	14 (22.2%)	38 (60.3%)	2 (3.2%)

may learn you are gay/homosexual/MSM/have sex with men? (N=63; missing=3)				
Has someone ever verbally harassed you because you are gay/homosexual/MSM/have sex with men? (N=63; missing=2)	12 (19.0%)	14 (22.2%)	34 (54.0%)	3 (4.8%)
Has someone ever blackmailed you because you are gay/homosexual/MSM/have sex with men? (N=62; missing=3)	5 (7.9%)	11 (17.4%)	43 (68.3%)	4 (6.4%)
Has someone ever physically harassed or hurt you because you are gay/homosexual/MSM/have sex with men? (N=63; missing=2)	6 (9.5%)	8 (12.7%)	46 (73.0%)	3 (4.8%)

All MSM (n=63/63; 100%) stated that at least one member of their social environment, which includes other MSMs who are gay, homosexual, or who have sex with males, relatives, friends, or members of their community, was aware of their membership in this group. Only half of the MSM living with HIV stated that they disclosed their sexual orientation to their family members or friends (Table 42).

Table 42. Awareness of the social environment about the belonging of respondents to the group of MSM, n and %

In general, do the following people or groups of people know that you are gay/homosexual/MSM/have sex with men?	Yes n (%)	No n (%)
O	57 (90.4%)	6 (9.6%)
Family or other friends (N=58; missing=7)	30 (51.7%)	28 (48.3%)
Other people in your community (N=57; missing=8)	37 (64.9%)	20 (35.1%)

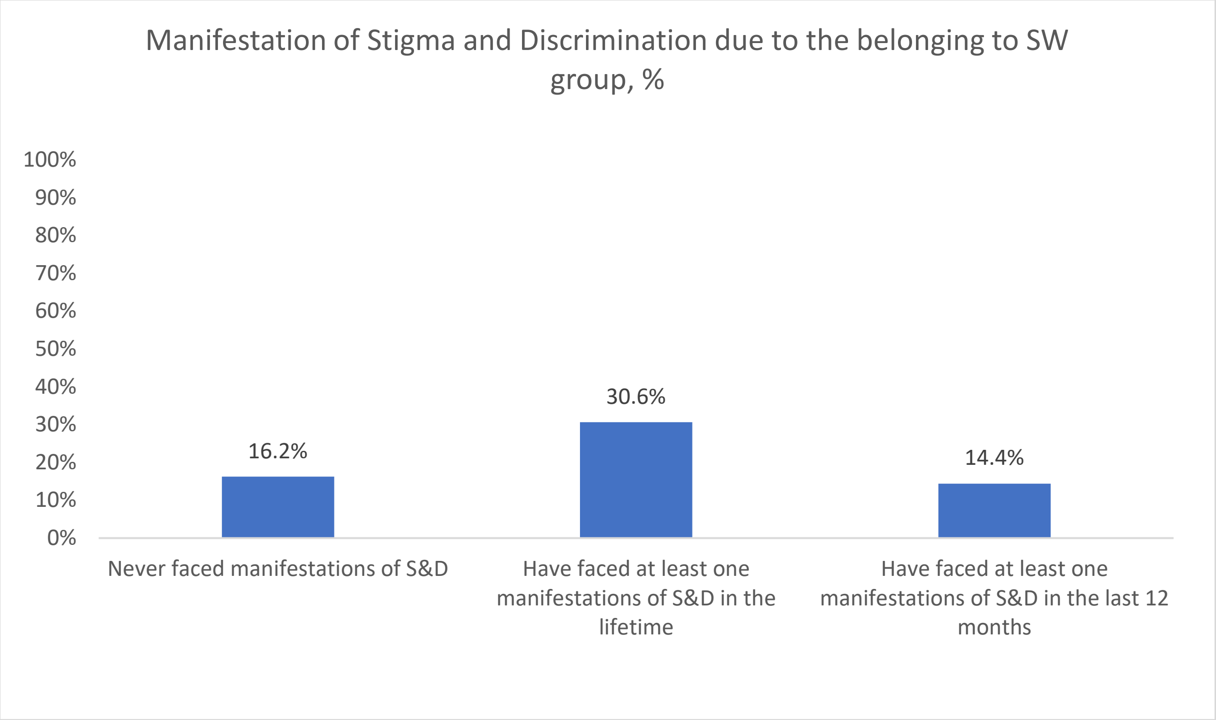
Out of the 63 participants who shared information about their affiliation with networks or support groups for individuals identifying as gay/homosexual/MSM/have sex with men, 14 individuals (22.2%) reported being members of such groups or networks.

6.7.3. Sex Workers

In the total sample the number of SWs was 111 (14.7%). Although, among them a significant number of respondents (n=65; 58.6%) indicated that while they have ever had sex in exchange for money or good, but they do not identify themselves as sex workers.

One in six of SWs (n=18; 16.2%) said that they had never encountered stigma or internalized stigma because of their belonging to this social group. Instead, 30.6% (n=34) of respondents had such experiences, including 14.4% (n=16) of them had faced at least one stigma and discrimination manifestation within the last 12 months (Fig. 16).

Fig. 16. Manifestation of Stigma and Discrimination due to the belonging to SW group, %, N=111



The most common manifestations of stigma and discrimination within the last 12 months as stated by the study participants from SW group was verbal (n=14; 26.4%) harassment. Seven participants (13.2%) stated about physical harassment, while experience of discriminatory remarks or gossiped from family members were mentioned by 6 (11.3%) SWs. Exclusion from family activities and being afraid to seek health services because someone could learn about their belonging to SW group were mentioned each by 5 (9.4%) participants and the avoidance of seeking health services and being blackmailed were mentioned each by 4 (7.6%) participants. SW reported higher frequencies of exclusion, stigma, and discrimination from family members, as well as incidents of blackmail and physical harassment in the period preceding the last 12 months (Table 43).

