Cambodian People Living with HIV Network (CPN+)

People Living with HIV Stigma Index

Cambodia, 2010

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Commissioned by UNAIDS Cambodia

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

ART	Antiretroviral Treatment
CoC	Continuum of Care
CPN+	Cambodian People Living with HIV Network
DU	Drug Users
ESW	Entertainment Sector Workers
FP	Family Planning
FGD	Focus Group Discussion
GIPA	Greater Involvement of People Living with HIV
GNP+	Global Network for People Living with HIV
HCBC	Home and Community Based Care
ICW	International Community of Women living with HIV/AIDS
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
KHANA	Khmer HIV/AIDS NGO Alliance
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population
MSM	Men who have sex with men
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STIs
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SHG	Self-Help Group
SRH	Sexual and Reproductive Health
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
VCT	Voluntary Counseling and Testing

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

Stigma and discrimination surrounding HIV/AIDS pose critical barriers to prevention, treatment, care and support programs. There is currently little reliable data or documentation relating to stigma and discrimination against people living with HIV (PLHIV) in Cambodia. The Cambodian People Living with HIV Network (CPN+) initiated this Stigma Index study to better understand the experiences and attitudes of PLHIV to stigma and discrimination issues. Results from the study can be utilized by CPN+ and other stakeholders to design evidence-based interventions that address needs and capacity building of PLHIV, and to advocate for policy change on key issues.

The study was carried out in five selected provinces where a total number of 394 PLHIV were interviewed, 71% of whom are females and 29% of whom are males. About 80% of respondents were aged 30-49 years. The gender and age profiles of respondents may be reflective of the large proportion of respondents who belonged to self-help groups and not of the PLHIV population in general. There was a low level of schooling (75% received either no schooling or primary schooling only) and >70% of respondents were working as farmers or sellers. The study methodology included a quantitative method based on the global HIV Stigma Index questionnaire and a qualitative method which involved focus group discussions and key informant interviews.

Manifestations of stigma and discrimination

Gossiping, harassment and threats

In the 12 months prior to the study, A large proportion of respondents experienced being gossiped about, verbally insulted or threatened, a large majority of whom (75%) reported that it was due to their HIV status. In addition, 22 respondents, mostly women, reported they were physically assaulted one or more times in the 12 months preceding the interview. The physical assaults were largely associated with HIV-related stigma and discrimination. Because of such discrimination, respondents harbored high levels of fear and anxiety, which were more frequently experienced by female respondents

Discrimination by family members

Of concern is that much of the physical violence experienced by female respondents was perpetrated by a spouse or partner, or members of the same household – the same people that they would normally rely on for support and acceptance. 16 out of the 18 female respondents had been assaulted by those who were known to the victim, including their husbands or those living in the same household. This illustrates the violent environment that many HIV-infected women live in. A third of all respondents had also been subjected to manipulation and psychological pressure by their spouses or partners as a direct result of their HIV status. Significantly, more female respondents (45%) experienced this form of discrimination than male respondents (18%).

Discriminatory reaction

Disclosure to family members had generally evoked supportive reaction, but almost a quarter of respondents reported that their neighbours reacted negatively; and a tenth of respondents said the same about their friends. In contrast, there were low levels of reported discriminatory reactions from health staff members (3%). However, this data contradicts the higher level of HIV-related denial of family planning and sexual and reproductive health services, and the lack of confidentiality of medical records reported in this study. This must be viewed in the context that most of the respondents belonged to self-help groups, possibly resulting in a reluctance to report on the discrimination within the health care environment which they themselves are part of.

Internal stigma

This study clearly shows that self-stigma is detrimental to the mental and physical health of PLHIV and leads to a significantly lower quality of life. Reported feelings of guilt (75%), shame (63%) and self-blame (54%) were common. More female respondents (51%) experienced low self-esteem than male respondents (41%), and were far more likely to contemplate suicide than male respondents (20% v 6%).

Internal stigma is associated with a sense of despondency among PLHIV, so much so that respondents developed a distinct sense of self-denial of opportunities of living a normal and fulfilling life. About a quarter of respondents reportedly isolated themselves from family and friends and chose not to attend social gatherings. Because of their HIV status, respondents had little intention of pursuing their life dreams of getting married and starting a family or of seeking career and educational opportunities. Abstinence among female respondents was reported to be much higher than males. Internal stigma also led to about 20% of respondents avoiding going to the hospital or clinic when they needed to.

The impact of HIV-related stigma and discrimination

Impact on livelihood, housing and education

About half of the respondents had suffered from loss of income or employment one or more times during the previous 12 months, largely due to HIV-related illness and/or discrimination. Female respondents were more likely to experience this form of discrimination than males. Given that almost 50% of female respondents had been widowed or divorced, difficulties associated with loss of income were compounded by household financial responsibilities that included supporting and caring for family members, some of whom were living with HIV. In addition, more than 40% of respondents were living on less than US$ 1 per day, which is worrying considering that 87% of respondents have dependents, leaving them with not enough food to eat and reducing the affordability of medical services.

PLHIV face major barriers to safe and adequate housing because of the stigma and discrimination surrounding HIV. 12% of respondents were forced to change their place of residence or were unable to rent accommodation in the previous 12 months, a large majority of whom attributed this, at least in part, to their HIV status. Inadequate housing can lead to higher risk of opportunistic infections, as well as higher rates of displacement and migration, resulting in a restriction of access to hospitals and home-based care services. HIV-related discrimination was found to limit the access to education of respondents' children. 13 respondents (4%) reported that they have at least one child who was denied, suspended or prevented from attending an educational institution in the 12 months preceding the interview because of the respondents' HIV status.

Impact on testing services

Although this study found that a large majority of respondents reportedly tested voluntarily, almost one in ten respondents reported that they had an HIV test only because they were under pressure, or had been tested without their knowledge. In fact, 12% of all respondents had also been reportedly forced to submit to an unwanted medical procedure, including HIV testing, in the previous 12 months. Many respondents, especially males, only tested when they presented with HIV-related symptoms. This is evident that respondents are testing late and reduces the health benefits of early treatment. Of further concern is the very small share of female respondents (6%) who were tested for HIV by being referred to from an STI clinic. The main reason for testing for female respondents was when a family member became ill or was found to be HIV-positive.

Disclosure of HIV status without consent

In general, there was a high level of voluntary disclosure of HIV status, either through direct disclosure or consenting for others to disclose, to family members and health care workers (>90%). However, a dilemma arises when some PLHIV are left with no choice but to disclose their status in order to access care and support services. Reasons for many respondents not to disclose their HIV status include the fear of further stigma, discrimination and judgment of their behaviour, as well as the potential harm that can be done to the reputation of their families.

Confidentiality of HIV status is a fundamental human right. Respondents revealed frequent instances of disclosure of their HIV status by someone else without their consent, mainly to neighbours (15%), community leaders (11%), teachers (11%) and friends (10%). Furthermore, 23 respondents (6%) stated that it was clear to them that their medical records had not been kept confidential and that they believed that a health professional had disclosed their HIV status to others without their consent.

Impact on health services

Even though high coverage of antiretroviral and opportunistic infection treatments was found among respondents, 23% and 14% of respondents reported that they did not have free and available access to ART and OI treatment, respectively, even though the AIDS Law guarantees such provision. Furthermore, 47% of male respondents reported that they can only access ART if they use certain forms of contraception.

Impact on reproductive health rights

One in ten respondents had been denied access to family planning and sexual and reproductive health services because of HIV-related discrimination. Of further concern is that 79% of respondents reported that they had been advised by health staff not to have any children and 19% of them reported having been strongly advised by health staff to use permanent sterilization. In addition, 14% of female respondents who were pregnant reported to have been strongly advised by health staff to terminate their pregnancy in the previous 12 months. These findings are incredibly disturbing and will need to inform future action to ensure the reproductive rights of PLHIV are adequately ensured.

Impact on prevention of mother-to-child treatment

It is worrying to discover that only 25% of female respondents received antiretroviral prophylaxis during child birth to prevent transmission of HIV from mother to child (PMTCT). In fact, over 20% of female respondents said they did not know that ART was available to them when they were pregnant. Such an apparent low level of PMTCT awareness and utilization may be due to the belated expansion of the PMTCT programme in Cambodia, after the birth of many of the respondents' children. Surprisingly, of those who did undergo PMTCT, 9 respondents (13%) did not receive any information about healthy pregnancy and motherhood.

Comprehension of Laws and policies

The UNGASS Declaration of Commitment on HIV/AIDS (2001) (the Declaration) provides a guideline of international norms and standards for an effective AIDS response; and the Cambodian Law on Prevention and Control of HIV/AIDS (2002) (AIDS Law) which addresses issues on human rights, discrimination, confidentiality and access to treatment. Even though a large majority of respondents were reportedly aware and knowledgeable of both the Declaration and the AIDS law, qualitative data revealed only superficial understanding of either document. Furthermore, such apparent high level of awareness and knowledge on the AIDS Law may not be representative of the entire PLHIV community, and may be due to the high proportion of respondents who were self-help group members and/or working and with projects that provided assistance to PLHIV.

Community support and participation

Apart from the physical violence and the violation of rights to sexual and reproductive health, confidentiality, employment, housing and education, some respondents also had their rights violated through forced medical or health procedures, denial of health insurance, forced disclosure of their HIV status before entering another country or when applying for a visa or residence to another country. However, in light of such violations, there were low reported levels of access to legal services and human rights organizations (<10% of those who had their rights violated) even though more than 65% of those who had their rights violated had attempted to access legal assistance. In addition, one in ten respondents did not know of anyone to approach for help if they were stigmatized and discriminated against. Furthermore, there is evidence to suggest that major barriers that prevent PLHIV from participating in the development of legislation, policies or guidelines related to HIV continue to persist.

1. INTRODUCTION

Cambodia is one of the few countries to achieve Millennium Development Goal 6 (MDG6): To halt and begin to reverse the spread of HIV by 2015. National prevalence fell to a projected 0.7% in 2010, down from a high of 2% in 1998[1] . The latest estimates of HIV prevalence by sentinel surveillance groups are: 14% among brothel based sex workers (2006), 11.8% among non-brothel based sex workers (2003), 2.5% among policemen (2003), and 1.1% among pregnant women attending antenatal care clinics (2006) [2,3] .

The success in Cambodia in bringing the HIV epidemic under control is thanks to the joint efforts and strong commitment from the government and non-government sectors, as well as donors. One remarkable intervention was an intensive and multi-sectoral condom use program which promoted condom use in all brothels and entertainment establishments where transactional sex occurs, and provided sexually transmitted infections (STI) services for most at risk populations (MARP) and the general population[4,5] .

HIV care and support in Cambodia is considered a success, particularly since the introduction and the scale up of anti retroviral treatment (ART) in 2004. Numbers of PLHIV receiving ART have steadily increased. The National Center for HIV/AIDS, Dermatology and STIs (NCHADS) reported that more than 41,000 PLHIV had received ART by the end of Quarter 3, 2010, covering up to 90% of adults and children in need of treatment[6] .

A comprehensive Continuum of Care (CoC) model has been implemented nationally through NCHADS, which coordinates different services (OI/ART, VCT, laboratory support, home-based care and community support). Many NGOs, in partnership with the government, have developed services for Orphan and Vulnerable Children (OVC) and their affected families, but the need for more care and support remains high.

At the same time, stigma and discrimination against PLHIV and their families at various levels and various dimensions has been observed. HIV-related stigma and discrimination pose critical barriers to HIV prevention, care and support for PLHIV, and also violates human rights and prevents access to job opportunities and other social support for PLHIV and their families.

In the HIV/AIDS context, stigma and discrimination is defined as a ‘process of devaluation’ of people either living with or associated with HIV and AIDS[7] . Stigma is an attribute that significantly discredits or disqualifies the individual from full social acceptance. It influences the way individuals look at themselves[8] . Discrimination follows stigma and is an unfair and unjust treatment of an individual based on their real or perceived HIV status. While stigma seems intangible, discrimination is more directly observable. HIV related stigma

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[1] NCHADS (2007) Report of a Consensus Workshop: HIV Estimates and Projections for Cambodia 2006-2012.

[2] Sopheab H, Neal JJ, Morineau G, Saphonn V, Vun MC (2006) Report on HIV Sentinel Surveillance in Cambodia 2006. NCHADS.

[3] NCHADS (2006) HIV Sentinel Surveillance: Official Dissemination Result.

[4] Rojanapithayakorn W (2006) The 100% condom use programme in Asia. Reproductive Health Matters 14(28):41-52.

[5] Saphonn V, Sopheab H, Sun LP, Vun MC, Wantha SS, Gorbach PM, Detels R (2005) Current HIV/AIDS/STI epidemic: intervention programs in Cambodia, 1993-2003. AIDS Education and Prevention 16(3 Suppl A):64-77.

[6] NCHADS (2010) Fourth Quarterly Comprehensive Report: HIV/AIDS & STI Prevention and Care Programme.

[7] UNAIDS (2003) Fact sheet: stigma and discriminationhttp://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf

[8] Parker R, Aggleton P (2003) HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Social Science & Medicine 57:13-24.

and discrimination discourage PLHIV from seeking testing, care and treatment services if they have faced discriminatory behaviours or attitudes from health services providers, in terms of confidentiality and privacy[9] . Stigma and discrimination, whether experienced at a political, economic, social, psychological or institutional level, breach fundamental human rights[10] .

Anecdotal observations have been reported recently about the decline of stigma and discrimination against PLHIV in Cambodia. However, no concrete or reliable data have been documented. In addition, the Law on Prevention and Control of HIV/AIDS (2002) (the AIDS Law), ratified by the Cambodian National Assembly in 2002, intended to address human rights issues, non-discrimination, confidentiality and other issues, has not been fully implemented and understood[11] . The understanding of how PLHIV experience stigma and discrimination remains poor. Therefore, CPN+ in collaboration with KHANA and with UNAIDS funding support, initiated this study to better understand the experiences and attitudes of PLHIV regarding stigma and discrimination issues.

This study is part of the global People Living with HIV Stigma Index initiative that has been conducted in more than 15 countries and is intended for use as a research tool for developing evidence-based advocacy by and for PLHIV. In Cambodia, it is hoped that the findings will be useful for all stakeholders, particularly networks of people living with HIV, to design evidence-based interventions to address the needs of PLHIV. It is also hoped that it will empower PLHIV to advocate for policy change on key issues including protection of rights, and fulfillment of GIPA principles across all levels of society.

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[9] Wu S, Li L, Wu Z, Liang LJ, Cao H, Yan Z, Li J (2008) A brief HIV stigma reduction intervention for service providers in China. AIDS Patient Care and STDs 22(6):513-520.

[10] UNAIDS (2003) Fact sheet: stigma and discrimination http://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf

[11] Sou S, Tia P, Ward C (2004) Implementing Cambodia's law on the prevention and control of HIV/AIDS. International Conference on AIDS, abstract no MoPeE4173. Bangkok, Thailand, Jul 11-16 2004.

2. OBJECTIVES OF THE PLHIV STIGMA INDEX

The objectives of the People Living with HIV Stigma Index study in Cambodia were:

1. To provide an evidence base to improve policies, to promote the human rights of PLHIV, and to advocate for policy change on key issues including contributing to a review of the implementation barriers of the AIDS Law.
2. To contribute to improved programming, influenced by the perspectives of PLHIV, to better meet the needs of PLHIV as well as increase access to and uptake of services.
3. To identify barriers created by HIV-related stigma and discrimination and develop strategies to address priority issues.
4. To model best practice for greater involvement of people living with HIV (GIPA) in the study to empower and develop the capacity of PLHIV.
5. To improve evidence-based advocacy on HIV-related stigma and discrimination, and communicate key messages.

3. RESEARCH METHODOLOGY

The Stigma Index study includes quantitative and qualitative research. PLHIV participated actively and meaningfully in all stages of the research process, including in the adaptation of tools, interviewer's recruitment and training, data collection, data entry, discussion, dissemination of results, and follow-up advocacy.

The study was implemented under the guidance of an Advisory Committee. The committee provided technical inputs through all stages of the study, particularly on the methods, tools and draft report. The committee was chaired by the National AIDS Authority (NAA) and was comprised of representatives from government, civil society, bilateral and multilateral agencies as well as PLHIV and key population networks.

3.1. Quantitative Research

3.1.1. Sampling strategy

The sample size of the study was based on data related to the levels of discrimination, referrals to home-based care (HBC) and self-help groups (SHG), and psychological support from previous studies[12] .The Epi Info statistical software was used to calculate the required sample size. The sample size required for this study was 370. After taking into account the expected refusal rate by people to be interviewed (5%), the final sample size was rounded up to 400 people.

The study took place in four provinces and one municipality, including Kampong Cham, Battambang, Takeo, Kampong Thom and Phnom Penh. These locations were selected based on high HIV prevalence, concentration of PLHIV, and presence of KHANA's implementing partners.

In order to obtain representative samples of PLHIV in the five selected provinces/ municipality, a multi-stage cluster sampling procedure was used. The procedure utilized probability proportional to population size to select required clusters of PLHIV (defined as health center catchment areas). As a result, 40 health center (HC) catchment areas were selected for data collection. HC that had coverage of fewer than 20 PLHIV were excluded from the sampling frame.

Within these 40 selected HC, systematic random sampling was used to select approximately 10 PLHIV from the list of PLHIV in each selected HC. The sampling frame (the list) was updated by KHANA and its implementing partners through consultation with the HBC teams and SHG working in the study areas. The sampling frame in the five provinces and municipality included both KHANA and non-KHANA coverage areas. The overall number of PLHIV covered by this sampling frame exceeded 90% of the coverage reported by NCHADS in these areas. Selected PLHIV were first contacted by the HBC team or SHG members. For HC where KHANA did not have implementing partner coverage, CPN+ coordinated the data collection including obtaining the PLHIV list, contacting PLHIV and organizing interviews.

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[12] Sopheab H, Chhea C, Tuot S (2010) Mid-term review of the integrated care and prevention project (ICP) regarding PLHIV and OVC. KHANA.

3.1.2. Survey Tool

The global PLHIV Stigma Index questionnaire developed by the International Planned Parenthood Federation (IPPF) in partnership with Joint United Nations Program on HIV/AIDS (UNAIDS), Global Network for People Living with HIV (GNP+) and International Community of Women living with HIV/AIDS (ICW) was the main research tool used in this study[13] . The questionnaire was developed through extensive field testing in pilot studies and has been shown to be a valid and reliable tool. The English version of the questionnaire was translated into Khmer by CPN+. It was revised by the KHANA research team for local context. The questionnaire was pre-tested to ascertain that the wording was culturally appropriate and understandable for PLHIV. The questionnaire (see Annex 1) consisted of more than 100 questions covering main dimensions of the Stigma Index as follows:

1. Socio-demographic situation
2. Experience of stigma and discrimination
3. Access to work, health and education
4. Internal stigma and fears
5. Rights, law and policies and effecting change
6. Testing and diagnosis
7. Disclosure and confidentiality
8. Treatment
9. Having children

3.2. Qualitative Research

A qualitative study was conducted to explore people's understanding and personal experience of stigma and discrimination, as well as their challenges to accessing health, rights and other relevant services. In addition, questions were asked to define the perception of stigma and discrimination in the Cambodian context. Qualitative discussion presented a rich and valuable complement to the quantitative data. A total of five focus group discussions (FGD) were conducted with PLHIV and people belonging to MARPs group, including positive men who have sex with men (MSM), entertainment sector workers (ESW), including karaoke and massage workers and beer promotion women, and drug users (DU). One FGD was conducted in each of the targeted provinces with a total of 5 FGDs and 27 participants overall.

In addition, 10 key informant interviews (KII) were also conducted with non-PLHIV who are key stakeholders in the HIV response including health service providers, religious leaders, community people, HBC volunteers and private sector institutions. Purposive sampling was used to select participants. Provincial PLHIV networks and SHG were contacted to identify study participants for both the FGDs and KIIs. A total of 37 respondents participated.

Two research field guides were developed by the KHANA research team taking into account the study objectives, personal experience of stigma and discrimination, and access to health services and rights. Feedback from the Advisory Committee was integrated and the final version translated into Khmer (see Annex 3).

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[13] IPPF (2008) Getting the evidence: The People Living with HIV Stigma Index.

3.3. Research teams, training and field work

The interviewers and supervisors selected to conduct this survey were all PLHIV. Terms of reference and recruitment criteria for the data collection team were developed in collaboration with CPN+ during the preparation of the project. The research team was drawn from PLHIV who are active members of SHG and provincial PLHIV networks. There were five teams (one from each province/municipality) and each team consisting of 10 members, including two supervisors and eight interviewers. Numbers of male and female interviewers were about equal.

All research teams were trained over four days in Phnom Penh. The training topics included study protocol, questionnaire and tools for focus group discussions and key informant interviews, interviewing techniques, confidentiality and communication skills as well as relevant HIV knowledge.

The interviewers carried out quantitative data collection with monitoring from the supervisors to ensure the data collection followed the study protocol and that privacy and confidentiality were respected. Supervisors also supported and coordinated the focus group discussions and key informant interviews, which were largely conducted at the same time as the quantitative data collection by the KHANA research team.

In addition, quality assurance for each team was carried out by KHANA, UNAIDS and CPN+. Feedback was given to interviewers to improve their fieldwork performance.

3.4. Data entry, cleaning, analysis and report writing

A database was developed by the KHANA research team using Epi-Data 3.1[14] . The data entry team of four PLHIV were selected from the data collection team and trained to carry out data entry. Training, technical support and supervision were provided by the KHANA research team. The entered data were checked twice daily, once during the data entry process and again, at the end of the working day. Data checking was carried out by the research coordinators. Double data entry was performed to reduce data entry errors. The complete dataset was cleaned before and throughout the analysis. Descriptive analysis was conducted to generate frequency counts, mean, median and range values. Stratified analysis by sex was performed. It should be noted that many questions were structured for multiple answers. Therefore, the displayed total percentages in some tables do not sum to 100%. Also, total percentages do not always sum to exactly 100% because of rounding.

All qualitative interviews were taped with informed consent from the participants. The KHANA research team transcribed the interviews, which were then validated by the research coordinators. Content analysis was performed. There were seven main themes identified from the focus group discussions and key informant interviews. All themes were analyzed across PLHIV and particular groups such as MSM, ESW and DU. Findings from both analyses were triangulated and presented in this final report.

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[14] Lauritsen JM (2008) EpiData Data Entry, Data Management and basic Statistical Analysis System. Odense Denmark, EpiData Association.

3.5. Ethical considerations

The study protocol was approved by the National Ethics Committee for Health Research at the Ministry of Health. The protocol was also endorsed by the National AIDS Authority (NAA) Monitoring and Evaluation Technical Working Group, and by the Stigma Index Advisory Committee.

Confidentiality of all study participants was guaranteed. No record was taken of the names of the study participants. Verbal informed consent was given and participants were informed about the study objective and participant rights regarding confidentiality and the voluntary nature of the participation. Interviewees signed the informed consent sheet indicating an agreement to participate in the study. All collected questionnaires and field notes are kept in a locked cabinet at KHANA under the responsibility of the Research Coordinator.

To ensure convenience of study participants, interview sessions were conducted at local health centers, SHG, homes or at another place chosen by respondents. All participation in the study was voluntary. Participants had the right to refuse to participate in the study and were able to stop at any time during the interview.