Table 43. Stigma and Discrimination towards SW identity, n and %, N=53 (missing=58)

	Yes, within the last 12 months n (%)	**Yes, but not in the last 12 months n (%)**	**No n (%)**	**Prefer not to answer n (%)**
Have you ever felt excluded from family activities because you are (or were) a sex worker or sell (or sold) sex?	5 (9.4%)	15 (28.3%)	30 (56.6%)	3 (5.7%)
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are (or were) a sex worker or sell (or sold) sex?	6 (11.3%)	12 (22.6%)	32 (60.4%)	3 (5.7%)
Have you ever felt afraid to seek health services because you worried someone may learn you are (or were) a sex worker or sell (or sold) sex?	5 (9.4%)	4 (7.6%)	43 (81.1%)	1 (1.9%)

Have you ever avoided seeking health services because you worried someone may learn you are (or were) a sex worker or sell (or sold) sex?	4 (7.6%)	6 (11.3%)	42 (79.2%)	1 (1.9%)
Has someone ever verbally harassed you because you are (or were) a sex worker or sell (or sold) sex?	14 (26.4%)	15 (28.3%)	23 (43.4%)	1 (1.9%)
Has someone ever blackmailed you because you are (or were) a sex worker or sell (or sold) sex?	4 (7.6%)	16 (30.2%)	32 (60.4%)	1 (1.9%)
Has someone ever physically harassed or hurt you because you are (or were) a sex worker or sell (or sold) sex?	7 (13.2%)	13 (24.5%)	32 (60.4%)	1 (1.9%)

Most sex workers surveyed (n=45/53; 85.0%) stated that at least a member of their social surroundings, such as other sex workers, family members, and acquaintances, was usually aware of their membership in this group. (Table 44).

Table 44. Awareness of the social environment about the belonging of respondents to the group of SW, n and %

In general, do the following people or groups of people know that you are (or were) a sex worker or sell (or sold) sex?	**Yes n (%)**	**No n (%)**
Other sex workers/peers in the sex work community (N=53; missing=58)	41 (77.4%)	12 (22.6%)
Family or other friends (N=53; missing=58)	34 (64.1%)	19 (35.9%)
Other people in your community (N=53; missing=58)	41 (77.4%)	12 (22.6%)

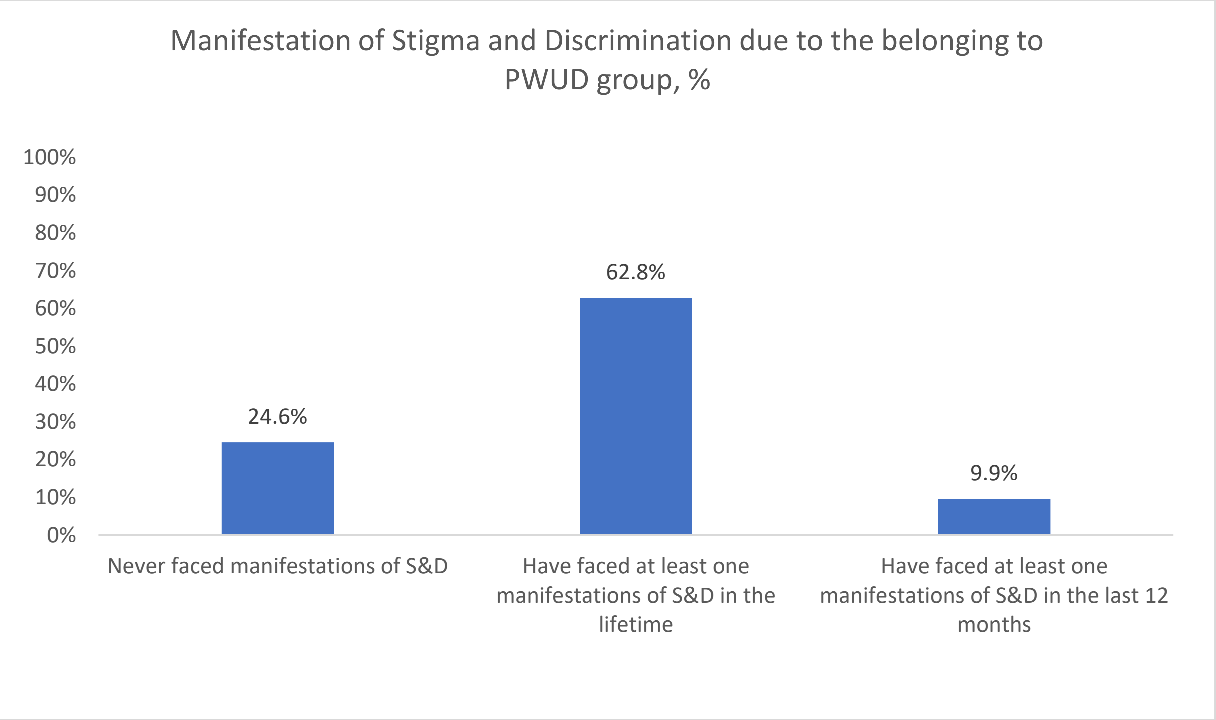
Out of the 53 participants who shared information about their affiliation with networks or support groups for individuals identifying as sex workers and/or people who sell sex, 11 individuals (20.7%) reported being members of such groups or networks.

6.7.4. People Who Use Drugs

25.4% (n=191) of respondents admitted to ever injecting or habitually using drugs such as heroin, cocaine, or methamphetamines. However, 25 (13.1%) of these respondents did not describe themselves as drug users.

Only 47 (24.6%) of PWUD claimed that being a member of this social group had not resulted in any stigmatization, including internalized stigmatization. Instead, 62.8% (n=120) of respondents had this type of experience, with 9.9% (n=19) of respondents having dealt with at least one stigma and discrimination manifestation in the last 12 months (Fig. 17).

Fig. 17. Manifestation of Stigma and Discrimination due to the belonging to PWUD group, %, N=191



Exclusion from family activities (n=13; 7.6%) and discriminatory remarks from family members (n=13; 7.6%) were the most common stigma and discrimination manifestations within the last 12 months mentioned by the study participants who belong to PWUD group. Encounters of verbal insults were mentioned by 9 (5.2%) PWUD. Avoidance of seeking health services was mentioned by 6 (3.4%) PWUD. Another 5 (2.9%) talked about cases of blackmail. In the period preceding the last 12 months, over 50% (n=88 excluded from family activities and n=94 felt that family members have made discriminatory remarks or gossiped) of PWUD reported instances of stigma and discrimination from family members. 36.6% (n=63) reported experiencing verbal and 27.9% (n=48) physical harassment. Additionally, a higher frequency of avoidance of seeking healthcare was reported during this same period (Table 45).

Table 45. Stigma and Discrimination towards PWUD identity, %, N=172 (missing=19)

	Yes, within the last 12 months n (%)	**Yes, but not in the last 12 months n (%)**	**No n (%)**	**Prefer not to answer n (%)**
Have you ever felt excluded from family activities because you use (or used) drugs?	13 (7.6%)	88 (51.2 %)	65 (37.8%)	6 (3.5%)
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you use (or used) drugs?	13 (7.6%)	94 (54.6%)	61 (35.5%)	4 (2.3%)
Have you ever felt afraid to seek health services because you worried someone may learn you use (or used) drugs?	3 (1.7%)	46 (26.7%)	114 (66.3%)	9 (5.2%)

Have you ever avoided seeking health services because you worried someone may learn you use (or used) drugs?	6 (3.4%)	38 (22.1%)	121 (70.4%)	7 (4.1%)
Has someone ever verbally harassed you because you use (or used) drugs?	9 (5.2%)	63 (36.6%)	96 (55.8%)	4 (2.3%)
Has someone ever blackmailed you because you use (or used) drugs?	5 (2.9%)	47 (I27.3%)	116 (67.4%)	4 (2.3%)
Has someone ever physically harassed or hurt you because you use (or used) drugs?	2 (1.2%)	48 (27.9%)	117 (68.0%)	5 (2.9%)

The majority of PWUD (n=160/171; 93.6%) who were interviewed stated that at least one group of people in their social context, such as other PWUD, family members, and acquaintances, was frequently informed about their membership in this group (Table 46).

Table 46. Awareness of the social environment about the belonging of respondents to the group of PWUD, n and %

In general, do the following people or groups of people know that you use (or used) drugs?	**Yes** **n (%)**	**No** **n (%)**
Other people who use drugs (N=169; missing=22)	147 (87.0%)	22 (13.0%)
Family or other friends (N=171; missing=20)	152 (88.9%)	19 (11.1%)
Other people in your community (N=169; missing=22)	133 (78.7%)	36 (21.3%)

Out of the 163 participants who shared information about their affiliation with networks or support groups for individuals identifying as drug users, 48 individuals (29.4%) reported being members of such groups or networks.

7. Discussion

This was the first attempt to document how stigma and discrimination impacts the lives of PLHIV and develop policy and advocacy recommendations for reducing HIV-related stigma and discrimination in Georgia. Before conducting this study, according to different sources and country situation assessments, Georgia belongs to the list of countries with a high degree of stigma and criminalization of key population groups. People who use drugs, sex workers and people living with HIV are subject to laws that directly criminalize acts or omissions related to their identity or health status[22]. Violence against women, including physical, sexual, and psychological abuse, remains a significant human rights violation and public health concern. Although policy progress has been made in recent years, prevalence statistics still do not fully capture the issue's scale. Adverse social norms and discriminatory attitudes are underlying causes of violence against women. Gender inequality causes this grave violation of women's rights, while the latter also reifies the former[23].

The population of Georgia has an equal and unlimited right to receive quality HIV prevention and treatment services. The following legal instruments protect the patient's entitlement to sufficient health care services while preserving their human rights and dignity: 1. Constitution of Georgia[24]; 2. Law of Georgia on Health Care[25]; 3. Law of Georgia on medical activity[26]; 4. Law of Georgia on patients' rights[27]; 5. Law of Georgia on HIV/AIDS[28].

The Law of Georgia on HIV/AIDS defines the obligation of the country's government to ensure the implementation of effective HIV prevention and treatment interventions. The law defines the main principles of the national response to HIV/AIDS, the rights and duties of HIV/AIDS patients and medical personnel, the state's obligation to ensure unlimited and equal access to high-quality HIV treatment services for all citizens of Georgia. Georgia's HIV/AIDS Law defines the government's obligation to ensure the implementation of effective HIV prevention and treatment measures. The legislation establishes the core principles of the national response to HIV/AIDS, the rights and responsibilities of HIV/AIDS patients and medical workers, and the state's commitment to assure limitless and equal access to high-quality HIV treatment services for all Georgia residents.

The primary goal of the study was to assess and comprehend the extent and characteristics of stigma and discrimination encountered by PLHIV including those from KPs in Georgia. Specific objectives included gathering information on the experiences of PLHIV with HIV-related stigma and discrimination in diverse settings such as the workplace, healthcare facilities, and within families, while considering the local cultural context. Additionally, the study aimed to examine the factors influencing access to HIV testing, treatment, and related services. Another objective was to establish a baseline for HIV-related stigma, facilitating comparisons over time and across different countries. Ultimately, the study sought to provide an empirical foundation to inform policy and advocacy recommendations geared towards reducing HIV-related stigma and discrimination in Georgia. The findings will be essential to address the existing gaps in program design and policies that must be addressed to ensure uptake of services, adherence to ART, viral suppression, and establish stigma-free settings for PLHIV in Georgia. The current study was conducted using PLHIV Stigma Index 2.0 standardized methodology and tools.

The main characteristics of the respondents: the demographic characteristics of the study participants, encompassing age and gender, align closely with the profile of people living with HIV (PLHIV) in Georgia. This alignment underscores the adherence to predefined quotas during the respondent recruitment process, affirming the representativeness of the collected data for PLHIV aged 18 and older. With a robust sample size of 753 PLHIV (500 (67.2%) male and 243 (32.7%) female; 10 participants did not answer question about sex assigned at birth), the study aimed for inclusivity by ensuring the participation of diverse key populations, including 25.4% (n=191) people who use drugs (PWUD), 14.7% (n=111) sex workers (SW), 8.6% (n=65) men who have sex with men (MSM), and 4.1% (n=31) transgender individuals (TG). Notably, 10.5% of all key populations exhibited intersecting representation, navigating dual or multiple stigmas. Examining socioeconomic aspects, a substantial proportion of the surveyed PLHIV fell within the 30-49 age range, predominantly holding secondary or vocational education. Employment challenges persisted, with over a third of PLHIV reporting unemployment. Alarmingly, despite employment, nearly 80% of the participants faced difficulties meeting their basic needs consistently throughout the 12 months preceding the survey.

HIV status disclosure is a pivotal component in the broader framework of HIV prevention and care, playing a crucial role in reducing transmission rates and facilitating engagement in care. However, the findings of our study underscore the significant challenges associated with HIV status disclosure among PLHIV in Georgia. Approximately a quarter of participants indicated that no one in their social circles was aware of their HIV status, revealing a substantial prevalence of non-disclosure.