As a result of intense discussion during the interviews, 71% of respondents required referrals to services following their interviews. Of the PLHIV needing referrals, more than half (56%) requested referrals to counseling and care as well as to self-help groups (28%) and to legal aid (14%). During the interviews, researchers did their best to help interviewees with these referrals. 61% of PLHIV were provided with sufficient information for referrals during the interviews and those who required further information or support were followed up subsequently.

3.6. Study limitations

In reading this report, readers should be aware of the limitations of the study. Firstly, the research methodology was designed to facilitate an exploration of the lived experiences and perceptions of PLHIV in Cambodia. It was not intended to facilitate the investigation of specific allegations of stigma or of discrimination. This report does not attempt to substantiate or refute specific allegations of stigma or discrimination. Rather, it aims to explore the variety of ways in which people living with HIV have experienced stigma and discrimination.

This study is not nationally representative. As indicated in the methods section above, the five locations were intentionally selected based on a high number of PLHIV and availability of PLHIV networks. Therefore, its findings only represent the five provinces and municipality included in the study coverage. However, the results are highly consistent with the large scale study on the Socio-Economic Impact Study of HIV at the Household Level in Cambodia (SEIS) conducted in 2010[15] .

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[15] UN (2010) Report on the Socioeconomic Impact of HIV at the Household Level in Cambodia, Phnom Penh .

In addition, feedback from the research team indicated some respondents (less than 1%) were reluctant to discuss experiences of stigma and discrimination even after the aims of the study had been outlined and confidentiality had been assured.

Although the sample of respondents was drawn mostly from within the sampling frame in the five provinces, PLHIV who were not part of the PLHIV network or SHG were unlikely to be included. This means that the respondents are not representative of the whole population of PLHIV in Cambodia. Wealthier PLHIV who were able to afford private treatment and care services were likely to be underrepresented in the sample because they were unlikely to engage with networks or SHG. This group of PLHIV may experience different levels and types of stigma and discrimination compared to the study participants.

The methodology used in this study did not include a control group of non-PLHIV. Therefore, it is difficult to attribute the findings categorically to the HIV status of the respondents. This study reports on respondents' individual perception of how and why stigma and discrimination is experienced and this, of course, was mostly subjective.

It should be understood that the complexity of the global stigma index questionnaire, which not always contextually appropriate, required many revisions in the language used, even after the translation into Khmer. The tool therefore may not capture all of the critical elements of stigma and discrimination in Cambodia. The tool has since been revised and refined by the Global UNAIDS and IPPF Technical Working Group so that the stigma indicators can be integrated into M&E frameworks to measure the effectiveness of stigma and discrimination reduction interventions[16] .

It was very important that PLHIV actively participated in the conduct of this study. To facilitate this, in fieldwork, research teams of PLHIV needed high levels of support and assistance from the KHANA research team, CPN+ and UNAIDS due to lack of previous experience in working as interviewers, combined with limited reading and writing skills. As a result of interviewers' inexperience, follow up probing questions were not consistently asked during interviews. In retrospect, interviewers should have been given more training.

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[16] Developing Indicators on HIV-related Stigma and Discrimination. Meeting of the MERG Indicator Technical Working Group, London, February, 2010.

4. RESULTS OF THE STUDY

The quantitative and qualitative findings of the study are presented together in this section. Where appropriate, qualitative findings are presented in a way that reflects, and possibly adds to the understanding of the quantitative findings. Common themes between the two are highlighted.

Table 1 provides information on the number of people who were interviewed in the five provinces where the study took place by means of a questionnaire, focus group discussions (FGD) and key informant interviews (KII).

Table 1. Samples from quantitative and qualitative approaches

Quantitative samples

Provinces	Male (n = 114)		Female (n = 283)		Total (n = 397)	
	Freq	%	Freq	%	Freq	%
Phnom Penh	30	26.3	104	36.7	134	33.8
Battambang	28	24.6	72	25.4	100	25.2
Takeo	20	17.5	53	18.7	73	18.4
Kampong Cham	28	24.6	38	13.4	66	16.6
Kampong Thom	8	7.0	16	5.7	24	6.0

Qualitative samples

No. FGD and participants	No. KII and participants
6 Male PLHIV	4 Health providers (1 female)
6 Female PLHIV	1 Religious leader (monk)
5 Drug users PLHIV (1 female)	1 Village chief
5 MSM PLHIV	1 Female village health volunteer
5 Entertainent workers, PLHIV	2 Female home-community based care
	1 Staff from GMAC*
5 FGD with 27 participants	**10 KII with 10 participants**

** GMAC: Garment Manufacturers Association of Cambodia*

4.1 Respondents profile

A total number of 394 PLHIV were interviewed. Females represented 71.1% and males 28.7% whereas three respondents identified as transgender[17] (Table 2). This gender imbalance in the sampling cohort is inconsistent with the official national PLHIV rate of 45.2% males and 54.4% females[18] and might have been due to the fact that most respondents are part of a PLHIV network or self-help group in the coverage areas. This may reflect enhanced health-seeking or community participatory behaviour among women or lower levels of HIV-testing among men, but is unlikely to reflect an evolving demographic profile for PLHIV within Cambodia. The majority of respondents (57.1%) were living in rural areas at the time of the study.

Table 2. Profile of respondents

Variables	Male (n=114)		Female (n=280)		Total (n=394)	
	Freq	%	Freq	%	Freq	%
Sex of respondents						
Male					114	28.9
Female					280	71.1
Total					394	100.0
Location of your household						
Rural area	78	68.4	147	52.5	225	57.1
Urban area	36	31.6	133	47.5	169	42.9
Total	114	100.0	280	100.0	394	100.0
Age group of the participants, in years						
15-19	0	0.0	2	0.7	2	0.5
20-24	0	0.0	8	2.9	8	2.0
25-29	6	5.3	23	8.2	29	7.4
30-39	56	49.1	131	46.8	187	47.5
40-49	42	36.8	86	30.7	128	32.5
≥50	10	8.8	30	10.7	40	10.2
Total	114	100.0	280	100.0	394	100.0
Duration living with HIV, in years						
<1	3	2.6	16	5.7	19	4.8
1-4	47	41.2	92	32.9	139	35.3
5-9	52	45.6	119	42.5	171	43.4
10-14	10	8.8	46	16.4	56	14.2
≥15	2	1.8	7	2.5	9	2.3
Total	114	100.0	280	100.0	394	100.0
Current relationship status						
Married and non-married but live together	93	81.6	132	47.1	225	57.1
Widow, widower	15	13.2	113	40.4	128	32.5
Divorced, separated	2	1.8	14	5.0	16	4.1
Single	1	0.9	10	3.6	11	2.8
Married but partner live away from household	1	0.9	8	2.9	9	2.3
In a relationship but not living together	2	1.8	3	1.1	5	1.3

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[17] Responses provided by transgender people were not included in the analysis due to their very small number.

[18] NCHADS (2010) Fourth Quarterly Comprehensive Report.

Total	114	100.0	280	100.0	394	100.0
Duration of relationship with spouse/partner, in years (n =239)						
<1	2	2.1	4	2.8	6	2.5
1- 4	14	14.6	34	23.8	48	20.1
5- 9	31	32.3	38	26.6	69	28.9
10- 14	31	32.3	47	32.9	78	32.6
≥15	18	18.8	20	14.0	38	15.9
Total	96	100.0	143	100.0	239	100.0
Highest level of formal education attained						
No schooling	12	10.5	89	31.8	101	25.6
Primary school	55	48.2	139	49.6	194	49.2
Secondary school and above	45	39.5	52	18.6	97	24.6
Technical college/university	2	1.75	0	0	2	0.51
Total	114	100.0	280	100.0	394	100.0
Main jobs currently you are having						
Farmer	49	43.0	116	41.4	165	41.9
Seller, vendor	21	18.4	101	36.1	122	31.0
Unemployed	11	9.6	46	16.4	57	14.5
Moto-taxi driver	20	17.5	1	0.4	21	5.3
Police/Military	5	4.4	1	0.4	6	1.5
Government/NGO staff	6	5.3	10	3.6	16	4.1
Others	2	1.8	5	1.8	7	1.8
Total	114	100.0	280	100.0	394	100.0

About 80% of respondents were aged 30-49 years and only 10 respondents between 15-25 years old (Figure 3), possibly reflecting the fact that most respondents were selected from PLHIV networks or self-help groups. It must be noted that the views of young PLHIV may not be well represented in this study.

Figure 1. Respondent distribution by province

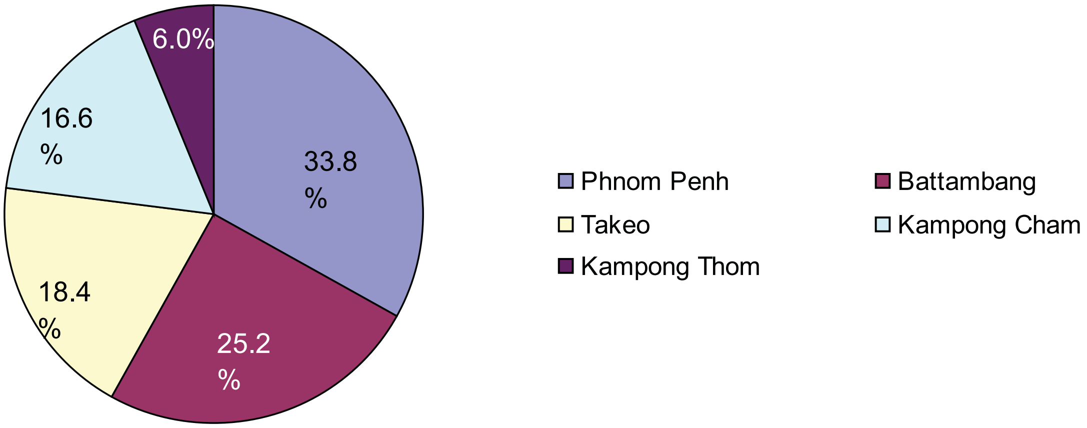


Figure 2. Respondent distribution by gender

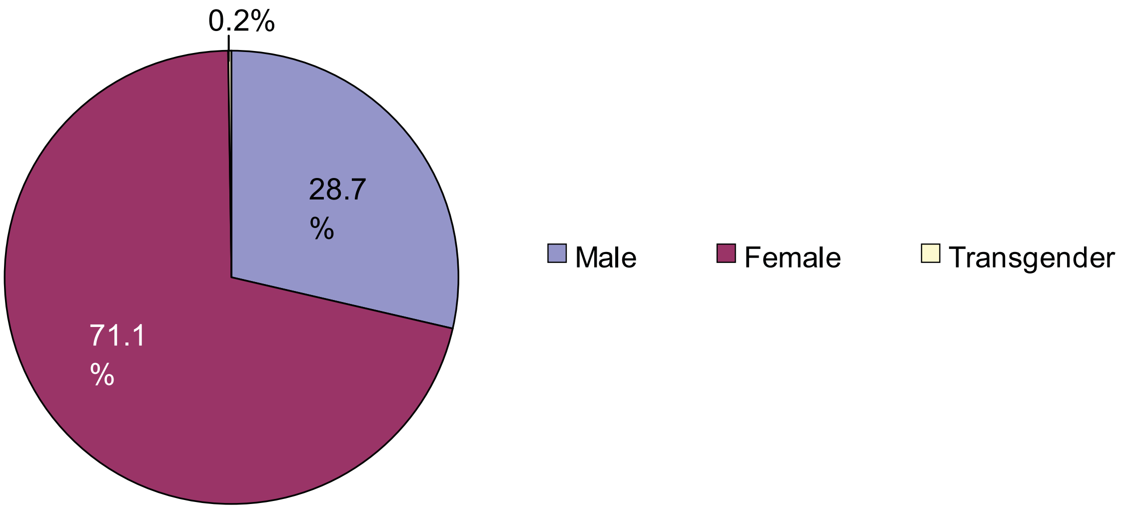
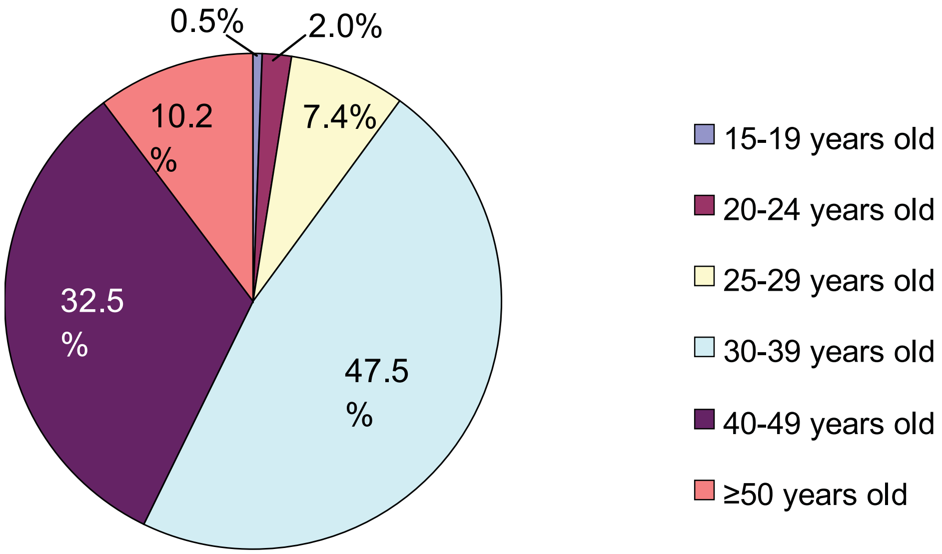


Figure 3. The age of the respondents



Only a small number of respondents identified as part of most-at-risk population groups. Three identified as men who have sex with men, 25 as sex workers (including ten males) and five as injecting drug users. 27 respondents said they were suffering from some kind of disability (6.9%). There were also a number of respondents who were migrant workers (12.2%) or internally displaced people (22.6%) [19].

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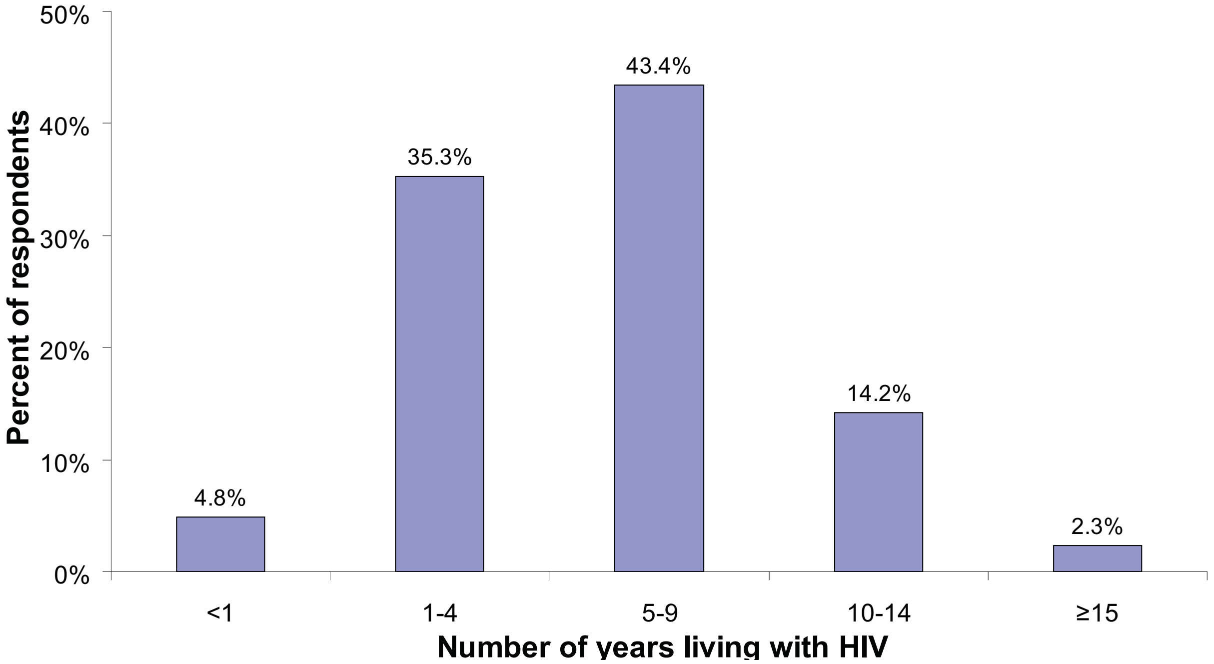
[19] Due to the small number of people living with HIV who identify as being part of MARPs in this study, no quantitative findings were analyzed relating to the different forms of stigma and discrimination experienced by these populations.

Figure 4. The number of years respondents have been living with HIV



40.1% of respondents had known their HIV status for less than 5 years, whereas 43.4% and 16.5% had been living with HIV for 5–9 years and for 10 years or more, respectively (Figure 4).

Figure 5 shows that a large number of respondents were living with at least one other PLHIV in the same household. 73.1% of the respondents had at least one child aged less than 15 years old living with HIV in the same household and 11.9% had three or more children living with HIV in the same household. 31.5% of respondents reported at least one HIV-positive orphan living in the same household as them, and two respondents reported as many as six HIV-positive orphans living with them in the same household. It is assumed that many of the parents of the orphans had died of AIDS-related complications.

In terms of education, 75% of respondents reported receiving either no schooling or primary schooling only (Table 2). 31.8% of female respondents had not received any schooling whatsoever, compared to only 10.5% of male respondents. This correlates to the high proportion of respondents who were currently working in low-skilled jobs (Figure 6). More than 70% of respondents currently were working as farmers or selling while only a small percentage of respondents were working as moto-taxi drivers or as government or NGO staff or were engaged with the police or military.

Figure 5. The number and ages of other PLHIV in the same household

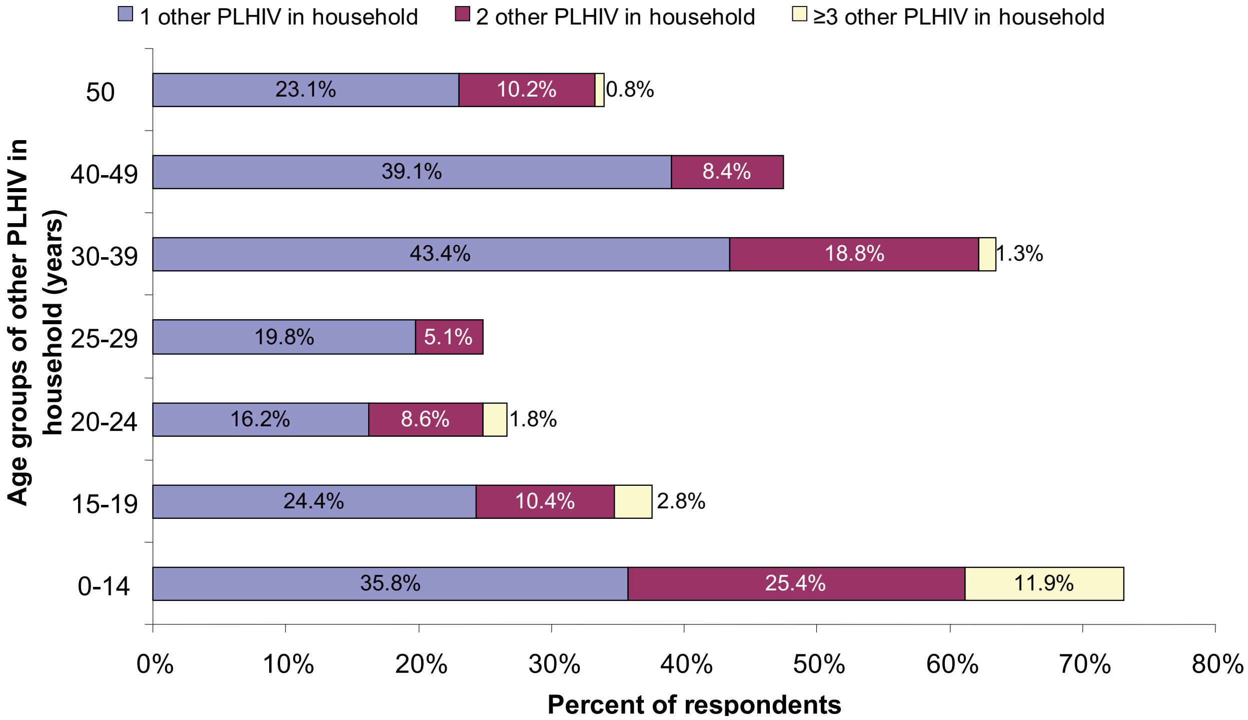
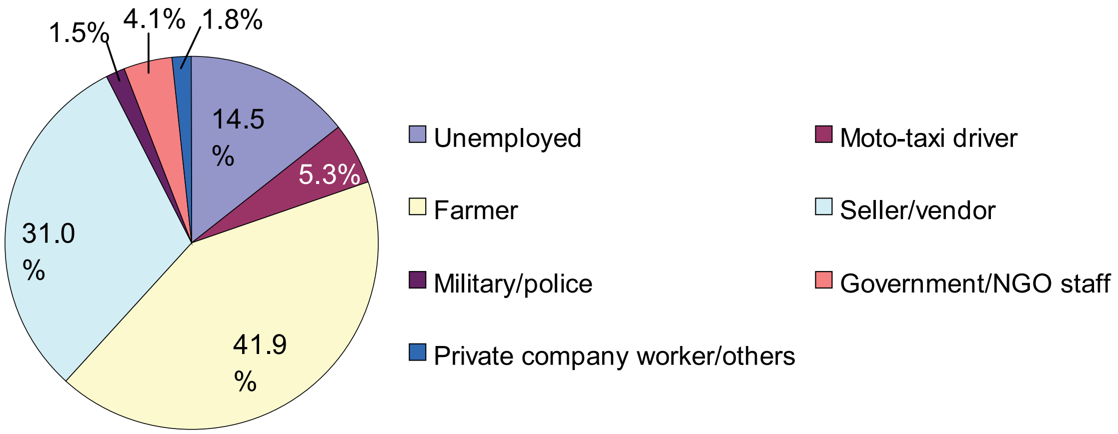


Figure 6. Main job currently held by respondents



The average monthly income of the respondents in the 12 months preceding the study was approximately US$ 49 (Figure 7). More than 40% of respondents lived on less than US$ 1 per day, which is even more worrying considering that 86.8% of respondents have dependents. Such high levels of poverty are associated with a very high share of respondents (85.7%) who reported that at least one household member did not have enough food to eat at some stage during the month before the interview (Figure 8). 15% of respondents and their households spent longer than two weeks of food shortage in the previous month. On average, respondents and their households experienced a food shortage over a period of 7 days in the previous month.

Figure 7. Average monthly income in the last 12 months (in US$)

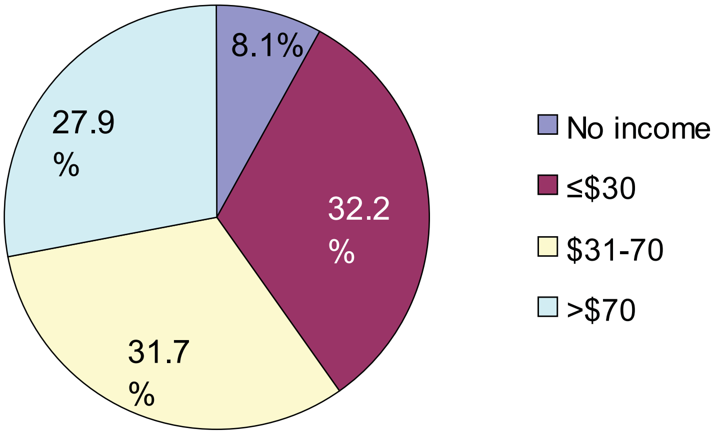
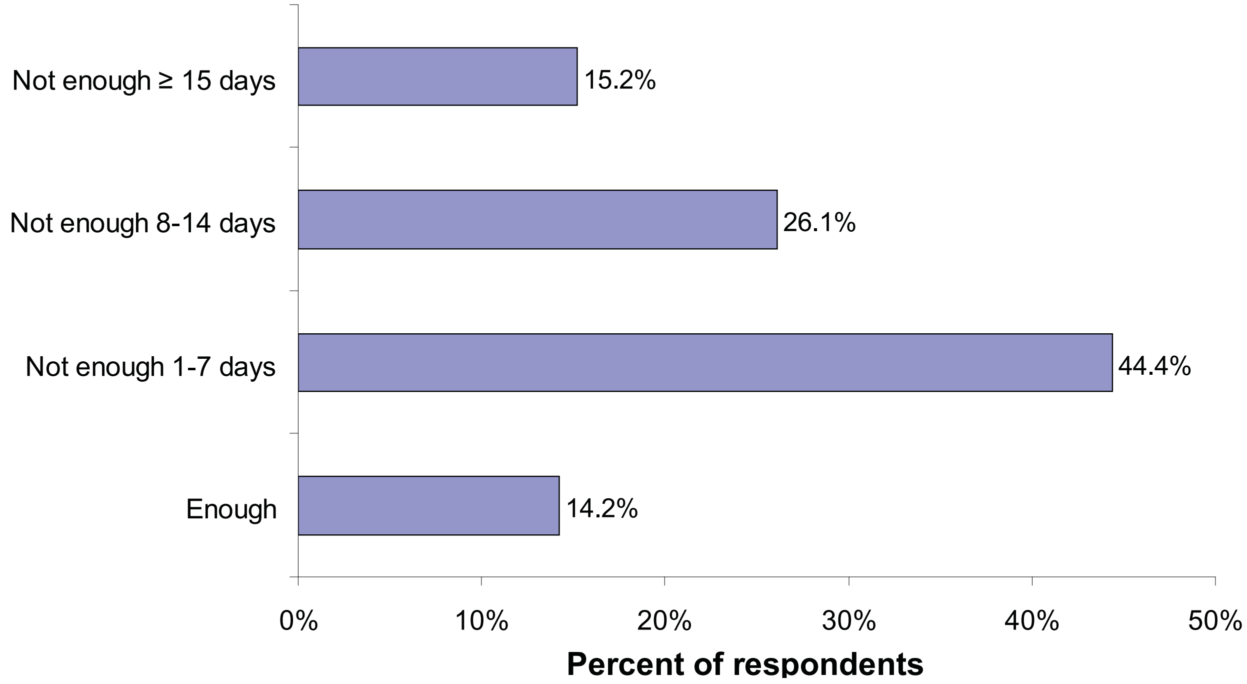


Figure 8. The number of days the respondents or their household members did not have enough food to eat in the previous month



More than 50% of respondents were living in coupled relationships (married or non-married; Table 3) at the time of the survey, with an additional 14 respondents who were in relationships but living apart. 32.2% of respondents have been widowed. A large majority of the relationships have lasted 5 years or more (77%), with 15.9% of relationships lasting 15 years or more.

Table 3. Relationship status of respondents

Variables	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Current relationship status (n=394)						
Married and non-married but live together	93	81.6	132	47.1	225	57.1
Married but partner live away from household	1	0.9	8	2.9	9	2.3
In a relationship but not living together	2	1.8	3	1.1	5	1.3
Widow, widower	15	13.2	113	40.4	128	32.5
Divorced, separated	2	1.8	14	5.0	16	4.1
Single	1	0.9	10	3.6	11	2.8
Total	114	100.0	280	100.0	394	100.0
Duration of current relationship with spouse/partner in years (n=239)						
<1	2	2.1	4	2.8	6	2.5
1-4	14	14.6	34	23.8	48	20.1
5-9	31	32.3	38	26.6	69	28.9
10-14	31	32.3	47	32.9	78	32.6
≥15	18	18.8	20	14.0	38	15.9
Total	96	100.0	143	100.0	239	100.0

4.2 Understanding stigma and discrimination

Stigma is a complex concept that operates at the social, psychological, institutional, economic and political levels. In practice, it occurs when PLHIV suffer from negative attitudes, discrimination, abuse and maltreatment. Stigma associated with HIV occurs at home, in the neighbourhood, in the community and in the workplace as well as in health-care, religious and other social settings. Stigma occurs even towards oneself, a phenomenon which is called ‘internal stigma’.

Many studies have described the experiences of stigma and discrimination suffered by PLHIV and of those living in the same household [20,21] . As a result, they suffer from denial, shame, blame, fear, anger, rejection and isolation. Stigma and discrimination breach fundamental human rights and have a serious impact on the lives and livelihoods of PLHIV. Furthermore, HIV-related stigma and discrimination discourage PLHIV from seeking testing, care and treatment services[22] .

A minor limitation of this study stems from the difficulty that respondents had in distinguishing between stigma and discrimination, mainly due to the lack of an adequate Khmer translation for either concepts. Participants in the study had varied understandings and experiences of stigma and discrimination, which were reflected in the focus group discussions.

From the qualitative data, it is apparent that the respondents understood the implications of stigma and discrimination which can be manifested through attitudes, feelings and thoughts, but can also be more directly observable and experienced through actions (Table 4). Respondents were asked how they thought they have been stigmatized and discriminated against:

‘No one likes us and people are afraid of us. They don’t consider us as human beings’ (MSM-PLHIV-FGD)

‘They look down on PLHIV; they detest us and they walk away [from us]. They won’t talk to us even when we speak to them’ (PLHIV-FGD)

‘[stigma and discrimination] decrease the value of our life… we are discriminated against by [people] who do not want to be our friends’ DU-PLHIV-FGD)

‘They hate us and…do not consider us when we apply for a job’ (ESW-PLHIV-FGD)

Common among the respondents is the understanding that stigma and discrimination are associated with the process of ‘devaluation’, social discredit and exclusion. Therefore, in the context of this study, both stigma and discrimination are closely related, and they describe the unfair and unjust treatment of an individual based on their real or perceived HIV status.

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[20] UN (2010) Report on the Socioeconomic Impact of HIV at the Household Level in Cambodia, Phnom Penh.

[21] UNAIDS (2009) The China Stigma Index Report. Institute of Social Development Research, China Central Party School.

[22] Wu S, Li L, Wu Z, Liang LJ, Cao H, Yan Z, Li J (2008) A brief HIV stigma reduction intervention for service providers in China. AIDS Patient Care and STDS 22(6):513-520.

Similarly, those who work with PLHIV, from community service providers to religious leaders, also understood stigma and discrimination relating to PLHIV in terms of social exclusion, verbal abuse and humiliation, all of which can be observed in verbal communication between people.

'Stigma and discrimination means not wanting to be friends with PLHIV' (Community service provider-KII)

'PLHIV are insulted verbally through negative attitude or mistreatment' (Private sector staff-KII)

'[stigma and discrimination means] not doing anything for PLHIV, not talking to PLHIV and not wanting to be close to them' (Private sector staff-KII)

'Teasing PLHIV through words and gesture[s] and not giving them any opportunity to find work' (Religious leader-KII)

'People base their definition [of stigmatisation] mostly on their opinions and feelings [about PLHIV]. Sometimes, when the community remains silent [about PLHIV] or make fun of PLHIV, they feel stigmatised' (Religious leader-KII)

Table 4. Respondents' understanding of stigma and discrimination

PLHIV Perspective	**Non-PLHIV Perspective**
PLHIV are: - looked down upon - detested - denied friendships - are not spoken to - hated - dismissed from a social setting	*PLHIV are:* - gossiped about - insulted - targets of negative attitudes - mistreated - made fun of and teased - not spoken to

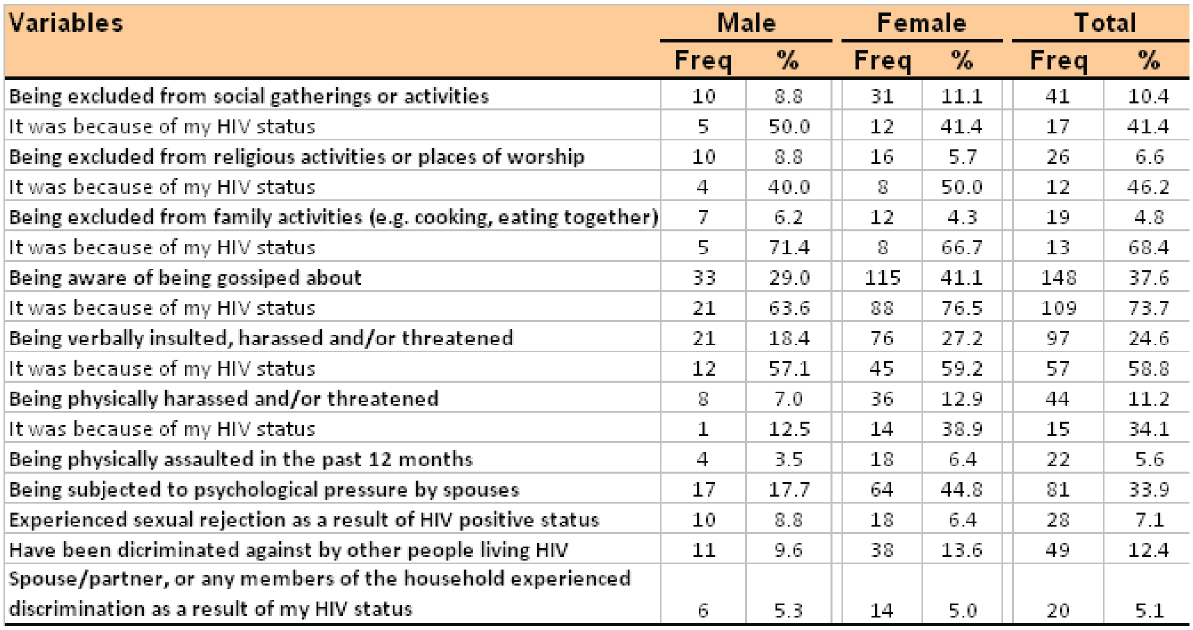
4.3 Implications of stigma and discrimination

Stigma and discrimination can be manifested in a number of different ways and respondents were asked a number of questions in order to assess the different dimensions of stigma and discrimination experienced in the 12 months prior to the study.

Stigma and discrimination can be perpetrated insidiously through gossip. Table 5 shows that 37.6% of respondents experienced being gossiped about; with a much higher proportion among females than males. Among those who experienced gossip, the great majority (74%) reported that the gossip was related to their HIV status. Overall, females (76.5%) said that they were gossiped about more frequently than males (63.6%).

One in four respondents indicated they were verbally insulted, harassed or threatened. Female respondents (27.2%) reported this form of mistreatment significantly more often than male respondents (18.4%). Roughly one in ten respondents reported that they had been physically harassed and/or threatened, again with females significantly outnumbering males. One third of all of those who had experienced this kind of abuse believed that it was due to their HIV status. Females (38.9%), much more often than males (12.5%), thought that the violence was directed at them because of their HIV status.

Table 5. Experiences of stigma and discrimination in the past 12 months



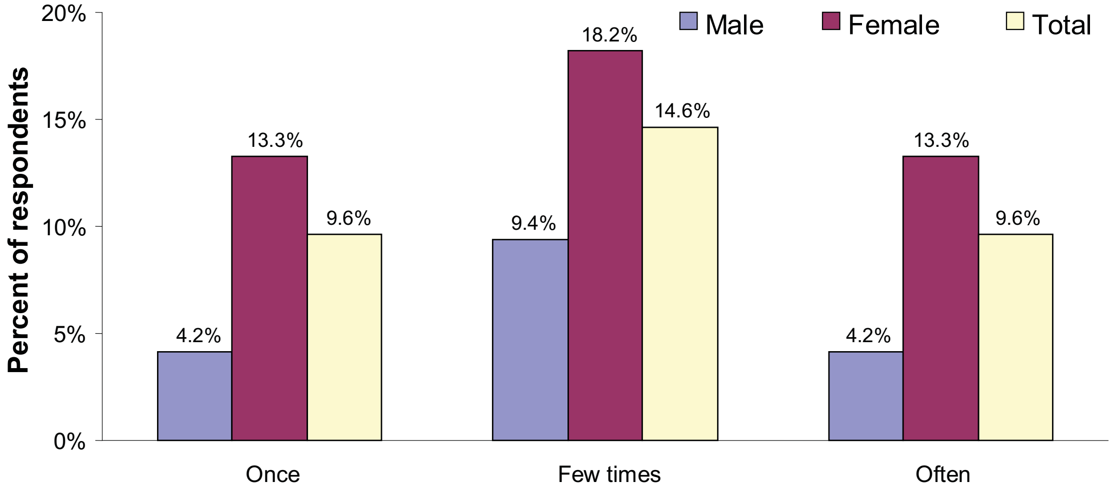
Variables	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Being excluded from social gatherings or activities	10	8.8	31	11.1	41	10.4
It was because of my HIV status	5	50.0	12	41.4	17	41.4
Being excluded from religious activities or places of worship	10	8.8	16	5.7	26	6.6
It was because of my HIV status	4	40.0	8	50.0	12	46.2
Being excluded from family activities (e.g. cooking, eating together)	7	6.2	12	4.3	19	4.8
It was because of my HIV status	5	71.4	8	66.7	13	68.4
Being aware of being gossiped about	33	29.0	115	41.1	148	37.6
It was because of my HIV status	21	63.6	88	76.5	109	73.7
Being verbally insulted, harassed and/or threatened	21	18.4	76	27.2	97	24.6
It was because of my HIV status	12	57.1	45	59.2	57	58.8
Being physically harassed and/or threatened	8	7.0	36	12.9	44	11.2
It was because of my HIV status	1	12.5	14	38.9	15	34.1
Being physically assaulted in the past 12 months	4	3.5	18	6.4	22	5.6
Being subjected to psychological pressure by spouses	17	17.7	64	44.8	81	33.9
Experienced sexual rejection as a result of HIV positive status	10	8.8	18	6.4	28	7.1
Have been dicriminated against by other people living HIV	11	9.6	38	13.6	49	12.4
Spouse/partner, or any members of the household experienced discrimination as a result of my HIV status	6	5.3	14	5.0	20	5.1

Furthermore, 22 respondents reported having been physically assaulted in the 12 months preceding the interview (Table 5). The very great majority of these are females and three of them said they were assaulted 'often' over that period of time. The physical threats and assaults were largely associated with HIV-related stigma and discrimination, according to the respondents.

Of further concern is that much of the physical violence experienced by female respondents was perpetrated by members of the same household. Of the 18 female respondents who were assaulted, six indicated they were assaulted by their husband or partner, and nine by another member of their own household. In all, 16 out of the 18 respondents who were assaulted had been assaulted by those who are known to the victim. This illustrates the violent environment that many HIV-infected women live in. It may have been difficult for many female respondents to distinguish the violence that they would normally encounter from that which targeted their HIV status. Nonetheless, many, if not most of the reported experiences of violence were attributed to their HIV status.

Not only were some of the respondents subjected to physical violence by their spouse or partner because of their HIV status, many more were also subjected to psychological pressure and manipulation by their spouse or partner. Overall, 33.9% of all respondents who were in relationships reported that they experienced psychological pressure or manipulation from their spouse or partner as a result of their HIV status one or more times in the previous 12 months . Significantly more female respondents (44.8%) experienced this form of discrimination one or more times from their spouse than male respondents (17.7%). Figure 9 shows the frequency with which respondents, who were in a relationship at the time of the survey, experienced psychological pressure and manipulation from their spouse or partner.

Figure 9. The percentage of respondents who experienced psychological pressure and manipulation from their spouse or partner



Apart from the physical assaults and psychological pressure by spouses, partners or household members, whom PLHIV should normally be able to rely on for support and acceptance, respondents also suffered from other forms of stigma and discrimination. Respondents reported exclusion from important family (4.8%), social (10.4%) and religious gatherings (6.6%); and activities such as cooking and eating together, weddings, funerals and religious festivities in places of worship.

Focus group discussion and key informant interview respondents clearly described the social isolation that they felt from their friends and family as a result of their HIV status, which very much aligned with the quantitative data that was obtained.

'Before, I used to be invited to join religious celebrations, but after finding out that I am HIV positive, my very close friends stopped visiting me and even stopped talking to me over the phone' (PLHIV-FGD)

'My relatives discriminated against me; they did not want to eat the food that I cooked' (PLHIV-FGD)

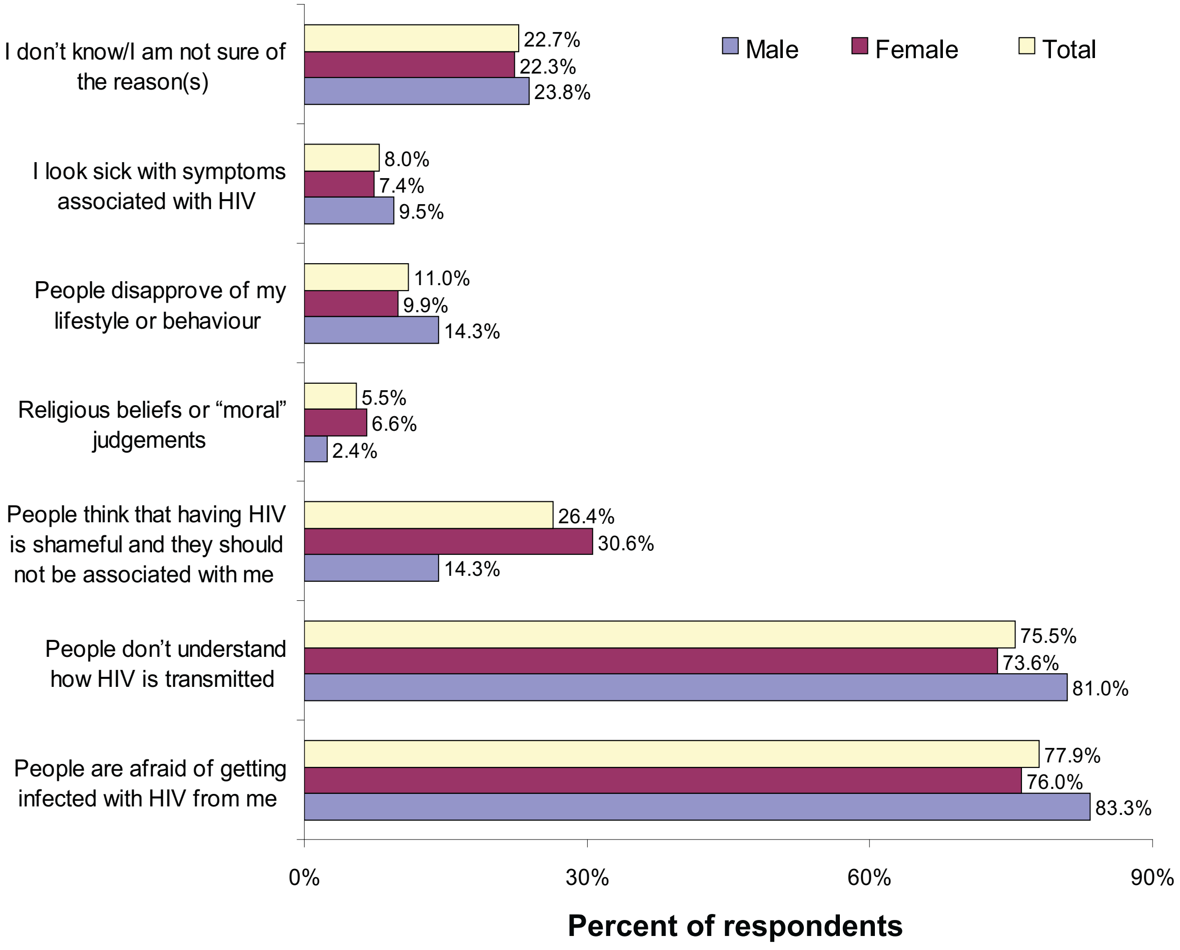
'My sister in law discriminated against me when I played with my niece. She advised me not to play with [my niece] since she was afraid that [my niece] would get infected from me' (PLHIV-FGD)

'[My friends] know my status and when they run into me, they pretend not to see me and would walk away without acknowledging me' (PLHIV-FGD)

The study also found that 12.4% of respondents reported being discriminated against by another PLHIV one or more times in the past 12 months, with this more pertinent to women (13.6%) than men (9.6%). 5.1% of the respondents reported their spouse or partner, or another member of their household, experienced discrimination as a result of the respondent's HIV status.

External stigma is rooted in fear and judgment of what is different, leading to blame, distancing, and discrimination. Figure 10 illustrates the reasons why PLHIV consider that they have experienced stigma and discrimination in the past 12 months. Different reasons were cited but most were related to a misunderstanding about HIV transmission, fear of getting infected, or discomfort with lifestyles or behaviours.

Figure 10. The different reasons for stigma and discrimination



From focus group discussions it became apparent that PLHIV who are also men who have sex with men, drug users or sex workers tend to experience more stigma and discrimination for their occupation or lifestyle choices, but also their HIV status.

'My siblings discriminated against me because of my transgender identity even before I was HIV positive. But now, I am an HIV positive MSM and a sex worker. They now discriminate against me even more' (MSM PLHIV-FGD)

'They knew of my gender identity [transgender] and decided not to invite me to wedding ceremonies. This is because they did not want their married friends to behave like me' (MSM-PLHIV- FDG)

'I do not have a job and am not seen as a good man [because of my drug use]. Now that I am positive, [a neighbor] said, "let me die" (DU PLHIV- FDG)

Such enhanced stigma and discrimination toward most-at-risk populations were also found in a 2010 study[24] , where 20% of MSM reported an increase of discrimination levels experienced as a result of their HIV status.

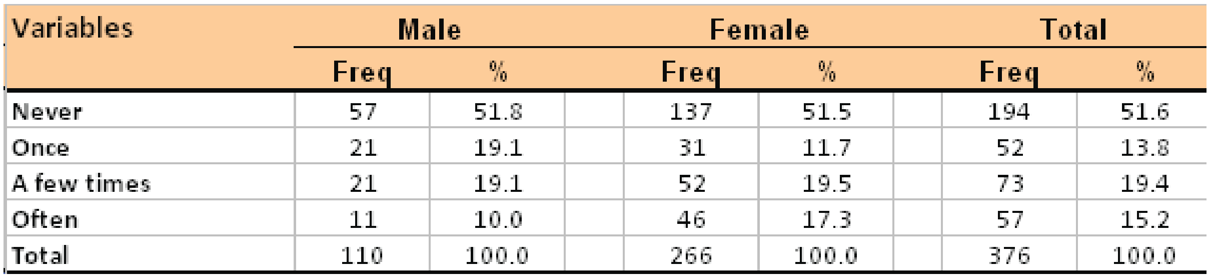
4.4 Access to work, housing and education

4.4.1 Access to work

Stigma and discrimination surrounding HIV pose as significant barriers to adequate employment for PLHIV. This study found that a total of 18 respondents did not have any form of work in the 12 months preceding the interview.