The disclosure patterns revealed that, while a significant proportion shared their HIV status with individuals within their close social networks (62.3% to husband/wife/partner(s); 24.7% to their children; 58.8% to other family members and 43.4% to their friends), disclosure outside these circles was markedly lower, with less than 10% reporting such instances (9.9% to their neighbors; 6.2% to employer(s); 6.8% to co-workers; 3.0% to teacher(s)/school administrator(s); 2.9% to classmates; 2.4 % to local leaders and 4.2% to authority figures). Moreover, participants who disclosed their status to individuals they did not know well often encountered negative experiences, with half describing the disclosure as a challenging and unsupportive encounter.

Disturbingly, almost one-fifth of surveyed participants experienced unauthorized disclosure of their HIV status at least once, and this incidence was notably higher among representatives of PLHIV from KP groups. Only one-fifth of respondents reported an improvement over time in their ability to disclose their HIV status, suggesting persistent challenges in this regard.

Considering these findings, it becomes evident that fears of discrimination, blame, and potential disruption of relationships are formidable barriers influencing the decision-making process around disclosure for PLHIV in Georgia. We assume that one of the most important factor that contributes to this problem is HIV-related legislation in the country. The Criminal Code[29] of Georgia provides penalties for both placing people at risk of transmitting HIV and for transmitting HIV[30]. The Law of Georgia on HIV/AIDS obliges people living with HIV to report their HIV status to spouse/intimate partner(s), imposing a burden of responsibility for failure to report the diagnosis[31]. According to the same Law, if HIV-positive patients, aware of their HIV status, do not inform their partners about HIV, then the medical institution is obliged to inform the mentioned partners about exposure to HIV, if the contact information about the partners is known. Although it is not possible to find the procedure established by law regulating the notification of a spouse/sexual partner in the public domain. The study highlights a pressing need for the development and implementation of new strategies aiming at supporting and facilitating HIV status disclosure, fostering a more inclusive and understanding social environment for individuals living with HIV. The success of such strategies could significantly contribute to reducing stigma, improving care engagement, and ultimately enhancing the overall well-being of PLHIV in the country.

The frequency of **stigma and discrimination manifestations from the social environment** were quite low among study participants, which again could be linked to the low frequency of status disclosure. More surveyed PLHIV talked about encounters of stigma and discrimination that has happened earlier than 12 months preceding the survey. Stigma and discrimination manifestations mostly included discriminatory remarks or gossiping about participants' HIV status from both their close and outside social surroundings. In the recent 12 months, 5.4% of the surveyed individuals encountered at least one instance of stigma and discrimination, while 19.8% reported experiencing such incidents beyond the last 12 months. Again, PLHIV from KPs are more often experiencing stigma and discrimination manifestations by the social environment than PLHIV from general population, which could be linked to intersectional stigma, since they experience stigma and discrimination both as a PLHIV and as a member of the KP they represent. It should be noted that Georgia has a law against discrimination since 2014[32]. The Law on the Elimination of All Forms of Discrimination prohibits discrimination based on various factors, including race, language, religion, gender, and sexual orientation, in this context, we can presume that Georgia's anti-discrimination laws may play a role in low stigma and discrimination manifestations from the social environment revealed by this study. Although it is under question mark whether key affected population is aware about anti-discrimination law and the measures how to apply for it.

The study results underscore the profound impact of **internalized stigmatization** among participants, revealing pervasive feelings of shame, fear of disclosure, isolation, and despair. Overall, more than half (54.8%) of participants reported that at least one aspect of their lives (including self-confidence, self-respect, ability to respect others, ability to cope with stress, ability to have close and secure relationships with others, ability to find love, desire to have children, ability to achieve personal and/or professional goals, ability to contribute to my community, and ability to practice a religion/faith) has been negatively affected by their HIV status.

Study revealed that internalized stigmatization was manifested in self-discriminatory decisions, particularly the avoidance of seeking medical care, a critical concern for the overall health and well-being of individuals living with HIV. The pervasive difficulty in disclosing HIV status, reported by over 85% of participants, further underscores the profound impact of internalized stigma on interpersonal relationships.

It is important to highlight the potential for further exploration of the correlation between disclosure status and the level of internalized stigma, as well as the relationship between HIV disclosure and the level of stigma and discrimination manifestations from the social environment. It is worth noting that further analysis of these correlations will be conducted as part of ongoing research within the Public Health and Epidemiology PhD program at Tbilisi State University. A PhD student within the program is currently focusing on stigma in Georgia, and her work will delve deeper into these important relationships.

Noteworthy demographic variations were observed, with older individuals and those using drugs more frequently expressing statements indicative of internalized stigmatization. These findings emphasize the urgent need for targeted interventions addressing internalized stigma, especially within key populations, to enhance overall mental health, well-being, and healthcare-seeking behavior among individuals living with HIV. Crafting strategies that promote a supportive and understanding environment, coupled with age and sex-specific (focusing on women living with HIV) and substance-use-specific interventions, is crucial for mitigating the pervasive effects of internalized stigmatization in this population. It should be noted that community-led interventions to eliminate stigma are extremely restricted in the country; they are generally fragmented, dependent on funding from specific donors, and lack an intersectional approach.

The current study evaluated the situation with **stigma and discrimination against PLHIV in different health care settings,** as well as their **interaction with health care services,** including across the HIV care cascade. We have other evidence that the medical personnel often refuse medical care provision to HIV-positive people because of their status or provides services of inadequate quality. PLHIV are often forced to leave their residence[33]. It should be noted that Georgian legislation broadly addresses discrimination of the patient in health-care settings. Law on Health Protection (Article 6) and Law on Patient Rights (Article 6) bans discrimination of the patient due to gender, social affiliation, disease, sexual orientation or personal negative attitudes[34]. The study findings expose concerning delays and challenges at various stages of the HIV care continuum among surveyed participants. 10% of participants postponed taking the HIV test for over six months, primarily driven by apprehension about others' reactions to potential positive results. More than half of the respondents experienced delayed linkage to HIV treatment and care, with fear of disclosure and unreadiness to confront their HIV status being predominant barriers. The time lapse between HIV diagnosis and treatment initiation, exceeding one month for over 30% of respondents, with 6.2% reporting delays of more than two years, underscores systemic issues that impede timely access to care. Furthermore, a significant proportion acknowledged missing antiretroviral doses due to the fear of HIV status disclosure, with key populations reporting higher frequencies of non-adherence due to ahead mentioned fear. Up to 10% of participants had detectable viral loads at the time of the study, with TG more frequently reporting such instances. Treatment interruptions were experienced by almost a quarter of participants, particularly among key populations, with substance use cited as a significant reason, while only 4% had never received ART or were not on treatment at the time of the study. Stigma-related reasons, such as disbelief in the necessity of treatment, were prominent, alongside non-stigma-related factors tied to drug and alcohol use. The hesitancy to restart treatment after interruption, frequently linked to the fear of status disclosure and the perceived inability to cope with HIV infection, underscores the complex interplay of stigma and its impact on treatment continuity. Apart from this study HIV activists in Georgia talked openly about the urgent need to work with treatment initiation and continuation with PLHIV from key affected groups at different gatherings and forums. Community-led activities that intend addressing barriers to adherence are limited and concentrated only in 4 cities of the country. In addition, there is a lack of evidence what HIV treatment adherence barriers exists in the country that could formulate a plan and backup plan for each barrier, identify supportive interventions for initiation or returning to care after having stopped within special situations and track progress. These findings highlight the critical need for targeted interventions addressing stigma, promoting timely testing, and facilitating uninterrupted access to HIV care, particularly within key populations.

Health care professionals' stigmatizing/discriminatory behavior towards women PLHIV while receiving reproductive health services was noted by the very small portion of study participant. Although a recent community-led survey on Sexual and Reproductive Health and Rights of Women Living with HIV in Georgia highlights significant challenges faced by this population in accessing sexual and reproductive health services. Key issues include limited awareness of available treatments, lack of access to free and quality SRH services, and a notable gap in knowledge about reproductive rights. The findings emphasize the importance of addressing barriers to SRH services, promoting gender equality, and providing comprehensive support to improve the overall well-being of women living with HIV. Additionally, it underscores the intersectionality of factors such as violence, financial constraints, and gender norms that contribute to the complex landscape of reproductive health for this population[35]. The 2022 SRHR study among HIV-positive women revealed a number of regular correlations between the challenges of engaging in activism in this community and the violation/restriction of their sexual and reproductive rights. In many cases, their health problems stem from traumas related to sexuality and reproduction that remain largely unprocessed. Intersectional stigma and the fear of breach of confidentiality determine the very fact that even the active part is not seen in the field of activism by its HIV status, but by another sign. The group is very vulnerable to SRHR basic needs. While the country is steadily providing life-saving medicines, unfortunately SRHR needs are completely neglected.

Based on the SRHR study results, the network of women living with HIV in Georgia elaborated educational module consisting of information about sexual and reproductive health (meaning, rights), Papilloma virus and prevention of cervical cancer, safe abortion, violence from sex partner and organization of self-support/peer-led support groups. The module has not been integrated to the national HIV treatment and care program yet, but it can be considered as a positive meaningful involvement of PLHIV members in advocacy to increase access and awareness on SRHR services.

According to National guideline of eliminating mother to child transmission of HIV, the safest feeding for an infant born to an HIV-infected mother is artificial feeding, as there is no risk of repeated exposure, and the risk of vertical transmission is reduced[36]. The guideline clearly describes the steps of medical management of HIV-positive pregnant women including prevention of opportunistic and other infections, HIV treatment regimes, issues for choosing the way to give birth to healthy child.

Since HIV treatment and care is centralized in Georgia, almost all respondents noted that they received HIV services at AIDS center, which is a state institution providing services at four locations throughout the country: Tbilisi, Kutaisi, Batumi, and Zugdidi. Community-based HIV prevention services for KPs have been provided since 2002, when the first Global Fund grant was launched in Georgia. These services are mainly provided by NGOs and CBOs. Over 40% of our respondents were aware of community-based centers that provide HIV service and almost 17% had access to those services. Not surprisingly, the awareness of those services was higher among PLHIV from KP groups than those from general population. Stigma and discrimination towards PLHIV at general health care institutions exceeds the level of stigma and discrimination at HIV-specific facilities (31.2% vs 10.4%). Unauthorized status disclosure, avoidance of physical contact with the patient and being talked badly about or gossiped about because of their HIV status were the most frequent manifestations of stigma and discrimination at both type of healthcare institution (HIV specific and general) as noted by the study participants. PLHIV from KP groups were more frequently experiencing stigma and discrimination at health care facilities. Furthermore, it is important to acknowledge that individuals living with HIV often chose not to reveal their HIV status when accessing services at general healthcare facilities. As a result, the manifestation of stigma and discrimination may be underestimated in such settings. There is special law on Patient Rights[37] in Georgian legislation, that prohibits unauthorized disease status disclosure, the patient has the right to decide whether or not someone should receive information about his/her health condition. When making a positive decision, the individual must name the person to whom this information should be provided. Article 27 of the same law considers protection of confidentiality of the medical documentation. The medical service providers are obliged to protect the confidentiality of the information about the patients at their disposal both during the patients' life and after their death.

Human rights violations against PLHIV: our study indicates that instances of human rights violations against PLHIV in Georgia are relatively rare, with up to 4% of respondents reporting at least one case of rights violation in the past year. However, it's crucial to recognize the potential underreporting of cases, as fears of HIV status disclosure often deter individuals from taking action when breaches occur. Law literacy was lower among men, PLHIV from general population and respondents with lower level of education. The majority of those who attempted to defend their rights faced challenges and limited success, highlighting the need for improved awareness of legal recourse and support mechanisms. It should be noted that there is no national plan or strategy to address gender-based violence and violence against women that includes HIV in Georgia, only general criminal laws, including legislation on domestic violence prohibiting violence can be considered as a main tool to respond all type of violence to protect key populations and people living with HIV from violence[38].