Out of the 376 respondents who were employed or self-employed, 48.4% had lost employment one or more times during the previous 12 months for a variety of reasons (Table 6). More than one third of these respondents had lost employment or income generation more than once in the past year. More than one in ten of them had lost employment repetitively in a short time period.

Table 6. Respondents who have lost employment or source of income
in the past 12 months



Variables	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Never	57	51.8	137	51.5	194	51.6
Once	21	19.1	31	11.7	52	13.8
A few times	21	19.1	52	19.5	73	19.4
Often	11	10.0	46	17.3	57	15.2
Total	110	100.0	266	100.0	376	100.0

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[24] Sopheab H, Chhea C, Tuot S (2010) The Baseline survey on HIV/AIDS knowledge, attitudes, practices and related risk behaviors among MARP in Phnom Penh, Cambodia. KHANA.

Females represented a much higher proportion than males among those who had often lost employment or another source of income in the past 12 months. One in five female respondents belonged to this category which confirms that women not only suffer from higher levels of stigma and discrimination, but were also subjected to more serious forms of stigma and discrimination compared to men. Given that almost 50% of female respondents had been widowed or divorced, difficulties associated with loss of income were compounded by household financial responsibilities including supporting and caring for family members, some of whom were living with HIV.

Three quarters of all the respondents who lost their employment or other source of income in the past 12 months said that this was a direct result of their HIV status. Figure 11 illustrates specific HIV-related reasons as to why these respondents had suffered this loss. Poor health alone accounted for a large proportion of HIV-related unemployment, whereas other reasons were of much lesser relevance.

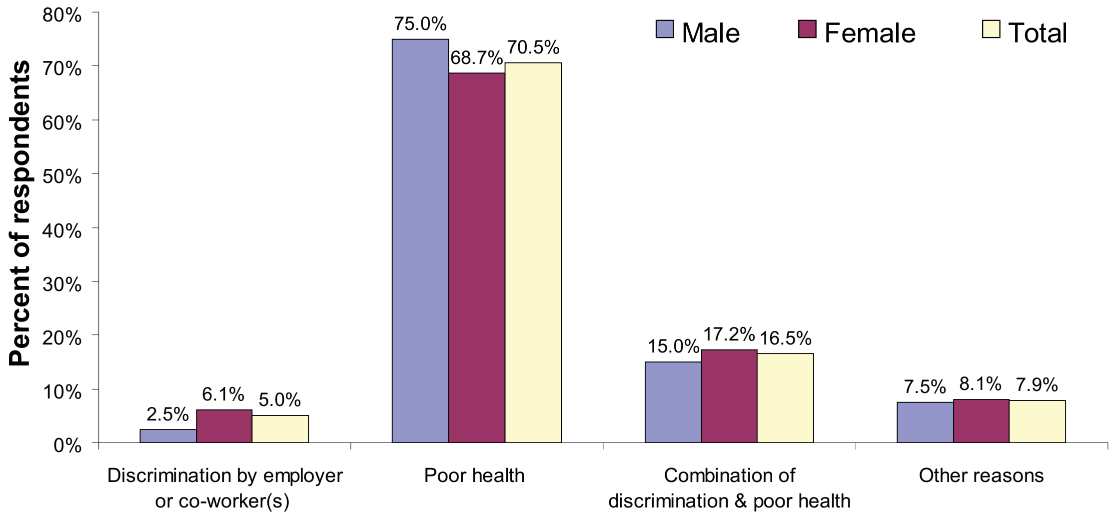
PLHIV described how their illness affected their work, including not having enough energy to work or that their weakening health condition will render them unproductive in their work:

'We couldn't perform any physically demanding work while our health condition got worse, so we decided to give up our jobs' (DU PLHIV-FGD)

'As a positive street sex worker, I can't work until 1-2 in the morning because my health will get worse' (ESW PLHIV-FGD)

In the questionnaire respondents were also asked if their job description or the nature of their work had changed, or if they had been refused a promotion. Only a very small number of respondents replied affirmatively to this question (7.7%). This is probably due to the fact that the question was not very relevant for the majority of respondents who, at the time of the study, were working as farmers or as vendors, or who were unemployed.

Figure 11. Percentage of respondents who lost their employment or source of income because of their HIV status and specific reasons for the loss



Quite possibly for the same reason, only few respondents (12.8%) answered affirmatively to the question of whether they had been refused employment or a work opportunity in the past 12 months because of their HIV status.

Apart from the physical effects of HIV-related illness in preventing PLHIV from retaining or obtaining employment, the quantitative data also unraveled discrimination in the workplace. Of the respondents who lost their employment or who had been refused promotion/had the nature of their work altered, 21.5% and 41.4%, respectively, attributed the reason to discrimination, at least in part.

Respondents' concerns over discrimination were also reflected in the qualitative discussions which highlighted the discrimination that is based on perceived weakness and illness of PLHIV:

'As MSM and HIV positive, [employers] are afraid that we may not be able to work because our health condition is poor and that we would always be seeking health services' (MSM PLHIV-FGD)

'They needed to get the work done within three days but I was often unhealthy with frequent tiredness, stomachache and diarrhea. As a result, the boss fired me' (DU PLHIV-FGD)

'I told the staff recruiter of the garment factory that I am positive; she responded by assuming that my health condition is weak and that I may not be capable of working for them' (ESW PLHIV-FGD)

'I was a laundry worker and my employer didn't allow me to work more often, because they were afraid of getting infected…so I quit' (PLHIV-FGD)

Self-employment such as selling products to earn a living was reported to be difficult for PLHIV and their families because of widespread stigma and discrimination. PLHIV households have lower levels of income compared to non-PLHIV households[25] :

'Before [being diagnosed], we had many clients, but now, they discriminate against us. Because of the drop in client numbers and profit, the business failed" (PLHIV-FGD)

4.4.2 Access to housing

PLHIV face major barriers to safe and adequate housing because of the stigma and discrimination surrounding HIV. A total of 46 respondents (11.7%) were forced to change place of residence or were unable to rent accommodation in the previous 12 months. 67.4% of them attributed this, at least in part, to their HIV status. This includes nine respondents who reported that they had been "often" forced to change residence or had been unable to rent accommodation in the previous 12 months. Seven among the nine respondents who experienced this problem were females, which may possibly be related to the fact that the sample included a much larger number of females than of males respondents.

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[25] UN (2010) Report on the Socioeconomic Impact of HIV at the Household Level in Cambodia, Phnom Penh

4.4.3 Access to education

Females represented a much higher proportion than males among those who had often lost employment or another source of income in the past 12 months. One in five female respondents belonged to this category which confirms that women not only suffer from higher levels of stigma and discrimination, but were also subjected to more serious forms of stigma and discrimination compared to men. Given that almost 50% of female respondents had been widowed or divorced, difficulties associated with loss of income were compounded by household financial responsibilities including supporting and caring for family members, some of whom were living with HIV.

Three quarters of all the respondents who lost their employment or other source of income in the past 12 months said that this was a direct result of their HIV status. Figure 11 illustrates specific HIV-related reasons as to why these respondents had suffered this loss. Poor health alone accounted for a large proportion of HIV-related unemployment, whereas other reasons were of much lesser relevance.

PLHIV described how their illness affected their work, including not having enough energy to work or that their weakening health condition will render them unproductive in their work:

‘We couldn’t perform any physically demanding work while our health condition got worse, so we decided to give up our jobs’ (DU PLHIV-FGD)

‘As a positive street sex worker, I can’t work until 1-2 in the morning because my health will get worse’ (ESW PLHIV-FGD)

In the questionnaire respondents were also asked if their job description or the nature of their work had changed, or if they had been refused a promotion. Only a very small number of respondents replied affirmatively to this question (7.7%). This is probably due to the fact that the question was not very relevant for the majority of respondents who, at the time of the study, were working as farmers or as vendors, or who were unemployed[26].

4.5 Access to health care and testing services

Access to essential health care and testing services can be compromised by the lack of employment and housing. This is associated with not being able to afford these services and the increased displacement and mobility of PLHIV restricts their access to hospitals and access to PLHIV by home-based care teams. However, a number of studies have also shown that HIV-related stigma and discrimination can also directly prevent the access to health care and testing services for PLHIV [27,28] .

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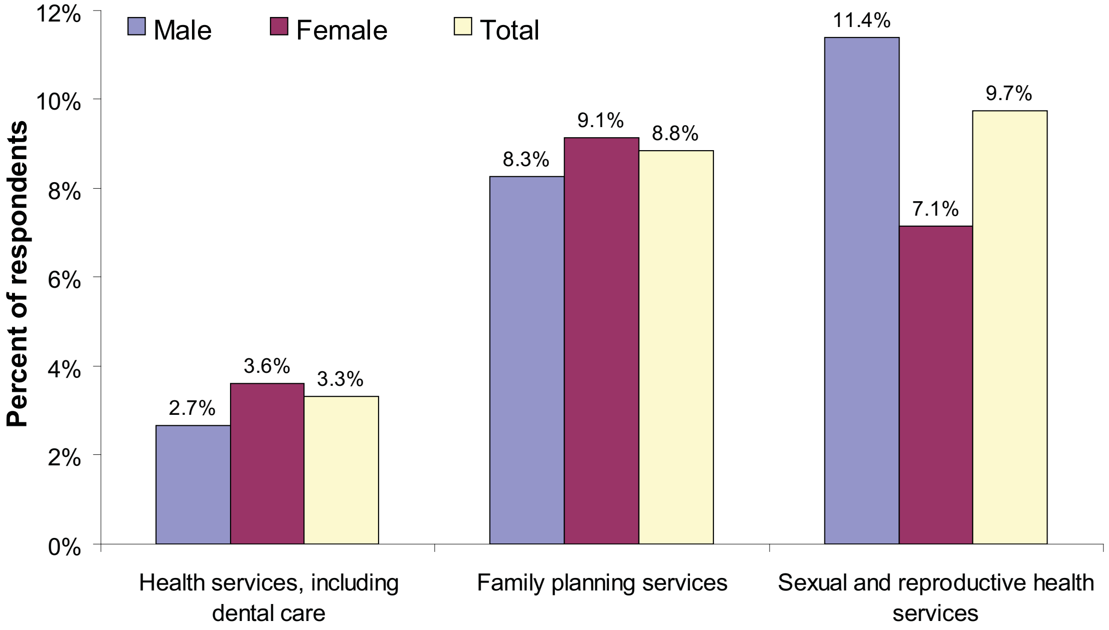
[26] UN (2010) Report on the Socioeconomic Impact of HIV at the Household Level in Cambodia, Phnom Penh

[27] UNAIDS (2009) The China Stigma Index Report. Institute of Social Developement Research, China Central Party School.

[28] Schuster MA, Collins R, Cunningham WE, et al. (2005) Perceived Discrimination in Clinical Care in a Nationally Representative Sample of HIV-infected Adults Receiving Health Care. Journal of General Internal Medicine 20(9):807-13.

[29] In the context of this study, sexual and reproductive health refers to abortion, maternal and peri-natal care, including care associated with pregnancy, childbirth and breast feeding. It has to be noted that the percentage of respondents having been denied access to sexual and reproductive health services may be higher given that the denominator should not be all of the respondents but rather only those respondents who have sought to access such services. The ‘not applicable’ answer category is missing in the questionnaire and hence the right denominator is not available. The data suggests that for many respondents sexual and reproductive health services are the same as family planning services
Therefore one can presume that the number of respondents not having sought access to each of these two kinds of services is roughly the same (n=55). Under this assumption, the percentage of respondents who have been denied access to sexual and reproductive health services in the past 12 months is 9.7%.

Figure 12. Percentage of respondents who have been denied access to different health and family planning services because of their HIV status in the previous 12 months



Stigma indices conducted in other developing and developed countries have found larger proportions of PLHIV who have been denied access to vital health care services. For example, in Myanmar, 35% of PLHIV were denied access to family planning services and 20% to sexual and reproductive health services in the previous 12 months[30] . Similarly in the United Kingdom, 17% of respondents reported have been denied access to health services one or more times in the previous 12 months because of their HIV status [31].

4.5.2 Access to testing services

There were a number of reasons why respondents tested for HIV. The main reason for testing was referral by a doctor due to suspected HIV-related symptoms such as tuberculosis. Male respondents (47.4%) were much more likely to seek an HIV test only when they were symptomatic compared to female respondents (33.2%), which correlates with another study that found that males are more likely to test late[32] . Late testing in both men and women is perhaps due to a lack of awareness of the risks associated with risky behaviour and an insufficient understanding of the benefits related to knowing one's HIV status and starting treatment early.

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[30] UNAIDS (2010) People living with HIV stigma index, Myanmar. Myanmar Positive Group & MMRD Research Services.

[31] Sou S, Tia P, Ward C (2004) Implementing Cambodia's law on the prevention and control of HIV/AIDS. International Conference on AIDS, abstract no MoPeE4173. Bangkok, Thailand, July 11-16 2004.

[32] BBC-WST (2009) Cambodia Sentinel Survey.

Table 7. Reasons for getting tested for HIV*

Variables	Male (n = 114)		Female (n = 280)		Total (n = 394)	
	Freq	%	Freq	%	Freq	%
Suspected HIV-related symptoms	54	47.4%	93	33.2%	147	37.3%
Illness or the death of partner/family member	23	20.2%	115	41.1%	138	35.0%
I just wanted to know	30	26.3%	64	22.9%	94	23.9%
Partner/family member tested positive	19	16.7%	72	25.7%	91	23.1%
Referred by a clinic for STI	14	12.3%	16	5.7%	30	7.6%
Pregnancy	0	0.0%	16	5.7%	16	4.1%
Marriage/sexual relationship	3	2.6%	7	2.5%	10	2.5%
Employment	0	0.0%	2	0.7%	2	0.5%
Others	4	3.5%	3	1.1%	7	1.8%

* More than one response to this question was possible

Table 7 shows that there is twice the percentage of female respondents (41.1%) to that of male respondents (20.1%) who tested for HIV test only after their partner or a family member became ill. Also, a much higher percentage of females (25.7%) compared to males (16.7%) went for HIV testing after their partner or a family member was found to be HIV-positive, which explains why more women than men get HIV testing at an earlier stage before they are symptomatic.

These findings need to be interpreted in the context of Cambodia's epidemic while keeping the profile of the study sample in mind. A large share of female respondents belonged to the 30-40 year-old age group who were most likely infected by their spouses or partners in the mid-1990s when Cambodia's epidemic was at its peak (2.0% in 1998[33]). As shown earlier, 43.4% of respondents said they had been living with HIV for 5-10 years at the time of the study and had presumably found out about their status only several years after they became infected. It is therefore not surprising that two thirds of all female respondents indicated that they got an HIV test either because of the illness, or of the death, of their intimate partner, and only one third said they got tested because of their own HIV-related symptoms.

What is surprising, however, is the very small share of female respondents who reported being tested because of a referral from an STI clinic. This is concerning because one would hope that such referrals are made frequently as part of HIV prevention programmes. However, such concern may be premature because it may be due to the respondent sampling characteristics which included a large share of female PLHIV who were aged between 30-50 years old and who may not have the need to frequently attend STI clinics.

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[33] NCHADS (2007) Report of a Consensus Workshop: HIV Estimates and Projections for Cambodia 2006-2012.

The illness or death of the husband as the major reason for women to test was also reflected in the focus group discussion:

'I knew [that I was HIV positive] from my husband's sickness, and when I had a blood test, it came back with a positive result' (PLHIV-FGD)

'I was suspicious that my husband's death was due to an AIDS illness, so I went to get an HIV test and received the result later that same day' (PLHIV-FGD)

'I did not know anything about HIV. I didn't take the HIV test until both my husband and I got very sick' (PLHIV-FGD)

The death of a wife may impact a man's HIV vulnerability, as described in the following statement:

'I was really depressed after my wife passed away…I started using drugs and had sex with multiple partners. When I became sick, I was tested and found out my status' (DU-PLHIV-FGD)

The lack of awareness of the risk of HIV infection can delay HIV testing. The fear of confirming the HIV positive status of the individual and the consequences of such a result can also delay testing. Furthermore, discriminatory attitudes from health service providers, as described in the previous section, may contribute to the discouragement of many to seek testing services. Yet, the large majority of respondents reportedly obtained an HIV test voluntarily (91.4%) (Table 8). It should be noted, however, that almost one in ten respondents also reported that they had an HIV test only because they were coerced or pressured, or had been tested without their knowledge.

Table 8 shows that 92.6% of all respondents received both pre- and post-test counseling which is an encouraging finding. A total of eight respondents did not receive any counseling whatsoever.

Table 8. Decision to be tested and pre- and post-test counseling

Variables	Male (n = 114)		Female (n = 280)		Total (n = 394)	
	Freq	%	Freq	%	Freq	%
The decision to be tested for HIV						
I took the decision myself to be tested (i.e. it was	106	93.0	254	90.7	360	91.4
I took the decision to be tested, but it was under pressure from others	5	4.4	16	5.7	21	5.3
I was made to take an HIV test (coercion)	1	0.9	7	2.5	8	2.0
I was tested without my knowledge – I only found out after the test had been done	2	1.8	3	1.1	5	1.3
Total	114	100.0	280	100.0	394	100.0
Receive counselling when to be tested for HIV						
I received both pre- and post-HIV test counsellin	105	92.1	260	92.9	365	92.6
I only received pre-test HIV counselling	2	1.8	3	1.1	5	1.3
I only received post-test HIV counselling	6	5.3	10	3.6	16	4.1
I did not receive any counselling when I had an H	1	0.9	7	2.5	8	2.0
Total	114	100.0	280	100.0	394	100.0

4.6 Disclosure of status and confidentiality

An important discrimination-related barrier to early testing relates to practices involving confidentiality and privacy[34] . As shown in Table 9, the voluntary disclosure by respondents of their HIV status to other people depended on the type of relationship they had with these people. Respondents' HIV status was voluntarily disclosed much more frequently to family members and health care workers than with friends or neighbours. Respondents disclosed their status less often to their co-workers, employers, clients and public authorities.

Almost all of the respondents personally disclosed their HIV status to their spouse/ partner (97.1%) or to other adult family members (94.5%) on a voluntary basis (Table 9). There was a lower level of disclosure to children in the family (88.2%) or to other PLHIV (89.0%), either by respondents telling them directly or giving consent for someone else to tell them. Lower yet is the level of direct and indirect voluntary disclosure to friends and neighbours (78.3% and 74.0%, respectively); and in the workplace with roughly 70% reporting disclosure of their HIV status to their co-workers and employers. Overall there was a much lower level of voluntary disclosure to customers or clients (35.6%).

The exploration of respondents' experiences around the disclosure of their HIV status during qualitative discussions showed that confidence and trust significantly influence to whom, and when, status was disclosed. Among family members, this trust and confidence was stronger:

'I didn't keep [my status] a secret from my family; I told them as soon as I found out' (ESW PLHIV-FGD)

'I told all of my five siblings that [my husband and I] are both infected with HIV' (PLHIV-FGD)

That most respondents said they personally disclosed their HIV status voluntarily to health care workers (88.6%) is not surprising given the high levels of pre- and post-test counseling reported. However, the dilemma that some PLHIV may experience is that, in order to access care and support services, they must first disclose their status to service providers who need to account for the resources that they provide.

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[34] Wu S, Li L, Wu Z, Liang LJ, Cao H, Yan Z, Li J (2008) A brief HIV stigma reduction intervention for service providers in China. AIDS Patient Care and STDs 22(6):513-520

Table 9. How HIV status of respondents was disclosed to others. The total number of respondents (n) that each category is applicable to is stated in brackets.

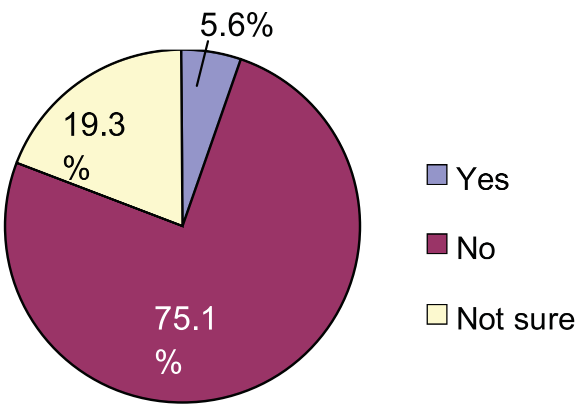
Variables	I told them (%)	Someone else told them with my consent (%)	Someone else told them without my consent (%)	They don't know my HIV status (%)
Spouse/partner (n=343)	93.9	3.2	1.5	1.5
Other adult family members (n=378)	92.1	2.4	1.3	4.2
Health care workers (n=386)	90.4	4.1	3.9	1.6
Child family members (n=341)	85.0	3.2	1.5	10.3
Other PLHIV (n=373)	84.7	4.3	8.3	2.7
Social workers/counsellors (n=321)	83.2	5.0	5.3	6.5
Community leaders (n=369)	77.8	6.8	10.8	4.6
Friends (n=336)	72.0	6.3	9.5	12.2
Employers (n=147)	65.3	4.8	6.8	23.1
Co-workers (n=212)	63.7	5.2	6.1	25.0
Neighbours (n=346)	63.6	10.4	14.5	11.6
Religious leaders (n=284)	55.3	6.3	8.5	29.9
Government officials (n=199)	54.8	4.5	9.0	31.7
Teachers (n=203)	51.2	4.4	10.8	33.5
The media (n=97)	38.1	1.0	6.2	54.6
Customers/clients (n=149)	30.2	5.4	10.1	54.4

Just over half of all respondents reported direct or indirect voluntary disclosure to government officials, teachers and religious leaders. The surprisingly high level of voluntary disclosure to community leaders (84.6%) may be due to the fact that leaders of the PLHIV community networks, which most of the respondents belonged to, were also considered as community leaders in this context.

Overall, there were high levels of disclosure of HIV status without consent. Of particular concern is the high level of disclosure without consent to neighbours (14.5%), community leaders and teachers (both 10.8%), customers or clients (10.1%), government officials (9.0%), friends (9.5%), employers (6.8%) and co-workers (6.1%). Such a break in confidence can have serious consequences, including subjecting the individual and his or her family to discrimination and physical violence; and fewer opportunities for work and education.

Figure 13 illustrates the cumulated responses to the question of whether respondents thought a health care professional had ever disclosed their HIV status without consent.

Figure 13. Health care professionals have disclosed my status without consent



Confidentiality of HIV status is a fundamental human right, and the level of disclosure without consent found in this study must be seriously noted by program planners and policy makers working with PLHIV.

Some PLHIV who participated in the study considered disclosing their HIV status to be very challenging. They feared judgment of their behaviour and expressed concerns about the impact of the disclosure on the reputation of their families. These testimonies from focus group discussion express some of these concerns:

‘[By telling people of my positive status], I was afraid that I might lose my family’s dignity’ (DU PLHIV-FGD)

‘After previous experiences of stigma and discrimination as a result of telling people about my status, I decided that it is better not to disclose. I was aware that they [my neighbours] gossiped about me to everyone else ’ (PLHIV-FGD)

‘I did not want to disclose. I was afraid of being stigmatized and discriminated against’ (MSM PLHIV-FGD)

‘[PLHIV] are afraid that people might know [their status], so they tend to look for treatment and care services that are far from where they live so that people that they work with won’t know their HIV status’ (Health service provider-KII)

A number of respondents indicated that there were people who did not know about their HIV status (Figure 14). 54.4% said this of their customers or clients, 33.5% of their children or teachers, 31.7% of government officials and 29.9% of religious leaders. Only 1.5% of all respondents, who at the time of the study were in a relationship, said their spouse or partner was unaware of their HIV status. Similarly, only 4.2% of all respondents said this was the case for other adult family members.