To address human rights violation within challenging legal environment for key affected population, in 2019 Georgian civil society organizations started to use REAct (Rights – Evidence – Action) - instrument, which was developed by the organization of Frontline AIDS[39] for monitoring and instant response to human rights violations at the level of the communities. In Georgia, likewise in several Eastern Europe and Central Asia region, REAct system is being managed and implemented by the Alliance for Public Health in the framework of the regional project #SoS_project with The Global Fund to Fight AIDS, Tuberculosis and Malaria financial support. The cases of human rights violation have been documented about several key groups (HIV positive people, transgender sex workers and PWID sex workers) in order to address the barriers related to human rights, access to services of HIV prevention and treatment. According to REAct results, perpetrators of violation of the rights of PLHIV are family members -25%, neighbors-15%, employers-15%, representatives of the service sector-15%, police-10%, acquaintances-10%. Typically, violation of the rights of people with HIV-positive status is physical and psychological violence[40].

Notably, a significant gap in knowledge about the legal system and available avenues for addressing rights violations was identified among PLHIV. This knowledge gap suggests that cases of human rights violations may be underestimated, emphasizing the necessity for targeted interventions to enhance awareness and empower individuals to protect their rights effectively.

Encouragingly, almost a quarter of surveyed individuals reported engaging in activities aimed at combating stigma and discrimination based on HIV status or providing support to fellow PLHIV. These findings underscore the importance of fostering a supportive community and implementing targeted interventions to empower PLHIV, enhance legal literacy, and address the existing gaps in addressing human rights violations. The proactive engagement of individuals in activities to combat stigma and discrimination reflects a positive step forward in building a more inclusive and rights-respecting environment for those affected by HIV in Georgia.

When we look at the findings of our study in terms of sex assigned at birth, we see that stigma and discrimination are approximately equally prevalent among men and women living with HIV. For the majority of stigma and discrimination indicators there were no statistically significant differences among the 2 groups.

The results of the current study suggest that PLHIV who at the same time belong to KPs experience a double, sometimes triple burden of stigma and discrimination, caused by combination of HIV-related stigma and stigma associated with their membership to socially vulnerable groups such as drug users, sex workers, and LGBT community. More than 60% of KPs living with HIV reported being stigmatized and/or discriminated against due to their belonging to a certain key population group. Given the high prevalence of HIV status non-disclosure, it is expected that stigma and discrimination would incur a greater cost if people from KP groups freely disclosed their status. Although the representation of KPs living with HIV were ensured according to the planned numbers, more in-depth research on the impact of intersectional stigmas would be desirable in the future. Overall, disclosing information about belonging to a certain KP group was higher compared to HIV status disclosure.

8. Study Limitations

The present study could be subject to certain limitations:

- Since this was a first time to conduct Stigma Index 2.0 Study in Georgia and the complexity and the length of the questionnaire for the data collection, some of the terms/concepts in the surveys could be difficult to comprehend. Nevertheless, interviewers underwent intensive training in data collection to ensure that respondents could understand the questionnaire questions and provide accurate information to the extent possible.
- An inherent limitation of this study pertains to missing data, especially regarding gender-related inquiries. The sensitivity of gender and stigma-related questions within the Georgian population might have led to a reluctance to provide responses, resulting in gaps in the dataset, thus the number of responses for each variable may differ from one another. The accurate number of responses have been specified in each analysis for more precise interpretation.

- Given the cross-sectional nature of the study, self-reported responses could be influenced by social desirability bias; respondents could feel ashamed to share private information and under report their stigma and discrimination experiences, and the resultant bias could have altered the overall findings.

9. Conclusions

This was the first Stigma Index 2.0 study conducted in Georgia with the leadership and active participation of PLHIV and active collaboration with international and national research partners. The results indicate that there is high level of internalized stigma among Georgian PLHIV leading to a high frequency of status non-disclosure. In addition, there is a high burden of intersectional stigma and discrimination on PLHIV who at the same time belong to KP groups.

The results of the current study should be considered as a baseline of stigma and discrimination for comparison in future studies. Based on the results of this study, the leading PLHIV organization "Real People Real Vision" will further develop and implement an advocacy plan with activities aimed at combating all forms of stigma and discrimination towards people living with HIV in Georgia. Subsequent waves of Stigma Index 2.0 studies can show the effectiveness of these interventions.

10. Recommendations

In light of the study's findings, we propose the following recommendations across various domains to address and surmount the prevailing challenges of stigma and discrimination in the country of Georgia:

1. **Access to Healthcare:**
    - Healthcare professionals play a critical role in creating a stigma-free healthcare environment. Conducting training for healthcare providers (with an intersectional and gender-conscious approach based on human rights) to offer non-judgmental and culturally competent care will help to reduce stigma within healthcare settings.
    - To conduct qualitative study that will assess barriers of HIV treatment uptake within PLHIV from key affected groups to identify supportive interventions.
    - With the support of Ministry of Health and community-led organizations to implement awareness campaigns (both providing HIV and general services) to promote a stigma-free environment in healthcare settings.
    - Strengthen the integration of community-based centers providing HIV services to increase accessibility. Enhance the leadership PLHIV networks in coordinating and implementing actions to strengthen community centers providing HIV-related services in Georgia. Foster meaningful collaboration between PLHIV networks and health care providers, ensuring that programs are people-centered.
    - PLHIV, trans community and CSO to initiate broad dialogue with participation of state representatives to develop trans-competent services to support better linkage to HIV treatment and care
    - To conduct trainings of medical and service delivery personnel to increase their sensibility and knowledge about the needs of trans PLHIV community.
    - To develop an educational program on HIV related ethical and stigma related issues and integrate it in the continues medical education system.
2. **Internalized Stigma:**

- Develop targeted interventions (with involvement of healthcare professionals, field experts and community representatives) addressing internalized stigma, especially within key populations.
- Implement mental health support programs (both in health care centers and community-led organizations) to address feelings of shame, fear, and isolation among PLHIV (peer support groups, therapeutic groups with a psychologist, individual consultations with a psychologist, psychotherapist, psychiatrist, treatment appointments). Conduct awareness campaigns targeting KPs and women to reduce internalized stigma and discriminatory decisions, such as avoiding medical care.
- With broader participation of PLHIV community, CSOs and HIV national program representatives to develop National strategy for Media campaign (about all kay populations, general public) to combat stigma, actively applying U=U message box
- PLHIV and CSO to conduct awareness raising informational meetings with religious leaders to increase their sensibility to specific issues regarding HIV key population.

3. **Access to Justice:**
    - Strengthen and fund the leadership capacity of networks of people living with HIV through targeted programs, by engaging in advocacy and collaborating with legal experts to reduce stigma embedded in legal frameworks, thereby increasing the effectiveness of decriminalization efforts.
    - Establish legal education programs for PLHIV to raise awareness of rights and available legal recourse, with a particular focus on women and KPs.
    - Develop/strengthen mechanisms to track and address human rights violations, ensuring a supportive legal environment.
    - Conduct trainings for police on HIV transmission routes, U=U, discrimination, human rights, gender, working with key groups, harm reduction and other HIV programs.
4. **Capacity building of PLHIV networks and Engaging key stakeholders:**
    - Foster collaboration between **government agencies, NGOs, and community-based organizations** to create comprehensive support systems.
    - **Strengthen CBOs' and NGOs'** role as intermediaries between PLHIV and healthcare systems, offering support, resources, and advocacy to conduct community outreach, awareness campaigns, and education programs to challenge stigma and discrimination.
    - Engage Ministry of Education and educational institutions. **Schools, colleges, and universities** play a role in shaping attitudes and perceptions. Educational institutions should integrate HIV awareness and inclusivity programs on gender awareness, KP and human rights developed by PLHIV, women and KP networks on HIV prevention into their curricula to reduce stigma among future generations.
    - Collaborate with **media outlets** to help disseminate accurate information, challenge stereotypes, and reduce stigma. Encouraging responsible reporting and featuring positive stories about PLHIV contribute to changing societal perceptions.
    - Increase funding for gender-responsive programs and initiatives led by women to address the intersectionality of gender-based violence and HIV diagnosis in women and girls
    -
5. **Disclosure Concerns:**
    - Develop and implement strategies to support HIV status disclosure, emphasizing confidentiality and support mechanisms.
    - Conduct community-based workshops to address fears of discrimination, blame, and relationship disruption associated with disclosure.

    - Establish peer support programs where individuals living with HIV, particularly those who have successfully disclosed their status, can provide guidance and encouragement.
    - Offer family and partner counseling services to facilitate open and supportive discussions around HIV status disclosure within intimate relationships.
    - Provide resources to help partners and family members understand and cope with the disclosure process.
    - Use technology to provide a safe space for discussion and support. Create secure online platforms or forums where individuals can anonymously share their experiences with disclosure and receive advice from peers or professionals.
6. **Develop an Advocacy Plan:**
    - Collaboratively with all relevant stakeholders, formulate, fundraise and execute an advocacy strategy in direct response to the outcomes of this research. The leadership of PLHIV is imperative throughout the entire process, encompassing the plan's creation, execution, and assessment.
    - To advocate for programs to take a gender transformative approach and respond to the needs of women living with HIV in the country.
    - PLHIV and CSOs to lead advocacy to abolish regulation that restricts access to crisis centers for women living with HIV.
    - PLHIV and CSOs to lead advocacy to create shelters/social houses (PLHIV, women PLHIV from key population) in Tbilisi and regional cities.
    - PLHIV and CSOs to lead advocacy to ensure other benefits / social support services to facilitate PLHIV inclusion in HIV treatment and care programs
    - To support development of new model of community-led service delivery service - peer counseling, case management/link to existing social services, paralegal services (addressing violations)
    - To support development of new model of community-led HIV program monitoring, training of peers, provision of feedback to PLHIV community
    - PLHIV community to lead the advocacy for ensuring uninterrupted funding for community-led service delivery and community-led HIV program monitoring.
7. **Use Collected Data for Further Study:**
    - Continuously monitor and evaluate the impact of interventions using data collected in subsequent studies.
    - Conduct further research to explore the intersectionality of stigmas among PLHIV, especially those belonging to key populations. Explore qualitatively to get in-depth understanding on the perception of stigma and discrimination in women and KP.
    - Share study findings with policy makers, researchers, and healthcare professionals to inform evidence-based interventions and policies.

Annex 1. Information Sheet

Note for the interviewer: this information sheet is designed for the interviewers to guide the process of explaining the study aim, objectives, and procedures to the interviewee.

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

The People Living with HIV Stigma Index survey was created to find out more about the experiences of people living with HIV, especially experiences of stigma or discrimination. It is hoped that this survey will one day provide information that will help these efforts. In addition, cases of stigma and discrimination and violence against PHIV and KPs identified during the study implementation, in agreement with study participants will be documented in the REAct system and relevant support will be provided to the beneficiaries.

In order to collect such information (i.e. on what HIV-positive people are experiencing, specifically in relation to stigma and discrimination), the questionnaires and survey will be administered and managed by PLHIV organization in Georgia – Real People Real Vision (RPRV). The information that is collected from the questionnaires will then be put together and presented in a way that presents a general picture of the experiences of people living with HIV in Georgia. It is not information about individual experiences of stigma and/or discrimination. For example, in documenting the results of the survey, information will be presented in the report on “What percentage of people living with HIV experienced discrimination last year”, as opposed to presenting information on your own, personal experiences of stigma and discrimination.

Ultimately, the main aim of this study is to broaden the understanding of stigma and discrimination faced by people living with HIV in Georgia, and to be able to find out if there have been changes over a period of time. RPRV intends to use the information as a national and global advocacy tool to fight for the human rights for people living with HIV.

PROCEDURES AND PROCESSES INVOLVED IN PARTICIPATING

I would like to make clear that your participation in this study is entirely voluntary. It is your choice whether to participate or not. If you choose to participate, you are also free to not answer any of the questions, and you can also decide to stop participating in the interview at any time that you wish.

In terms of process, if you choose to participate in the survey, we will complete a questionnaire that asks you questions about your social environment, work, access to health services, knowledge about your rights, HIV testing and treatment. Please feel free to ask to see the questionnaire at this stage if you would like to take a more detailed look at the questions.

If you participate in the survey, we will fill in the questionnaire together. You can write down the answers and I will help explain anything that is not clear to you. Or, if you prefer, I can fill it in for you while you sit beside me checking that I am ticking the right boxes and recording your responses correctly.

We believe that stories sometimes help people better understand what other people experience. If you participate in the survey and at some point, in the interview you describe an experience that I would like to include in the survey report, I will stop and ask for your permission to do so. I may also request an additional interview with you to record your story and your experience so it can then be written up as a case study. You should always feel free to say no. If you tell me that I have your permission to include a particular experience you have had in the report, I will not use your name, and I will not include any personal information that would allow someone to identify you. The story will be completely anonymous.