Figure 14. Percentage of respondents saying that some people do not know about their HIV status

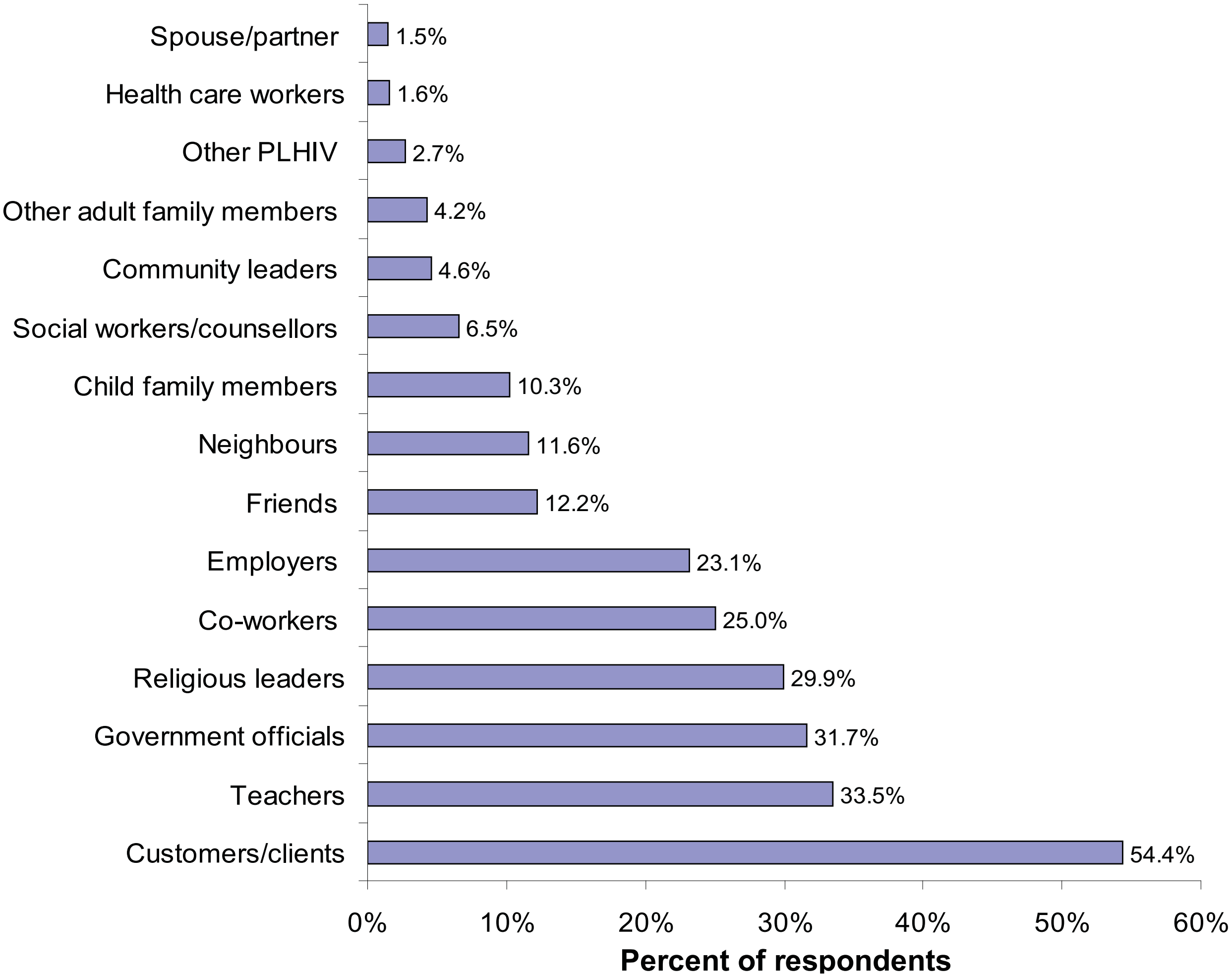
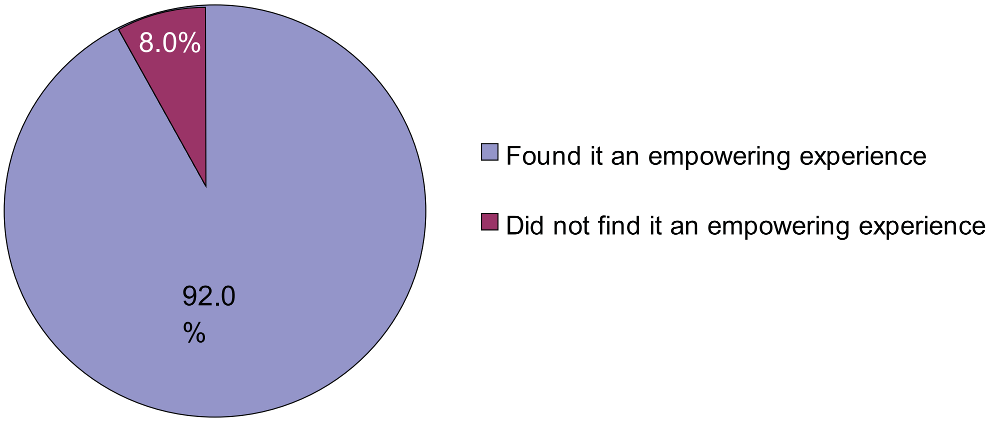


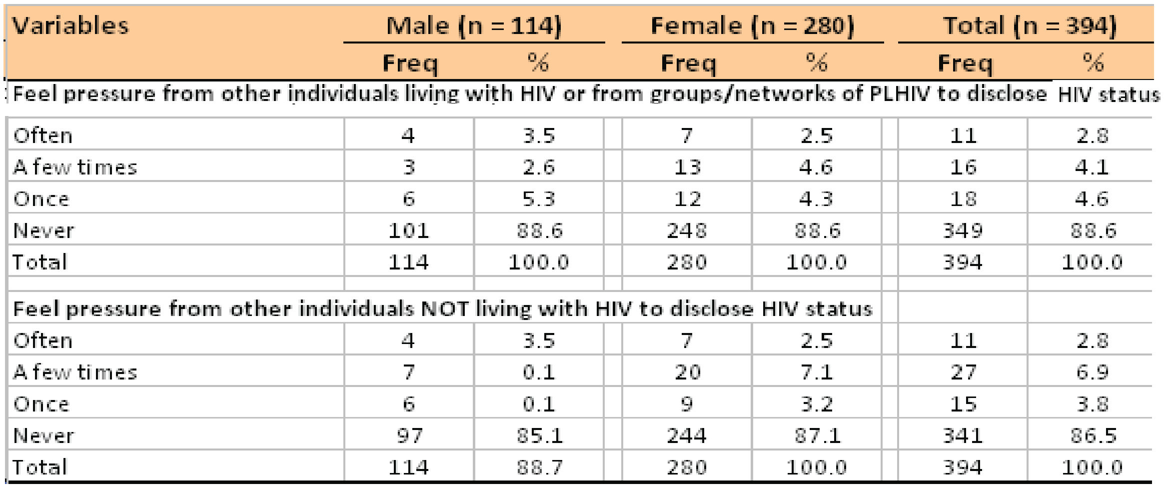
Figure 15. Respondents' experience after disclosure of HIV status



Overall, the study found high levels of voluntary disclosure by PLHIV of their status. In addition, of those respondents who had disclosed their HIV status, 92.0% said that disclosing their HIV status was an empowering experience (Figure 15). The negative experience as a result of disclosure felt by the remaining 8.0% may be associated with two factors – the pressure exerted by others to disclose and/or the discriminatory reactions received after disclosure.

Table 10 shows more than one in ten (11.5%) respondents reported that they felt under pressure from other PLHIV or PLHIV related groups or networks to disclose their HIV status one or more times in the previous 12 months. This included 11 respondents who reported that they were 'often' pressured by other PLHIV to disclose their status. A slightly higher proportion of respondents (13.4%) experienced the same pressure from other individuals who were not living with HIV, including family members and NGO staff.

Table 10. Pressure experienced by respondents to disclose HIV status



Variables	Male (n = 114)		Female (n = 280)		Total (n = 394)	
	Freq	%	Freq	%	Freq	%
Feel pressure from other individuals living with HIV or from groups/networks of PLHIV to disclose HIV status						
Often	4	3.5	7	2.5	11	2.8
A few times	3	2.6	13	4.6	16	4.1
Once	6	5.3	12	4.3	18	4.6
Never	101	88.6	248	88.6	349	88.6
Total	114	100.0	280	100.0	394	100.0
Feel pressure from other individuals NOT living with HIV to disclose HIV status						
Often	4	3.5	7	2.5	11	2.8
A few times	7	0.1	20	7.1	27	6.9
Once	6	0.1	9	3.2	15	3.8
Never	97	85.1	244	87.1	341	86.5
Total	114	88.7	280	100.0	394	100.0

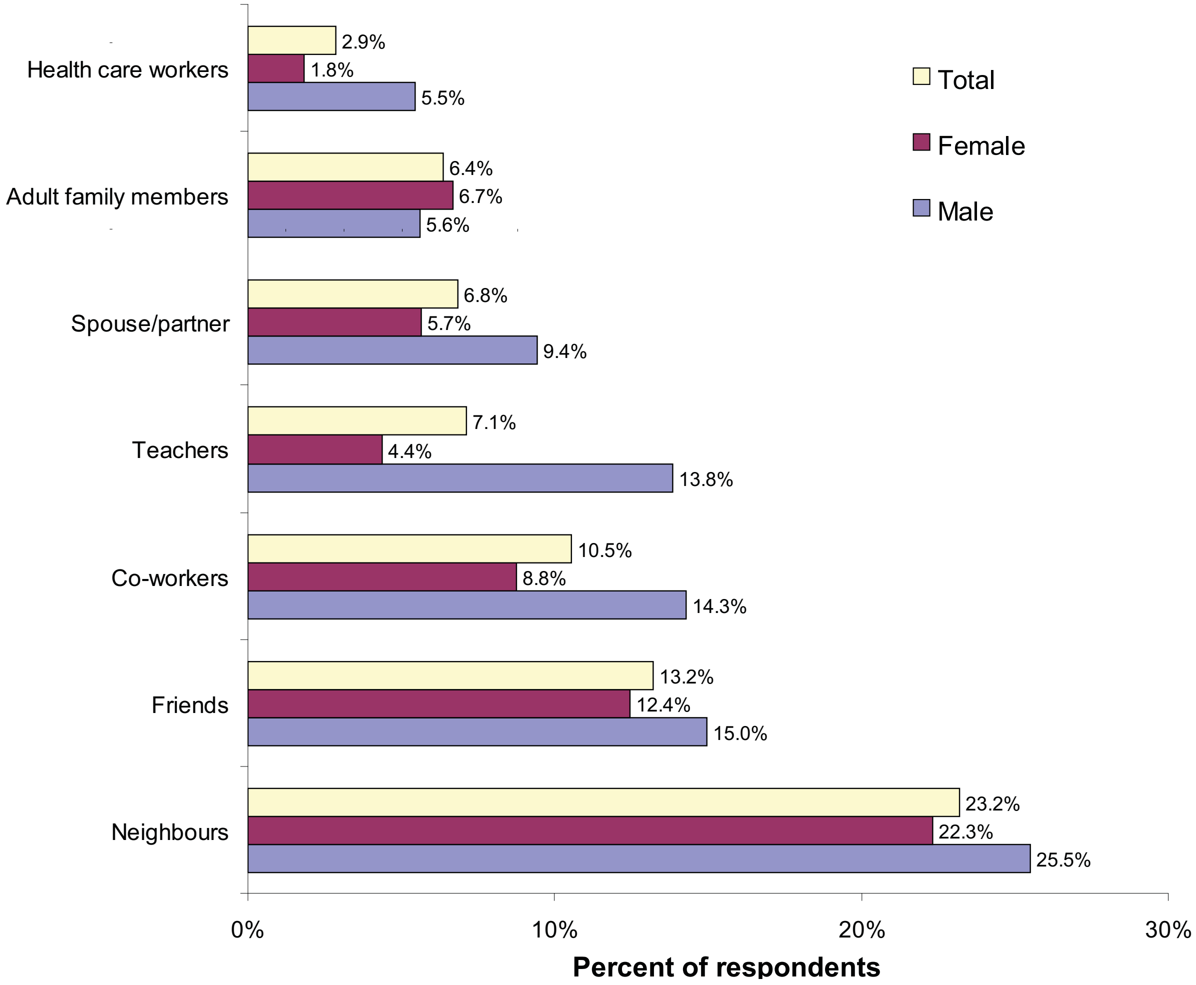
The questionnaire survey revealed that, when respondents disclosed their HIV status to family members, the reaction they received were mostly supportive or very supportive (Figure 13). This type of reaction was more common among family members, including spouses/partners of the respondents.

Data from focus group discussion provides an example of how family members reacted positively:

'My family encouraged me to keep active, not to be disappointed, and not to think too much [about my condition]. [They] want me to keep healthy and continue working' (PLHIV-FGD)

However, almost one in four respondents reported that their neighbours reacted negatively once they revealed their HIV-positive status (Figure 16). Also, one in ten respondents said they got a negative reaction from their friends. Negative reactions from co-workers and teachers were reported less frequently, but male respondents (13.8%) were 3 times more likely to experience discriminatory reactions from their teachers than females (4.4%).

Figure 16. Discriminatory reactions from people when they first knew respondents' status



While some respondents did experience rejection by family members and other relatives, only about 6% of spouses or other adult family members had a discriminatory reaction when the respondent announced his/her HIV status. These statements typify the negative reaction one receives:

'After finding out about my positive status, my family disowned me and didn't allow me to come into the house' (MSM-PLHIV-FGD)

'[My neighbours] felt frightened and sad, and they questioned how I became infected' (DU-PLHIV-FGD)

An encouraging finding in this study is that only 2.9% of respondents reported any form of discriminatory reactions from health staff. In contrast to this are the higher levels of discrimination by health staff (around 8%) reported in the China Stigma Index[35] . This low level of discrimination by health care workers in Cambodia was also reflected in the Socioeconomic Impact Study[36] . However, this must be viewed in the context that most of the respondents were members of self-help groups, which might have resulted in a reluctance to report on the discrimination within the health care environment which they themselves are part of and are therefore heavily reliant on it to perform their own work.

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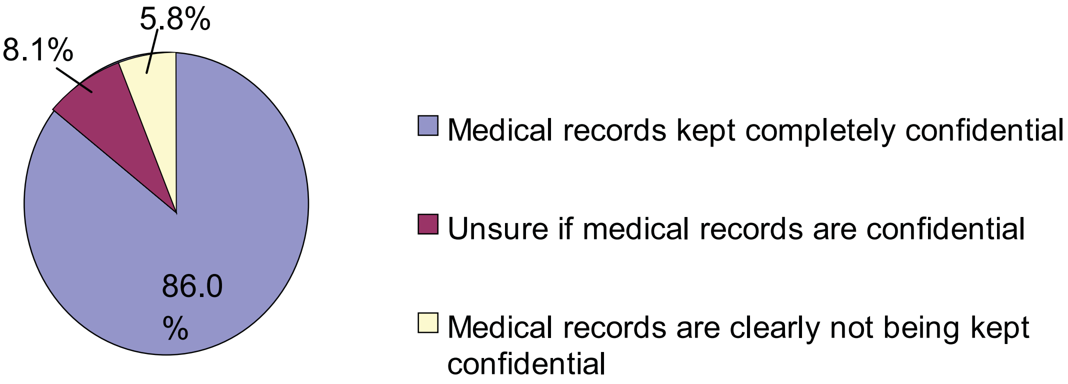
[35] UNAIDS (2009) The China Stigma Index Report. Institue of Social Developemnt Research, China Central Party School.

[36] UN (2010) Report on the Socioeconomic Impact of HIV at the Household Level in Cambodia, Phnom Penh.

While 86% of respondents expressed their trust in the confidentiality of their medical records, close to one in ten respondents stated they did not know whether their medical records were actually kept confidential (Figure 17). In fact, 23 respondents (5.8%) stated that it was clear to them that their medical records had not been kept confidential. Meanwhile, 22 patients (5.6%) reported that they believed that a health professional had disclosed their HIV status to others without their consent or awareness.

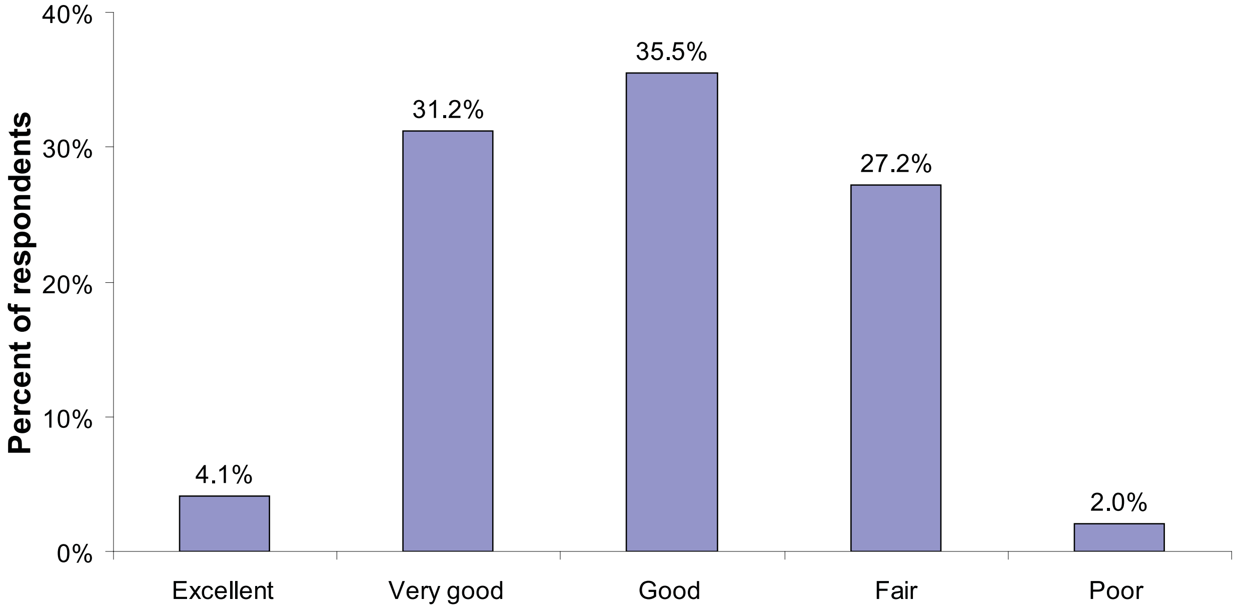
Figure 17. Perceptions of confidentiality of medical records



4.7 Health conditions and treatment

A large majority of respondents (70.8%) reported that they were in good, very good or excellent health. Only 8 respondents reported that they were in poor health. This was unexpected given that 113 respondents reported that they had lost employment in the previous 12 months due to HIV-related poor health. One possible explanation is a contrast between respondents' subjective perception of their health and wellbeing, and the reality that exertions of physical work may sometimes be unbearable.

Figure 17. Perceptions of confidentiality of medical records



Many respondents were on treatment at the time of the study, with 88.3% undergoing antiretroviral treatment (ART) and 68.0% undergoing opportunistic infection (OI) treatment (Figure 19). More respondents have free/affordable access to OI treatment (84.5%) compared to ART (73.9%); however, it was not determined if the type of accessible OI treatment included those for serious infections such as tuberculosis.

Of concern is that 23.4% and 14.0% of respondents reported that they do not have free and available access to ART and OI treatment (Figures 20 and 21), respectively, even though the Law on Prevention and Control of HIV/AIDS (2002) guarantees such provision. In addition, a small number of respondents (about 2%) said that they did not know if the access to ART/ORT was free and available. There was a slightly lower percentage of women who were currently on ART (86.8%) and OI treatment (66.8%), compared to men (92.1% and 71.1%, respectively), possibly because of the higher level of discrimination that women experience from health service staff members and their lower economic standing.

Figure 19. Percentage of respondents on treatment

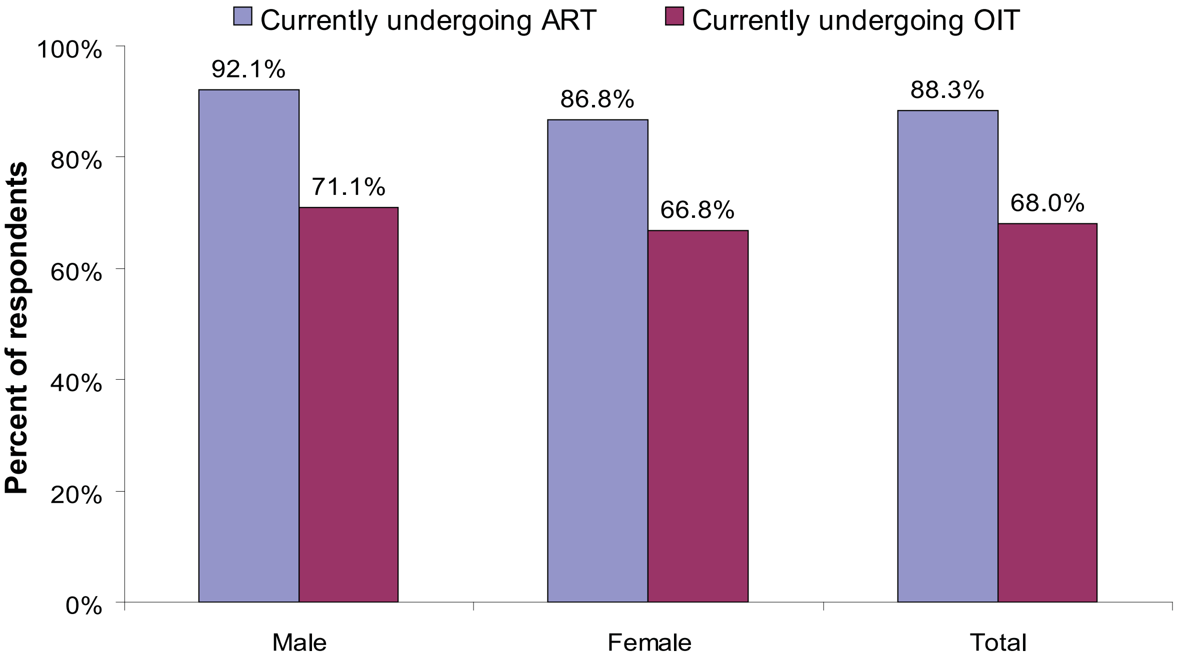


Figure 20. Access to ART

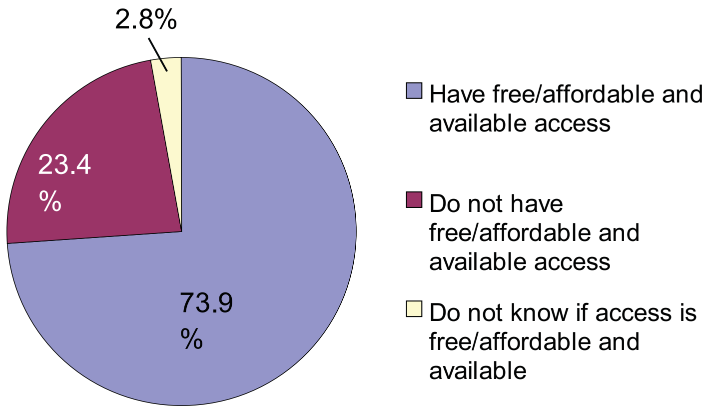
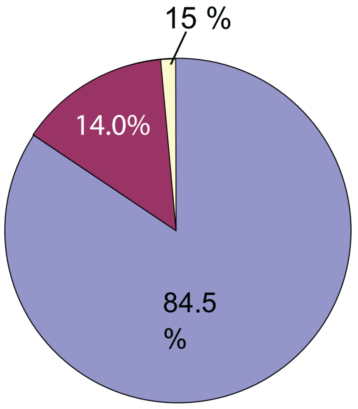


Figure 21. Access to OIT



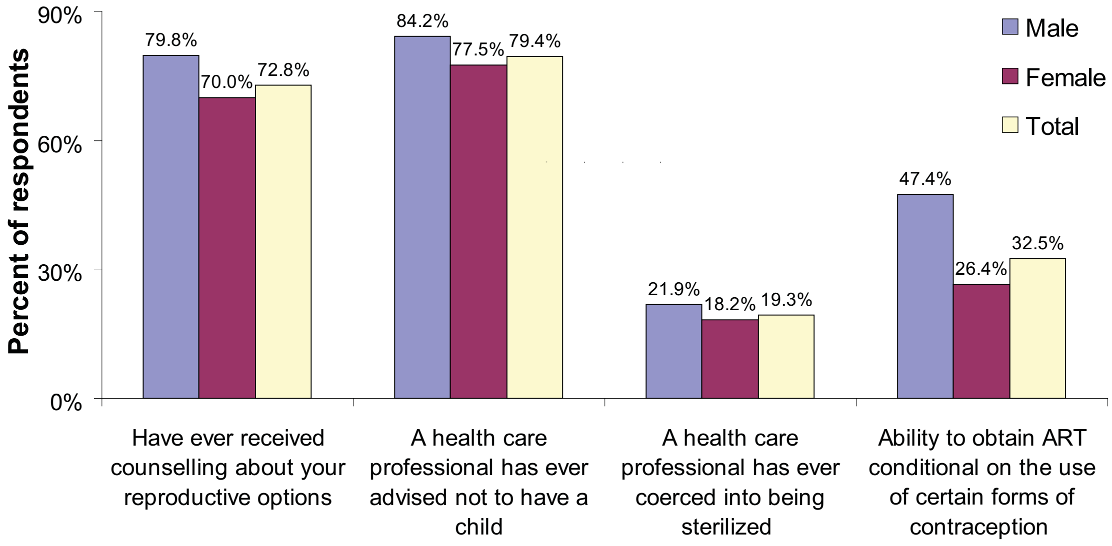
90.1% of respondents reported discussing various HIV-related treatment options with health service providers. This finding is consistent with the satisfaction levels reported in the Socio-Economic Impact Study where more than 85% reported satisfaction with health services in the public sector[37] . 81.0% of respondents reported discussing sexual and reproductive health, their sexual relationship, emotional well-being and drug use with a health service provider in the past 12 months.

4.8 Having children and prevention of mother-to-child transmission

Since being diagnosed with HIV, 72.8% of respondents had received counseling on their reproductive options. A significant percentage of respondents (79.4%) reported that because of their HIV status, they had been advised by health staff not to have any children; and 19.3% of them had even been strongly advised by health staff to undergo permanent sterilization (Figure 22).

These findings are disturbing and will need to inform future action to ensure the reproductive rights of PLHIV are adequately ensured. This is comparable to what was found in the China Stigma Index where 17% of the respondents who had been counseled in reproductive choices had been strongly advised by health professionals to opt for sterilization. In addition, 47.4% of male respondents reported that they can only access ART if they use certain forms of contraception[38], which is a far higher percentage than female respondents (26.4%).

Figure 22. Percentage of respondents counseled on reproductive options since being diagnosed with HIV



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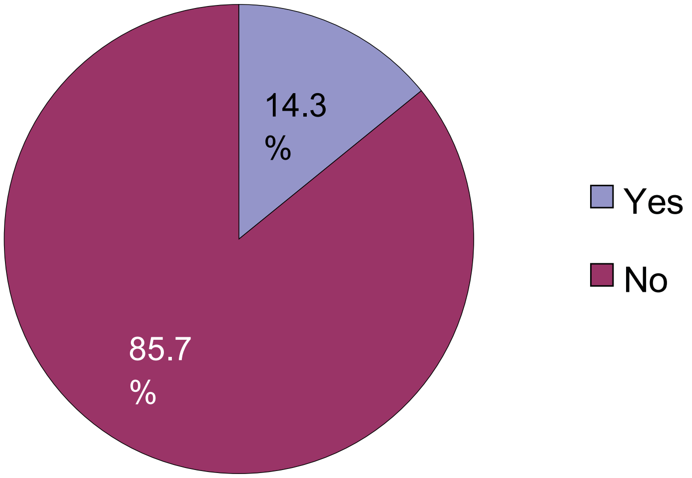
[37] UN (2010) Report on the Socioeconomic Impact of HIV at the Household Level in Cambodia, Phnom Penh.

[38] UNAIDS (2009) The China Stigma Index Report. Institute of Social Development Research, China Central Party School.

One of the most concerning findings of this study is of all the female respondents that were pregnant in the previous 12 months, 17 (14.3%) reported to have been strongly advised by health staff to terminate their pregnancy because of their HIV status (Figure 23). Whether these women actually terminated their pregnancy was not determined by this study. Some information on this issue was also obtained from focus group discussions:

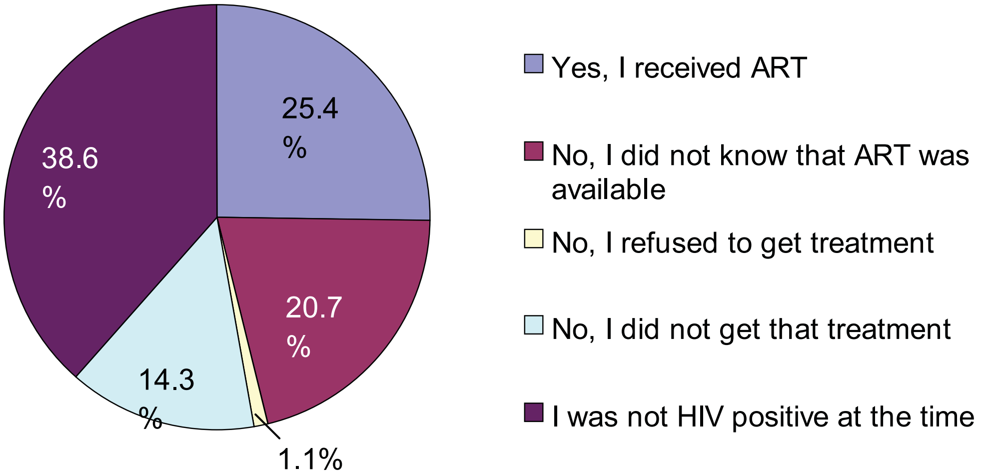
'The [health staff] did not want us to have a baby. They asked me whether I wanted to keep [the baby] or abort the pregnancy, but I insisted on keeping the baby. The health staff member said "keep at your own risk. You have HIV and poor health. You might have problems during delivery." (DU-PLHIV- FGD)

Figure 23. Female respondents were asked if they had been strongly advised by a health professional to terminate their pregnancy in the previous 12 months (n=119)



Of those women who had ever been pregnant, only 25.4% received ARV prophylaxis during child birth to prevent transmission of HIV from mother to child (Figure 24).

Figure 24. Female respondents who have ever been given ART for PMTCT during pregnancy



According to the qualitative discussions, some women benefited from PMTCT services:

'I knew my HIV status and I met with the doctor…I got monthly medicine for preventing the transmission to my baby' (ESW-PLHIV-FGD)

However, of those who underwent PMTCT, 9 respondents (12.7%) reported that they did not receive any information about healthy pregnancy and motherhood, which suggests negligence on the part of the PMTCT staff. Furthermore, over 20% of them said they did not know that ART was available when they were pregnant. This is not surprising given that the PMTCT programme was introduced and expanded later than the diagnosis of HIV for most of the women who participated in the study. ART use among pregnant women living with HIV in the previous 12 months was 78% . However, there were also respondents who did not draw benefit from PMTCT services for other reasons, for example this person:

'Health staff members told me to go for PMTCT during my pregnancy and to tell the doctor about my [HIV] status. But I didn't tell the doctor that I am HIV positive. After they found out they blamed me. They told me that I should have told them. My baby could have been infected' (ESW-PLHIV- FGD)

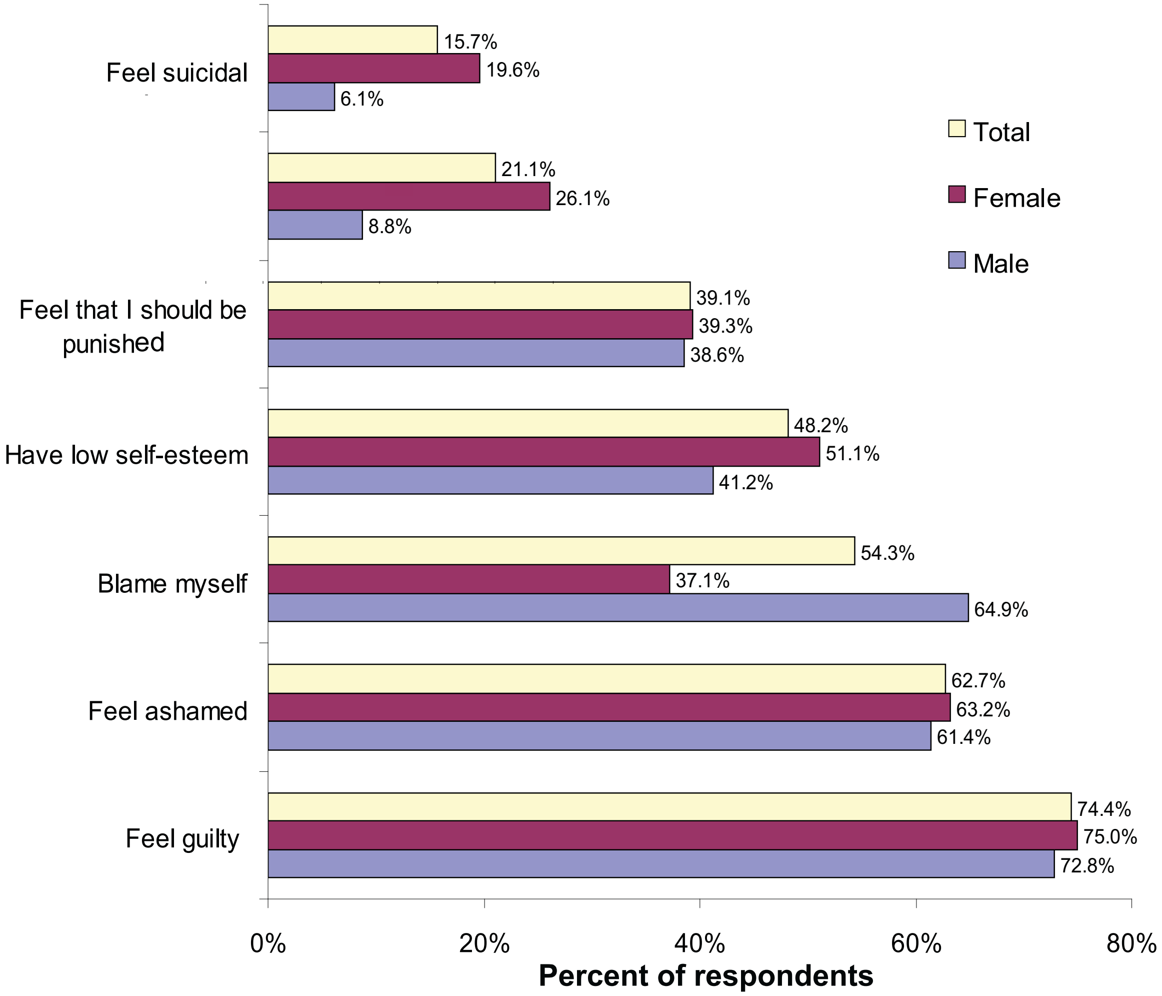
4.9 Internal stigma and fears

This study found a high level of internal stigma or self-stigma among respondents, which is in line with findings of the recent HIV Socio-Economic Impact Study at the household level . The majority of participants in this study reported feelings of guilt (74.7%) and of shame (62.7%) and more than half of them (54.3%) said that they blamed themselves for having been infected with HIV (Figure 25). Close to one in two of all respondents (48.2%) said they possessed low self-esteem and more than one in three (39.1%) said they deserved to be punished. 15.7% of all respondents reported that they have thought of committing suicide.

However, feelings of respondents differed significantly based on gender. Almost twice as many male respondents (64.9%) than female respondents (37.1%) reported that they blamed themselves for having been infected with HIV. Conversely, a much larger proportion of females than of males blamed someone else for their HIV infection (26.1% versus 8.8%). These findings are not surprising considering that most infections in Cambodia's women are contracted from their husbands/partners and occur in marriage or regular partnerships .

Of particular concern is the significant proportion of female respondents (19.6%) who had contemplated suicide in the previous 12 months, which is more than three times the rate seen in male respondents (6.1%) (Figure 25). The HIV Socio-Economic Impact Study similarly reported a high level of PLHIV respondents who had considered committing suicide (15.7%). A possible explanation for this gender disparity is the much higher levels of stigma and discrimination women experience in society, as well as the fact that women are more likely to get tested after a spouse or family member are diagnosed with HIV or die of related causes, and so many female respondents might have been concurrently experiencing pressures of grief, income loss and HIV diagnosis. It should be noted that in this study, low self-esteem was reported by a significantly larger share of female respondents (51%) than of male respondents (41%).

Figure 25. Internal stigma experienced by respondents



Evidence that respondents experienced a high level of internal stigma was also found in the focus group discussion. When asked about how they were feeling about themselves and living with HIV, respondents articulated feelings of shame and self-blame, and some mentioned considered suicide.

'I feel that I am an ignorant and bad man. I was unemployed, I used to smoke illicit drugs with friends and take part in [multiple] sexual engagements. This [lifestyle] has resulted in me being HIV positive' (PLHIV-DU-FGD)

'We are still too shy to join any social gatherings in the village. During religious and wedding celebrations, I would just go to the market [instead of joining these celebrations]' (PLHIV-FGD)

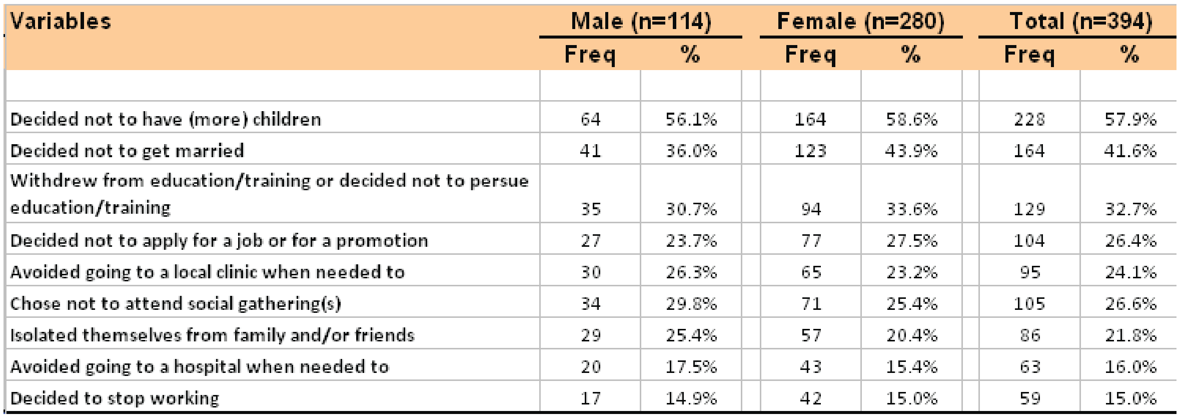
'I have had a difficult time, [which drove me] to attempt suicide by taking an over-dose of medicine' (DU PLHIV-FGD)

'When I first found out I am HIV positive, I felt terrified and emotionally [traumatised]. I wanted to die' (PLHIV-FDG)

Such high levels of internal stigma result in low self-esteem and sense of self-worth to the extent where people may cease to assert their right to treatment and other social benefits. From the survey, it was apparent that respondents had developed a distinct sense of self-denial, meaning that after finding out about their HIV status, they decided to deny themselves the opportunity of living a normal and fulfilling life.

Once they found out that they were HIV-positive, respondents reacted in different ways (Table 11). Male respondents were more likely to isolate themselves from family and friends (25.4%) and choose not to attend social gatherings (29.8%) than female respondents (20.4% and 25.4%, respectively).

Table 11. The effects of internal stigma



Variables	Male (n=114)		Female (n=280)		Total (n=394)	
	Freq	%	Freq	%	Freq	%
Decided not to have (more) children	64	56.1%	164	58.6%	228	57.9%
Decided not to get married	41	36.0%	123	43.9%	164	41.6%
Withdrew from education/training or decided not to persue education/training	35	30.7%	94	33.6%	129	32.7%
Decided not to apply for a job or for a promotion	27	23.7%	77	27.5%	104	26.4%
Avoided going to a local clinic when needed to	30	26.3%	65	23.2%	95	24.1%
Chose not to attend social gathering(s)	34	29.8%	71	25.4%	105	26.6%
Isolated themselves from family and/or friends	29	25.4%	57	20.4%	86	21.8%
Avoided going to a hospital when needed to	20	17.5%	43	15.4%	63	16.0%
Decided to stop working	17	14.9%	42	15.0%	59	15.0%

Many respondents showed evidence of despondency, where they had little intention of pursuing their life dreams of getting married and starting a family or of seeking career and educational opportunities. Because of their HIV status, 41.6% of all respondents decided not to get married or to re-marry, which is a large proportion of those who were not currently married, and 56.1% decided not to have (more) children (Figure 26). 15.0% of respondents decided to stop working as a result of their HIV status and 26.4% refrained from applying for a job or from attempting to obtain a promotion. Furthermore, 32.7% decided not to take advantage of opportunities to extend their formal education or vocational training.

This study revealed that internal stigma can also negatively impact on the physical health of PLHIV. Because of their HIV status, 16% of respondents avoided going to the hospital when they needed to, whereas 24.1% avoided the local clinic (Figure 26). The avoidance of health services may be in part due to the despondency of respondents, as evidenced by the decisions not to have a family or a career, but less likely due to discriminatory reactions of health service providers because of the low frequency that was reported

Figure 26. The percentage of respondents who reacted in various ways following the discovery of their HIV status

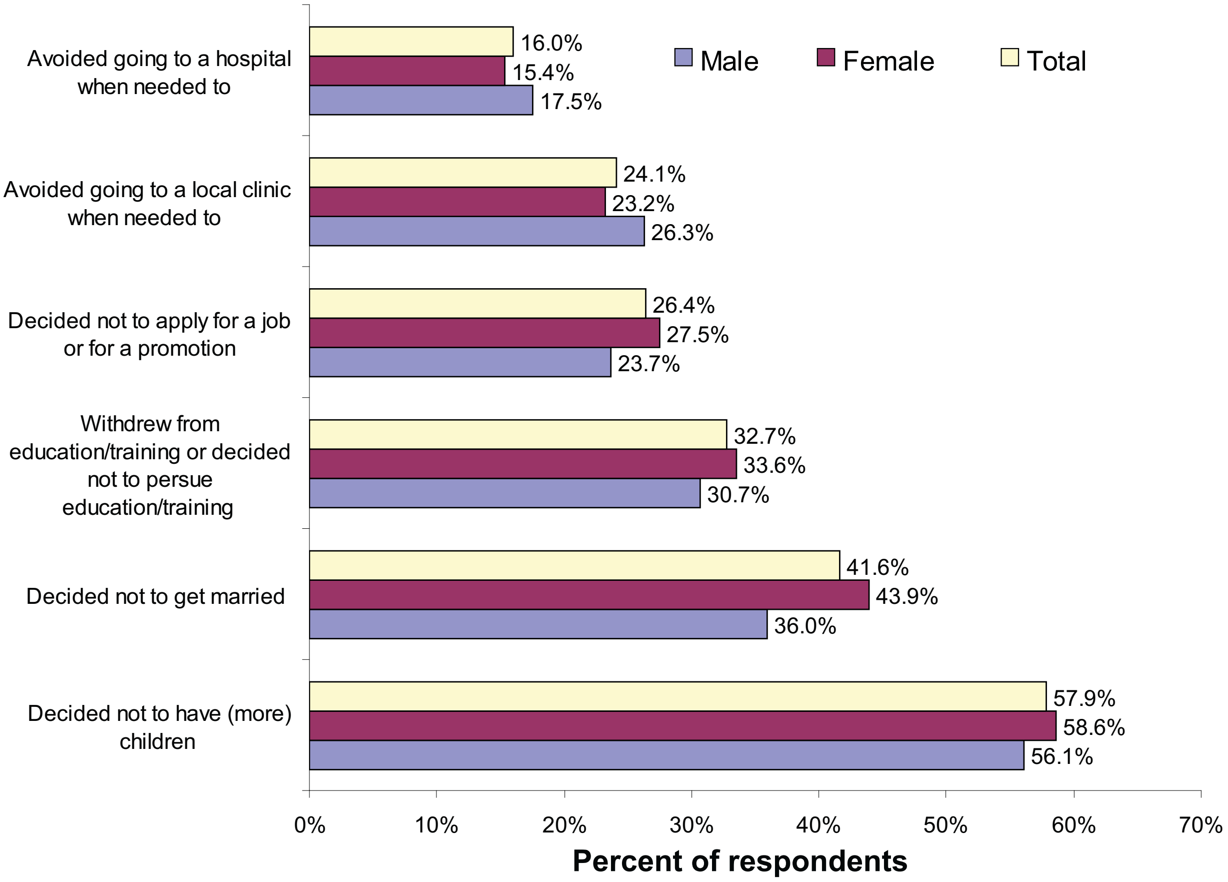
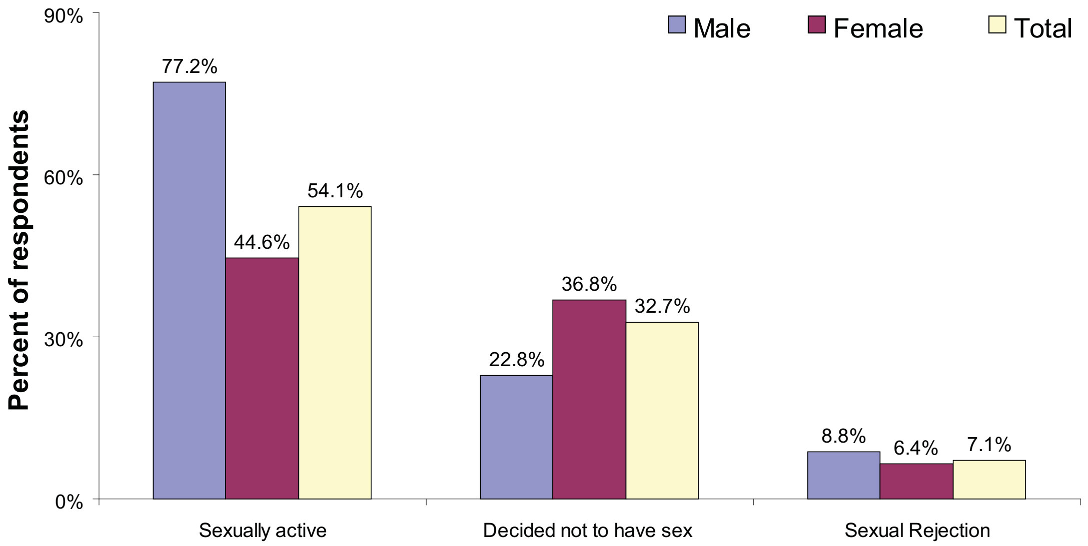


Figure 27 shows that a much higher proportion of male respondents compared to female respondents were sexually active at the time of the study (77.2% versus 44.6%). On average, approximately one in two respondents reported that they had engaged in sexual activity within the 3 months prior to the survey.