Lastly, before we begin to conduct an interview and administer the questionnaire, we need to obtain informed, verbal consent from all potential survey participants. This ensures that all those agreeing to participate in the survey are voluntarily willing to participate and that they have obtained all the information they need to make an informed choice about their participation.

CONFIDENTIALITY AND POTENTIAL RISKS OF PARTICIPATING IN THE SURVEY

This study is taking every possible step to ensure confidentiality, i.e., to prevent any personal information from being known to people outside the research team. We know that breaches of confidentiality could lead to problems for interviewees, so we have put in place measures to prevent this from happening. For example, we do not write your name on the questionnaire, and we do not write down anything that would allow someone to link the completed questionnaire to you. All questionnaires and other forms used in this study will be stored in a locked cabinet. This data will be destroyed as soon as it is no longer needed (i.e., once it is stored electronically in a suitably secure place).

Nevertheless, in all studies like this there is a very small risk that a breach of confidentiality could take place. While this is a very small risk and we do everything to ensure confidentiality, it is our duty to warn you of this.

DISCOMFORT THAT YOU MIGHT EXPERIENCE AS A PARTICIPANT

The questionnaire asks personal questions that may make you feel uncomfortable at times, and it may bring up topics that are difficult to talk about. We do not wish for this to happen. We want you to know that you do not have to answer any questions or take part in the interview if you feel the questions are too personal or if talking about them makes you uncomfortable. If you find you feel uncomfortable at any point during the interview, you can decide to pause or stop the interview at this time – it is completely up to you to decide this and to indicate to me, as the interviewer, that you wish to pause or stop the interview process.

Sometimes people want to explore certain issues and experiences in more depth after the interview. In case you need psychological or physical support, such as counselling or legal assistance or advice concerning educational, health or social support, we have developed a list of professional support services in our community. I will be happy to share this information with you.

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

We hope that the process of going through the questionnaire is an interesting one for you as it might cover some issues that you may not have thought about in detail. We also hope that you will learn from the interview process and from any discussions which may arise from it. However, it is hoped that, through you and other people living with HIV participating in this project, we will be able to produce rich and valuable information that will assist both our national and global efforts to reduce HIV-related stigma and discrimination and ultimately improve the lives of all people living with HIV.

Annex 2. Informed Consent Form

To be completed by the interviewee and the interviewer

My name is --, [insert the name of the interviewer].

I am administering a questionnaire about the experiences of people living with HIV, particularly the experiences of stigma and discrimination they may have had.

I have provided you with an information sheet that describes the purpose of this questionnaire and how the information collected from this questionnaire will form part of a larger survey that is being conducted in this country to document some of the experiences of people living with HIV. The information sheet also outlined what types of information you will be asked, how we will keep this information confidential, and the potential risks involved in your participating in this survey.

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

Please feel free to also contact the project team leaders if you have any questions or concerns about this questionnaire or the survey. Insert contact details the project team leaders: ____

If you choose to participate in the survey, I will ask you some questions about some of your experiences as a person living with HIV, in particular those related to the experiences of stigma or discrimination you may have had. I expect that the interview will take around two hours.

Before asking you whether you would like to be a participant, I would like you to know that:

- Your participation in this survey is entirely voluntary. It is your choice whether to participate or not.
- You are free to not answer any of the questions in the questionnaire.
- You may stop participating in the interview at any time that you wish.

The information collected in this interview will be kept strictly confidential. To help ensure confidentiality, I will not write your name on the questionnaire or this form, and I will not write down details that would allow you to be identified.

For your participation you will receive an incentive in the form of food voucher worth ____ Lari. In addition, I will provide you with a list of services that are available in our community, including health care, social support, and legal services.

Do you consent to participating in the interview?

Yes ☐ No ☐

If **NO:** Thank you for your time.

If **YES:** Thank you for agreeing to take part in this project.

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

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

____ __________

Signature [interviewer] **Date**

Your verbal consent is all that is needed to go ahead with the interview. If you feel comfortable enough doing so, however, you can also sign your name or initials below to indicate that you have consented in writing to participate in this interview.

However, please remember that verbal consent is all that is needed. You do not have to provide us with written consent, but you can if you would like to.

I have read the information on the information sheet, or it has been read to me. I have had the opportunity to ask questions related to the questionnaire and the People Living with HIV Stigma Index survey, and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this project and understand that I have the right to end the interview at any time.

____ __________

Signature [interviewee] **Date**

Annex 3. Study staff Agreement of Confidentiality

Ensuring the confidentiality of all reports, records, and completed questionnaires are of critical importance to Real People Real Vision (RPRV) study *"Measuring the Stigma Index of People Living with HIV in Georgia"*

I, ____, an employee of RPRV, agree to provide data collection services for the benefit of RPRV in connection with conducting the study - *"Measuring the Stigma Index of People Living with HIV in Georgia".*

Further, I **(please, place your initials in the space below if you agree to adhere to the following guidelines)**

_____hereby accept all duties and responsibilities of performing specified data collection tasks and will do so personally in accordance with the training and guidelines set out in the field manual provided to me. At no time will I engage the services of another person for the purpose of performing and data collection or other field tasks for me without prior approval from RPRV and the main researcher;

_____promise to perform only the data collection tasks specified to me by the main researcher and will not conduct any auxiliary data collection without the approval of the main researcher;

_____agree to treat as confidential and proprietary to RPRV any and all survey instruments, materials, and documentation provided or accessed during the course of my service on this project;

_____am aware that the survey instruments form the basis from which all the analysis will be drawn and therefore, agree that all work I do on the project will be of high quality and performed in compliance with all of the project specifications;

_____agree to treat as confidential all information accrued during data collection or obtained in any project-related way during the period I am providing services to RPRV;

_____agree to keep all completed questionnaires as well as any project-related documentation in accordance with the principles set forth by the main researcher;

_____agree to conduct myself in a manner that will obtain the respect and confidence of all individuals from whom data will be collected and that I will not betray the confidence by divulging any information obtained to anyone other than authorized representatives of RPRV;

_____agree to never discuss study sensitive issues or records outside of the office setting, nor confirm or deny any specific person's participation in the study;

_____agree to report any known or suspected breaches of confidentiality to the main researcher;

_____ understand that any breach of this agreement may result in the termination of any assignment with RPRV and/or my employment with RPRV, monetary fines, and/or civil suit.

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Signature **Date**

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