A relevant number of respondents, males (22.8%) much less so than females (36.8%), had decided not to have sex because of their HIV status in the 12 months preceding the interview. The higher percentage of females opting for abstinence possibly because they experience lower self-esteem, higher levels of stigma and discrimination, as well as a lack of a socially acceptable sexual outlet outside of a relationship. Yet there is no significant difference between the percentages of males and females who reported that they had sexually been rejected. 7.1% of all respondents reported they had been sexually rejected in the 12 months prior to the study.

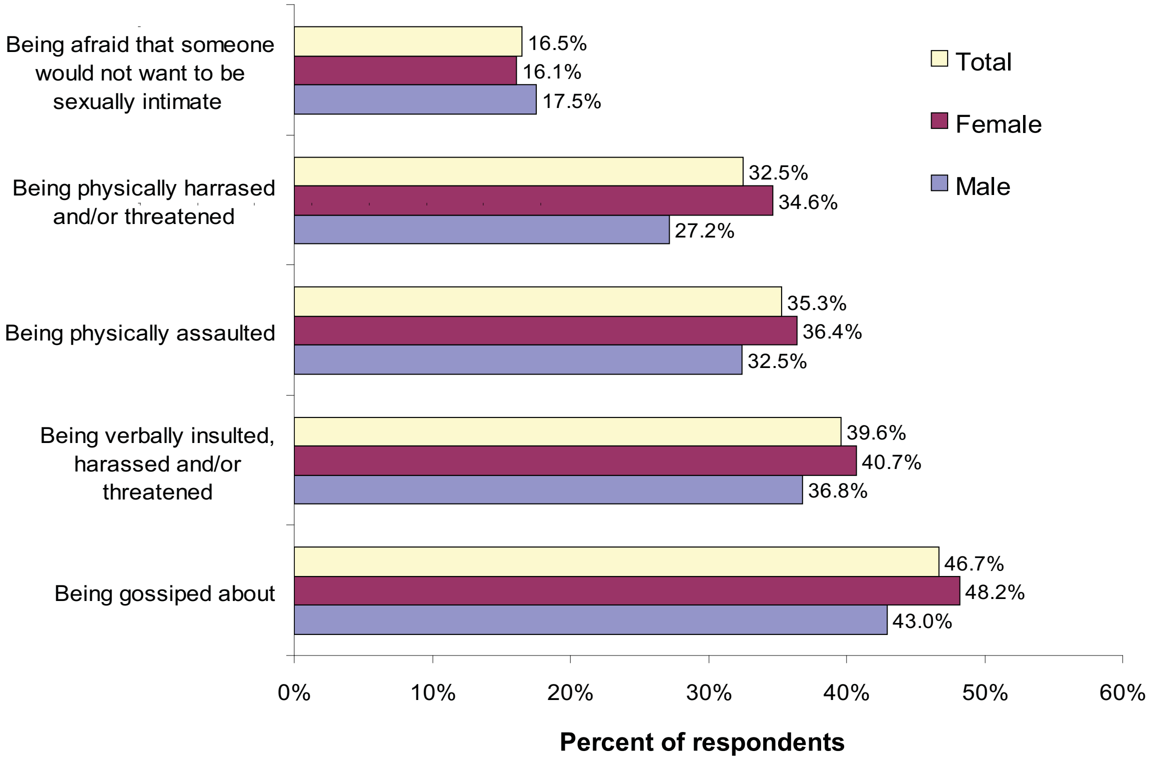
Figure 27. Effect of internal stigma on sexual activity of respondents



Participants in the study harboured high levels of fear and anxiety which appeared to be a direct consequence of their HIV-related internal stigma. Figure 28 shows that, in particular, respondents feared being the subject of gossip (46.7%) and of verbal harassment (39.6%) as well as of physical assaults (35.3%).

Fears of being insulted, harassed and threatened – both verbally and physically – were more frequently experience by female respondents compared to male respondents. This is not surprising considering that, as was seen above, many of the female respondents indicated that they have been the subject of such abuse.

Figure 28. HIV-related fears and anxieties of respondents



4.10 HIV-related policies and laws, and the rights of PLHIV

4.10.1 Awareness of policies and laws

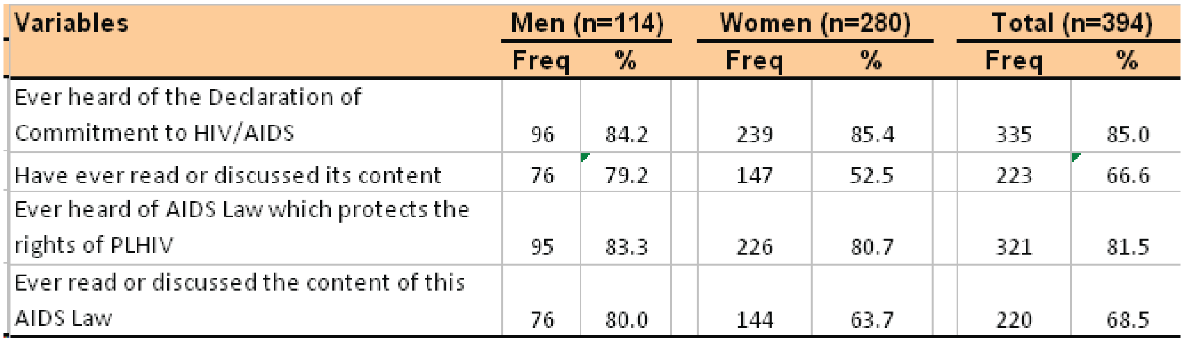
The Declaration of Commitment on HIV/AIDS was adopted by member States, including Cambodia at the United Nations General Assembly Special Session on HIV/AIDS in 2001. This Declaration provides a guideline of international norms and standards, and serves as evidence of international political commitment towards an effective AIDS response.

When asked if they have ever heard of the Declaration, 85% of the respondents replied affirmatively (Table 12). Among these respondents, 67% indicated they had read the Declaration or discussed its contents.

Such a high level of knowledge and awareness of the UNGASS Declaration seems unlikely given that it has not been translated into Khmer. It is likely that respondents and interviewers confused the Declaration with Cambodia's AIDS Law (2002). In fact, qualitative discussions revealed a very low level of awareness about the UNGASS Declaration. Also, the Stigma Index studies in other countries, such as Sri Lanka and Myanmar, have found that only a few respondents had heard about the UNGASS Declaration.

Cambodia's AIDS Law was developed by the National AIDS Authority (NAA) and endorsed by the National Assembly and the Senate in 2002. When asked if they had heard about the AIDS Law, more than 80% of respondents replied affirmatively of which 68% said they had read or discussed the content of the law. More male respondents said they had read or discussed the law than female respondents (80% vs. 63.7%) (Table 12).

Table 12. Awareness of laws and policies related to HIV and AIDS



Variables	Men (n=114)		Women (n=280)		Total (n=394)	
	Freq	%	Freq	%	Freq	%
Ever heard of the Declaration of Commitment to HIV/AIDS	96	84.2	239	85.4	335	85.0
Have ever read or discussed its content	76	79.2	147	52.5	223	66.6
Ever heard of AIDS Law which protects the rights of PLHIV	95	83.3	226	80.7	321	81.5
Ever read or discussed the content of this AIDS Law	76	80.0	144	63.7	220	68.5

This high proportion is likely due to selection and information biases. More than 90% of respondents were self-help group members and 66% of them were working and volunteering with projects or programs that provided assistance to PLHIV. Therefore, their awareness of relevant laws and policies is likely to be higher than the general PLHIV population. Also, members of self-help groups might have been hesitant to admit that they are unaware of major laws and policies.

The high level of awareness of Cambodia's AIDS Law might be partially a consequence of NAA's efforts in disseminating information about the Law through the media and through various events that PLHIV networks, including self-help group members, are usually actively involved in. This was apparent from the focus group discussion:

'I know [about the Law] through the media' (MSM PLHIV-FGD)

'We have learned about it through the media in the community such as printed [newspaper] and aired [Radio, TV] which is aimed to reduce stigma…' (Monk-KII)

Feedback from the Cambodian ART User Association was that generally, there is a low level of awareness and understanding of the Law among their PLHIV members. Although the majority of participants in the focus group discussion were aware of the Law, many demonstrated a superficial understanding of the Law, like this person:

'I understand a little on how to sue in case people gossip about me' (MSM PLHIV-FGD)

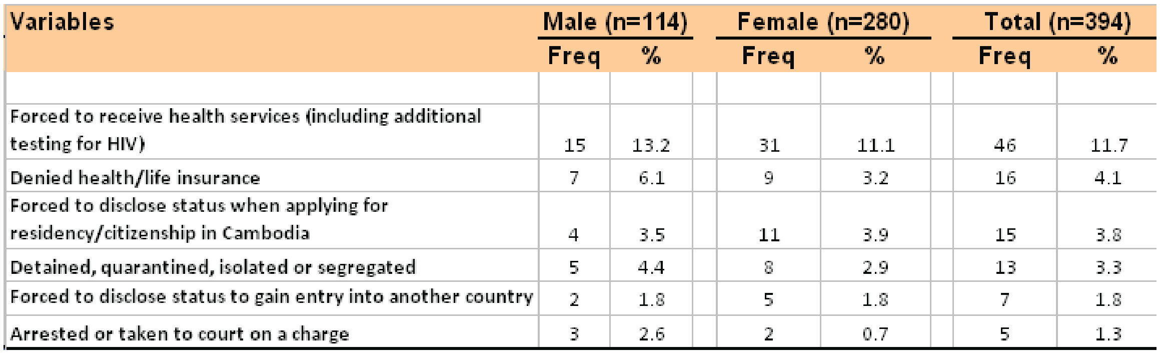
However, it is encouraging to see that some PLHIV and community service providers, such as home-based care staff members, seemed well aware of the AIDS Law and raised concerns about the barriers to successful implementation of the Law:

'I understand the issues [surrounding the protection] of PLHIV rights, but the effect of the Law is minimal because of its [weak] implementation…meaning that we have to continue to push for [more effective] implementation of the Law' (Community service provider-KII)

4.10.2 Violation of rights and legal assistance

When asked if their rights had been violated because of their HIV status in the 12 months prior to the study, 11.7% of respondents reported that they had been forced to undergo unwanted medical or health procedure, including an HIV test (Table 13). 4.1% reported that they were denied health insurance. Only 7 out of 394 respondents said they had disclosed their status before entering another country or before applying for a visa or residence to another country. This low rate is likely due to the fact that many respondents had never attempted to enter another country or applied for a visa. 13 out of 394 PLHIV reported they had been detained, quarantined, isolated or segregated. Only 5 respondents reported they had been arrested or taken to the court on a charge. No significant differences were detected based on gender.

Table 13. Violations of rights because of HIV status in past 12 months



Variables	Male (n=114)		Female (n=280)		Total (n=394)	
	Freq	%	Freq	%	Freq	%
Forced to receive health services (including additional testing for HIV)	15	13.2	31	11.1	46	11.7
Denied health/life insurance	7	6.1	9	3.2	16	4.1
Forced to disclose status when applying for residency/citizenship in Cambodia	4	3.5	11	3.9	15	3.8
Detained, quarantined, isolated or segregated	5	4.4	8	2.9	13	3.3
Forced to disclose status to gain entry into another country	2	1.8	5	1.8	7	1.8
Arrested or taken to court on a charge	3	2.6	2	0.7	5	1.3

Overall, 11.4% of female respondents and 9.7% of male respondents said their rights as PLHIV had been violated in the past 12 months. Of these, more than 65% reported attempting to get legal assistance to address the human rights violation. This included legal advice and referral to human rights organizations, but not necessarily to professional legal support or services. There was no significant difference between males and females in seeking legal assistance in response to the violation of their rights.

This study ascertained several barriers that prevented PLHIV from accessing legal assistance, including insufficient financial resources (17 respondents); unsure of where to go or whom to ask (12 respondents); and being intimidated by the bureaucratic processes or other aspects of legal action (10 respondents). These findings are important as they will help policy makers and program planners develop legal services that are accessible and tailored to the needs of PLHIV.

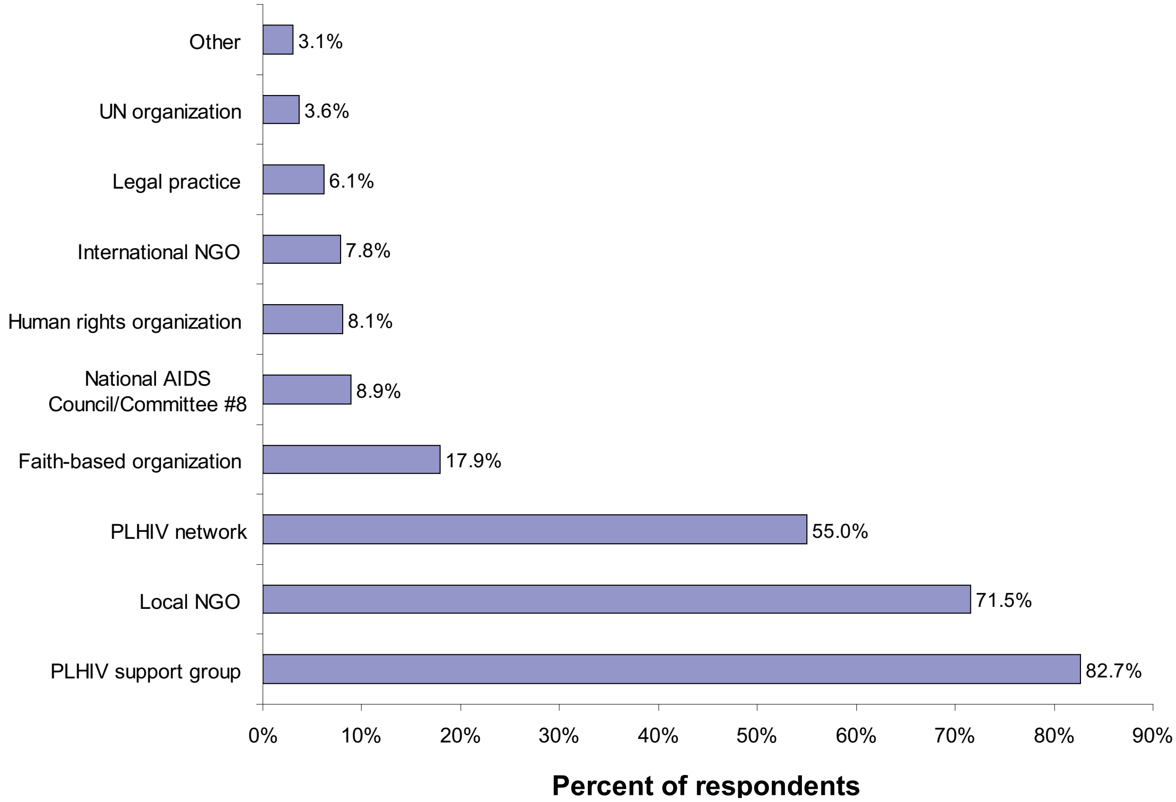
More than one third of the all participants in the study (37%) reported that they confronted, challenged or educated someone who was stigmatizing or discriminating a PLHIV. Females (38.9%) adopted this type of behaviour more often than males (33.3%).

4.11 Community support and participation

A large majority of respondents (90.9%) said they knew of organizations or groups that they can go to for help when experiencing stigma or discrimination. These included government institutions, non-governmental organizations (NGOs), PLHIV support groups, PLHIV networks, human rights and faith-based organizations.

Most frequently, respondents cited PLHIV support groups and local NGOs working on human rights (Figure 29). This is obvious because the great majority of respondents worked for such a group or organization at the time of the study.

Figure 29. Awareness of organizations and services that PLHIV can access if they experience stigma and discrimination



Overall, 41.2% of male respondents and 35.7% of female respondents said they had sought help from at least one of these organizations or groups when they experienced a situation of stigma and discrimination.

Qualitative data obtained from focus group discussions confirmed that home and community based care teams or outreach workers play a particularly important role in addressing issues of stigma and discrimination. Outreach workers provide valuable help to communities allowing them to better understand the situation and needs of PLHIV.

This respondent observed that there were positive changes in the community towards PLHIV because of the work of outreach workers:

'It is good [for me] now because people understand more about HIV… through our outreach workers' (PLHIV-FGD)

Focus group discussions confirmed that not only outreach workers but also community leaders can play a very important role in addressing stigma and discrimination and providing support to PLHIV in the communities:

'The village chief and local NGOs will help me if I experience stigma and discrimination' (PLHIV-FGD)

'The HBC team was very supportive. They visit me once or twice a week and refer me to the hospital when I am not well' (PLHIV-FGD)

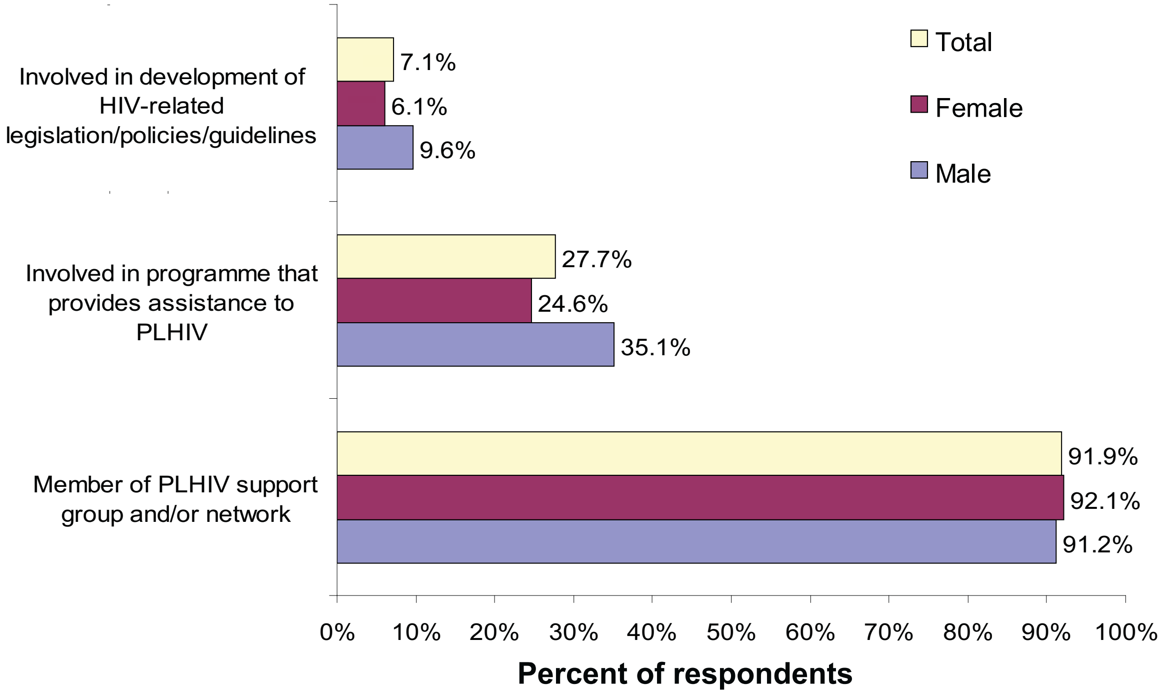
'We care about PLHIV. If we shame or embarrass them, they may commit suicide" (Health provider-KII)

However, it is somewhat concerning that even though more than 90% of respondents were members of self-help groups, only 82.7% identified PLHIV support groups as a place they would go for help. There was also a low level of access to, or awareness of, legal services and human rights organizations (6.1% and 8.1%, respectively). Furthermore, 36 respondents or one in 10 respondents did not know who to approach for help if they were stigmatized and discriminated against.

While the great majority of respondents were members of self-help groups only 27.7% of them said they had been involved, either as a volunteer or as an employee, in a programme or project that provides assistance to PLHIV (Figure 30). Females less often than males were formally involved with such projects or programmes.

An even smaller number had been involved in efforts to develop legislation, policies or guidelines related to HIV (7.1%). This suggests that even though PLHIV can find support and solidarity by joining community support groups and networks, and various other organizations, there are major barriers that prevent PLHIV from participating at the policy level.

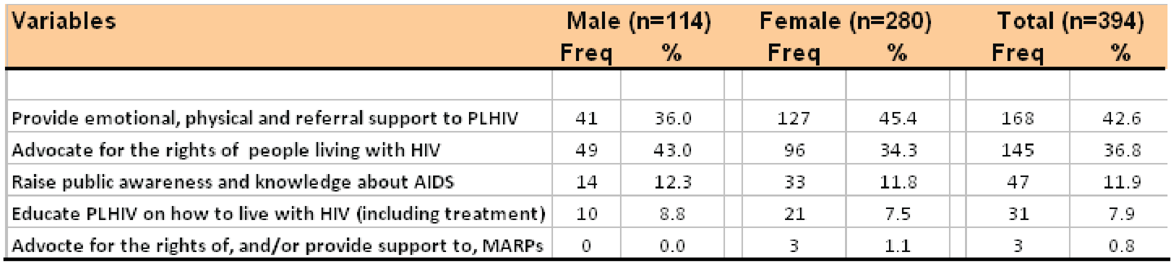
Figure 30. Community participation and involvement in policy and guideline development



72% of male respondents and 64% of female respondents reported that they supported other PLHIV in the previous 12 months (Table 14). Much of this support came in the form of providing emotional support (83.6%), which includes sharing of personal stories and experiences. Respondents also provided support by referring other PLHIV to services (58.0%) and by providing physical support (31.3%), which involved activities such as performing a task for other PLHIV or providing money and food. This suggests a high level of solidarity and social support amongst the PLHIV community, but it should be noted that this may be a direct consequence of the high self-help group membership rate in this cohort of respondents.

According to respondents, the most important things that HIV-related organizations should continue doing to address stigma and discrimination is to provide support to PLHIV (43%), including emotional, physical and referral support, and by advocating for the rights of PLHIV (37%) (Table 14).

Table 14. The most important services that organizations working with PLHIV must provide to address stigma and discrimination



Variables	Male (n=114)		Female (n=280)		Total (n=394)	
	Freq	%	Freq	%	Freq	%
Provide emotional, physical and referral support to PLHIV	41	36.0	127	45.4	168	42.6
Advocate for the rights of people living with HIV	49	43.0	96	34.3	145	36.8
Raise public awareness and knowledge about AIDS	14	12.3	33	11.8	47	11.9
Educate PLHIV on how to live with HIV (including treatment)	10	8.8	21	7.5	31	7.9
Advocte for the rights of, and/or provide support to, MARPs	0	0.0	3	1.1	3	0.8

5. DISCUSSION OF THE FINDINGS

It is important to interpret the study findings in the context of the characteristics of the people who were interviewed who were largely sampled through PLHIV self-help groups. Out of the total number of respondents, almost three quarters were females and a very high share of these was either widowed or divorced. Also, the majority of respondents was aged 30-49 years, had either only primary or no formal education, and was living in a rural area at the time of interview. Most respondents had been living with HIV for more than 5 years and were making a living mainly through farming and petty trade. A very large share of respondents was living in poverty. Most of them belonged to a PLHIV self-help group and are therefore not a general representation of PLHIV in Cambodia.

The study found that HIV-related stigma and discrimination occur in many different ways and affect males and females alike, but to different degrees. Stigma and discrimination manifest through gossiping and verbal insults, harassment or threats, as well as through physical assaults. Females, compared to males, are much more often the subject of verbal abuse and physical violence that are largely attributed to their HIV status. The violence is most commonly perpetrated by their husband or partner and by members of their family. This study confirms earlier findings of self-stigma among HIV positive men which resulted in increased violence against their wives and partners[39] . Domestic violence based on gender and HIV status is an important issue that will need to be addressed in greater depth.

Because of their depressing experiences with stigma and discrimination, PLHIV nurture a high level of anxiety and in particular the fear of being the subject of gossip, verbal harassment, as well as physical assaults. The fear of being insulted, harassed and threatened – both verbally and physically – is more frequently experienced by females because a larger number of them are the subject of such abuse.

Stigmatisation and discrimination against PLHIV can be manifested by people not wanting to be associated with PLHIV because of their strong fear of HIV-infected individuals, which stems from their lack of understanding about how HIV is transmitted. In addition to the psychological, physical and social impact, stigma and discrimination also negatively affect the livelihood of PLHIV. Whether they are employed or self-employed, they face major difficulties in remaining economically active. The study found that many PLHIV who participated in the study repeatedly lost their employment or source of income due to HIV-related illness or discrimination.

HIV can directly compromise the gaining and maintaining of employment. Most respondents reported that one of the key employment concerns was the condition of their health. This was reported both as a reason why employment was given up or denied; and why PLHIV were reluctant to apply for work. This finding is somewhat contradicted by the high level of good health reported by PLHIV in the study, and may indicate that HIV-related stigma and discrimination, which include the false perception by co-workers and employers of the weakness and incapacity of PLHIV, may be the core reason why PLHIV have limited employment opportunities. The subsequent loss of household income means that HIV-affected households are less likely to be able to afford adequate housing, which increases

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[39] GTZ (2005) Gender Based Violence and HIV/AIDS in Cambodia: Links, Opportunities and Potential Responses.

the likelihood of opportunistic infections as a result of overcrowded accommodation and limited access to water and sanitation. As such it is useful for programmers, particularly those working within the private sector, to address genuine issues of discrimination for employed and unemployed PLHIV.

Females living with HIV, much more often than males, struggle with earning an income because they are more likely to experience HIV-related discrimination in the workplace. This emanates from employers, co-workers and customers, and can all too easily result in the loss of income, employment and opportunities for promotion. This finding raises a serious concern because a large number of female PLHIV have lost their husband/partner or have divorced, and therefore remain the only breadwinner in the family. They are often the sole provider of care and support for their children and other household members, some of whom are also HIV-positive and who also face major stigma and discrimination.

The study found that the great majority of respondents were living on less than US$ 1 per day, suggesting that PLHIV and their household members experience considerable poverty and vulnerability. This corresponds to the large number of respondents and their households who reported frequent food shortages. These findings are in line with those of the Socio-Economic Impact Study and point out that the coverage and efficacy of interventions that seek to help PLHIV meet basic needs and develop viable income-generating activities remain limited. PLHIV not only experience problems in maintaining a source of income, they also experience major barriers to secure access to adequate housing, education and health services.

The lack of economic and social resources, as a result of HIV-related stigma and discrimination, can pose as indirect barriers for PLHIV who need to access basic services. Furthermore, the lack of awareness of HIV risk may also result in a lack of access to services. Males, more so than females, often test for HIV late because they likely seek a test only when they have developed HIV-related symptoms. This suggests that there is a lack of awareness among men of the risks associated with their behaviour and an insufficient understanding of the benefits related to knowing one’s HIV status and starting treatment early.

HIV-related stigma and discrimination can also directly reduce such accessibility. This study revealed that some PLHIV have been denied access to vital health care services, including family planning and sexual and reproductive health services. This is concerning and suggests that much more needs to be done to ensure access by PLHIV to services free of discrimination. Respect of PLHIV’s human rights will need to be promoted, especially through raising the awareness and training of health care staff so they adopt respectful attitudes toward PLHIV and provide PLHIV with informed reproductive choices.

In fact, this study revealed that, in a few cases, health care providers prevented PLHIV from making an informed decision on their reproductive health. The issue of health staff strongly advising PLHIV to use irreversible methods of family planning such as undergoing sterilization, and to terminate pregnancies, is not acceptable. All stakeholders need to present a consistent message, across all levels of policy, programming and training, of zero tolerance to such violations of human rights.

A more encouraging finding of the study was the low degree of discriminatory reactions by health care professionals relative to those found in other countries like China. However, this issue should be studied in more depth as the respondent sample in this study might have biased this particular data. Although most PLHIV tested voluntarily, some were pressured, or were tested without their knowledge. Similarly, some were forced to submit to an unwanted medical or health procedure. That HIV testing should both be voluntary and confidential is an important message to convey not only to health care staff, but also to the wider community.

Another issue of concern is the protection of confidentiality of the status of PLHIV. There were a number of cases where the status of PLHIV was disclosed without their consent, most often to neighbors, friends and community leaders. While it may be difficult to maintain confidentiality of the HIV status of a person in a small community, programmers and community self-help groups and networks should make this a particular focus of their community mobilization and advocacy campaigns.

One sphere where absolute trust and discretion must be practiced is in the relationship between a health care provider and a person living with HIV. Although confidentiality of medical records was respected in most cases, anything less than 100% confidentiality is an issue of concern. Again, consistent messages from all stakeholders on zero tolerance of disclosure of HIV status without consent must be applied and upheld because confidentiality of HIV status is a fundamental human right.

A high level of internal stigma involving self-blame and suicidal feelings was reported in the study. While males living with HIV are more likely to blame themselves, females are more likely to blame someone else. The verbal and physical abuse, as well as psychological pressure, that many PLHIV suffer at the hands of their family and other household members may lead to despair and a significant reduction in self-esteem, resulting in suicidal thoughts. High internal stigma is often coupled with a strong sense of despondency, where PLHIV isolate themselves and live apart from the rest of society.

Many PLHIV do not dare to pursue plans for the future, such as getting married, starting a family, or pursuing an education or a career. Internal stigma and the fear of being stigmatised and discriminated against negatively impact on the health of PLHIV and on their care-seeking behaviours. These findings confirm those from other studies such as Cambodia’s Socio-Economic Impact Study and other stigma index studies in the region. Therefore, targeted communication for PLHIV to raise their self-esteem, encourage positive living and positive prevention should be highly prioritized.

The study found a remarkably high level of awareness of the Cambodia AIDS Law, which may be due to the information campaigns carried out by the National AIDS Authority to promote understanding of the Law. This is a promising finding, although members of self-help groups are likely to have a better knowledge of HIV-related laws and policies than the general population of PLHIV.

Despite a high level of awareness about Cambodia AIDS Law, a good understanding of their rights and the meaningful participation in policy, guideline development and discussion are still lacking. All stakeholders, including government, civil society and development partners should continue working towards the empowerment of PLHIV networks and help them develop more effective information and communication plans around existing laws, policies and services. PLHIV need to know and understand their rights and be able to seek legal support when their rights are violated.

The high levels of solidarity and of mutual support found by the study among PLHIV are very encouraging but can also be largely attributed to the characteristics of the sample of respondents in the study. However, the types of support that were provided can provide evidence of where more investment is needed in the future. Support to address human rights violations, for instance, and efforts to remove the barriers preventing PLHIV from accessing legal services or human rights organizations, seems fundamental. Similarly more investment is needed in enhancing the participation of PLHIV in the development of legislation, policies or guidelines related to HIV.

6. RECOMMENDATIONS

The objectives of this survey were to provide PLHIV and those working with PLHIV at all levels with evidence to better understand HIV related stigma and discrimination and practical recommendations to enable them to work towards their elimination through effective policies, legislation and programmes. The recommendations apply across a broad range of stakeholders including PLHIV networks, the Government of Cambodia and non-government institutions. The key recommendations are:

Sensitizing communities to HIV

The study found that HIV-related stigma and discrimination are widespread and they manifest through harassment and abuse of PLHIV, largely stemming from a lack of understanding among the general population of the way HIV is transmitted and the experiences of those living with HIV. It is therefore necessary to:

- Enhance the understanding among the general public on how HIV is transmitted and sensitize people to the realities of living with HIV through mass media, education in schools, communication and awareness raising initiatives.
- Innovative information, education and communication (IEC) approaches need to be developed to increase knowledge of the modes of transmission of the HIV infection, to correct misconceptions about HIV and to dispel people's fears of contact with PLHIV.
- Mass and interpersonal communications to heighten public awareness that anyone can become infected with HIV and not only those who have been "behaving badly" in the past.
- Communication and advocacy campaigns need to disseminate consistent messages to address HIV related stigma and discrimination in line with the HIV and AIDS Communications and Advocacy Strategy (2011-2015). These messages should also help guide policy makers and programme planners.

Addressing internal stigma

The level of internal stigma or self-stigma is very high and this negatively affects the lives of PLHIV:

- Community networks of PLHIV and NGOs should design and implement interventions that empower PLHIV to participate in social and community actions to address both external and internal stigma and discrimination.
- Activities should include capacity and skills building and advocacy to raise awareness about the importance of self-esteem and rights. Integrated care and prevention interventions should always include messages about self-esteem and address issues related to internal stigma.
- Improve the quality of psychosocial health services and their linkages to self-help groups. Introduce cultural and sport groups to enhance solidarity and social support, and improve the self-esteem of PLHIV, especially female PLHIV who are more likely to suffer from low self-esteem and suicidal thoughts.
- Disseminate information about positive living to show that PLHIV can lead healthy and productive lives and use PLHIV role models to promote positive prevention.

Addressing gender-based inequities

This study confirms that women more often than men experience HIV-related stigma and discrimination, and may often involve domestic and gender-based violence (GBV). Interventions in this area are urgently required:

- Address gender-based violence, especially domestic violence directed at women living with HIV, through a set of well integrated measures including advocacy and communication to raise awareness that this kind of abuse is unacceptable.
- Mobilize high ranking officials, parliamentarians and role models to campaign against GBV and to promote gender equality.
- Work to change gender norms and rigidly defined gender roles by increasing the engagement of men and boys. Issues of masculinity should be addressed by orientating and sensitizing people about gender and HIV issues.
- Expand support services and strengthen referral mechanisms for victims of domestic violence affected or at risk of HIV by enhancing partnerships and coordination and through effective resource mobilization.
- Incorporate GBV and HIV issues systematically into training of PLHIV support networks, social workers, counselors and peer educators.
- Encourage victims of GBV to report cases of abuse and increase their access to legal services and other support services.
- Provide shelter, protection and counseling to PLHIV who suffered abuse and ensure they can be economically autonomous.

Reducing poverty and deprivation

Poverty adds a layer of burden on PLHIV, especially positive women, and their families. The study shows that living with HIV often involves the loss of jobs and income, homelessness, inability to access vital services and to satisfy basic needs as well as food shortages. It is therefore crucial to:

- Ensure that social protection programmes and social safety nets target PLHIV and provide support and services that are adapted to their special needs.
- Create income generation and livelihood opportunities for PLHIV through scaling up vocational training schemes, literacy programmes and links to micro-credit initiatives that are adequately supplemented by livelihood competency development initiatives so that debt does not become an additional burden for PLHIV and their families.
- Improve food security and nutritional support for HIV affected households by helping them improve farming practices, grow vegetables and breed livestock.
- Expand access of PLHIV to Health Equity Fund to ensure they get adequate health care.

Address issues of late testing

The study found that people, especially men, test very late only once they have clear symptoms. This means that many may be too sick to work and end up losing their job or source of income. It is therefore recommended to:

- Promote early testing and treatment for optimal treatment results by raising awareness of risky behaviors and improving the understanding of HIV related risks among those practicing these behaviours.
- Work with media, health care providers and other key stakeholders to inform them on the benefits of early testing, including the ability of antiretroviral treatment to restore PLHIV's good health and to reduce their viral load hence contribute to prevention of new HIV infections.
- Encourage and build demand for couple counseling and testing, especially for women who perceive themselves at risk of HIV.

Eliminating stigma and discrimination in the workplace

Cambodia has some of the most progressive HIV laws and policies in the region, one of which is the workplace policy (Prakas 086) requiring workplaces with more than eight employees to have HIV policies and an HIV committee to ensure the protection of PLHIV rights in their workplace. One of the purposes of this workplace policy is to provide a pathway for PLHIV to report and address experiences of stigma and discrimination.

- Programme planners working with PLHIV should be familiar with the requirements of this policy and work with the government in its enforcement.
- PLHIV networks, the private and public sectors and human rights organizations need to work closely together with government agencies to ensure that the effective implementation of Prakas 086, which legislates for the protection of PLHIV rights in the workplace, is enforced.

Addressing stigma and discrimination in schools

Stigma and discrimination needs to be eliminated in education establishments. There are two main recommendations:

- Work with schools and communities to eliminate the stigma and discrimination towards children affected by HIV and to improve their regular school attendance and ensure that all children are able to go to school without discrimination.
- Programme planners should engage with the women's and children's representatives in Commune Councils, as well as with provincial and district representatives of the School Health Department within the Ministry of Education, Youth and Sport to involve them in addressing issues of stigma and discrimination in their schools and communities.

Ensuring confidentiality of HIV status

Maintaining confidentiality of HIV status is of concern across multiple environments for PLHIV. Most immediate is the need to work with health service providers to reinforce the essential requirement of 100% confidentiality in respect of HIV status.

- Reinforce strict protocol that protects the confidentiality of PLHIV medical records, and introduce punitive measures against the break in confidence.

- Train health care providers on the rights of patients, importance of confidentiality and the strict protocol involved.
- The importance of respecting PLHIV confidentiality should be an essential message in any broader community awareness or mobilization activities.

Addressing issues related to treatment

It is of critical importance to ensure adequate access by PLHIV to antiretroviral treatment (ART) and treatment for opportunistic infections (OIT). It is therefore necessary to:

- Scale up the coverage of ART and OIT, including increasing second and third line treatment where needed, by securing long-term sustainable funding sources.
- Increase awareness among PLHIV of available treatments and ways to access them.
- Promote the enforcement of the HIV Law to ensure safe, easy and free access to ART and OI and testing services and that no illicit fees are charged.
- Strengthen the capacity of referral hospitals to ensure comprehensive care of good quality including consultation, hospitalization, laboratory testing, psychosocial support, nutritional screening and palliative care to better detect and care for any treatment failures and associated complications.

Protecting family planning and reproductive health rights

Additional work needs to be done among health care providers to address stigma and discrimination related to health services, especially family planning and sexual and reproductive health rights and choices. The following is needed:

- Ensure free or affordable access to sexual and reproductive health services by PLHIV. Include PLHIV as target group in reproductive health programmes.
- Increase the coverage and uptake of PMTCT among women living with HIV by scaling up the “Linked Response” which aims to strengthen linkage and referral between maternal and newborn health, comprehensive antenatal care, as well as sexual reproductive health services.
- Promote positive prevention through training of health care providers to advise PLHIV on their sexual and reproductive choices and on available contraceptive methods.
- Improve capacity and motivation of staff through training and on-the-job support to facilitate efforts and coordination. Training should include client rights declaration for all health care service provision, with particular emphasis on the rights of PLHIV; and in the areas of emotional sensitivity and tolerance.

Establish effective recourse mechanism for violations of rights

The study found high levels of awareness of the existence of the AIDS Law. This is an encouraging finding which will need to be built upon through the following actions:

- Continue to build an in-depth understanding of the AIDS Law and the rights of PLHIV among the general public, PLHIV and service providers.
- Sensitize judicial bodies and local authorities on the rights of PLHIV as guaranteed by the AIDS Law.
- Improve the awareness and understanding of PLHIV of their legal and human rights, as well as existing support services.

- Establish mechanisms for documentation, referral and reporting when the rights of PLHIV are violated.
- Strengthen legal aid services for PLHIV as part of the referral mechanism.

Greater involvement of PLHIV

A meaningful involvement of PLHIV at all levels is a critical strategy which must be promoted to ensure policies and programmes can achieve sustainable results. Government, civil society, development partners and private sector institutions are recommended to:

- Work towards mutual accountability and full engagement of PLHIV and key affected populations in policy and programme development, as well as in monitoring, evaluation, research and resource mobilization not only because of their experience and local knowledge but also because of their continued capacity building needs.
- The government needs to ensure a safe space for PLHIV to participate meaningfully in these processes.
- Expand partnerships between PLHIV networks and livelihood, gender and human rights organizations to boost efforts to eliminate stigma and discrimination.

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8. ANNEX

8.1. Stigma Index Questionnaire

BEFORE STARTING the interview you must:

Read the informed consent form to the interviewee. If he/she agrees to participate in the study, complete two copies of the form. After both forms have been signed, give one to the interviewee for him/her to keep and you keep the other one.

Does the interviewee agree to this interview? 1. Yes ☐ 2. No ☐

ON FINISHING the interview, please complete the following:

REFERRALS AND FOLLOW-UP

1. Did the interviewee need a referral?

Yes	☐ 1
No	☐ 2

NOTE: If **No**, please go to question **3**.

If Yes, what kind of referral(s)? (Tick one box only)

Legal	☐ 1
Counseling	☐ 2
Support group	☐ 3
Others (specify)	☐ 4

2. What steps have you taken to help the interviewee with the above referral(s)? (Tick more than one box if appropriate.)

I have given sufficient information on the referral(s) already	☐ 1
I will send the required information to the interview	☐ 2
Further follow-up is needed	☐ 3

NOTE: Please give details of what you promised to do about referral(s) after the interview, if any:

QUALITY CONTROL PROCEDURES

	Name	Signature	Date
Interviewer			
Team Leader			
Data Entry 1			
Data Entry 2			

- **The interviewer** must ensure that all sections of the questionnaire are completed properly and in full, unless the interviewee does not wish to complete them – in which case this must be noted alongside the relevant question(s).
- **The team leader** must check the questionnaire carefully and query any apparent discrepancies with the interviewer. The quality checks section at the end of this questionnaire will help the interviewer and team leader with these tasks.

Provincial Code

1. Takeo
2. Kampong Cham
3. Kampong Thom
4. Battambang
5. Phnom Penh

Questionnaire code __ __ __ __ Cluster code__ __ __ __

PEOPLE LIVING WITH HIV STIGMA INDEX : QUESTIONNAIRE

CONFIDENTIAL AND ANONYMOUS

SECTION 1 INFORMATION ABOUT YOU

1. Sex

Male ☐ 1
Female ☐ 2
Transgenders ☐ 3

2. How old are you?

Youth age 15-19 years ☐ 1
Adult age 20-24 years ☐ 2
Adult age 25-29 years ☐ 3
Adult age 30-39 years ☐ 4
Adult age 40-49 years ☐ 5
Adult age 50+ years ☐ 6

3. For how long have you been living with HIV? (Tick one box only)

0-1 year ☐ 1
1-4 years ☐ 2
5-9 years ☐ 3
10-14 years ☐ 4
15+ years ☐ 5

4. For how long have you been living with HIV? (Tick one box only)

Married or cohabiting and husband/wife/partner is currently living in household ☐ 1
Married or cohabiting but husband/wife/partner is temporarily living/working away from the household ☐ 2
In a relationship but not living together ☐ 3
Single ☐ 4
Divorced/separated ☐ 5
Widow/widower ☐ 6

NOTE: If answer from **4-6**, please go to question **6**.

5. If you are currently in a relationship (answer 1-3 above), for how long have you been involved with your husband/wife/partner?

0–1 year ☐ 1
1–4 years ☐ 2
5–9 years ☐ 3
10–14 years ☐ 4
15+ years ☐ 5

6. Are you sexually active in the past three months?

Yes ☐ 1
No ☐ 2

7. Do you belong to, or have you in the past belonged to, any of the following categories? (Tick at least one box. You can tick more than one if appropriate.)

MSM/Gay or Lesbian/Transgender ☐ 1
Entertainment Worker (direct and indirect) ☐ 2
Injecting Drug User ☐ 3
Internally displaced person ☐ 4
Migrant worker ☐ 5
Others (specify)...... ☐ 6

8. Do you have a physical disability of any kind (not including general ill health related to HIV)?

Yes ☐ 1
No ☐ 2

9. What is the highest level of formal education you have completed? (Tick one box only.)

No formal education ☐ 1
Primary school ☐ 2
Secondary school ☐ 3
Technical college/university ☐ 4

10. Which one of these statements best describes your current employment status?

Unemployed ☐ 1
Motor-taxi driver ☐ 2
Military, police or military police ☐ 3
Public servant (government staff) ☐ 4
Seller, vendor ☐ 5
Farmer ☐ 6
Civil Servant (NGO staff) ☐ 7
Private company worker ☐ 8
Others(specify)......... ☐ 9

11. How many people currently living with HIV in the same household as you in each of these age categories?

	Number of people
Children aged 0–14 years	
Youth aged 15–19 years	
Adults aged 20–24 years	
Adults aged 25–29 years	
Adults aged 30-39 years	
Adults aged 40-49 years	
Adults aged 50 years and above	

12. How many of the children and youth in your household are AIDS orphans?

Number of orphans ☐

13. Is your household in (Tick one box only)

A rural area ☐ 1
A small town or village ☐ 2
A large town or city ☐ 3

14. What was the average income of your household per month over the last 12 months? (in Riel)

Average income of household over last 12 months ☐

15. In the last month, how many days has any member of your household hot had enough food to eat?

Number of days ☐

SECTION 2A YOUR EXPERIENCE OF STIGMA AND DISCRIMINATION FROM OTHER PEOPLE

1a. In the last 12 months, how often have you been excluded from social gatherings or activities (e.g. weddings, funerals, parties, clubs)? (Tick one box only)

Never ☐1
Once ☐2
A few times ☐3
Often ☐4

NOTE: If the answer is **NEVER (1)**, please go to question **2a**.

1b. If so, was this…? (Tick one box only)

Because of your HIV status? ☐1
For (an)other reason(s)? ☐2
Both because of your HIV status and other reason(s)? ☐3
Not sure why ☐4

2a. In the last 12 months, how often have you been excluded from religious activities or places of worship? (Tick one box only.)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1)**, please go to question **3a**.

2b. If so, was this…? (Tick one box only.)

Because of your HIV status? ☐1
For (an)other reason(s)? ☐2
Both because of your HIV status and other reason(s)? ☐3
Not sure why ☐4

3a. In the last 12 months, how often have you been excluded from family activities (e.g. cooking, eating together, sleeping in the same room?) (Tick one box only.)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1)**, please go to question **4a**.

3b. If so, was this…? (Tick one box only.)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

4a. In the past 12 months, how often have you been aware of being gossiped about? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4
Do not know ☐ 5

NOTE: If the answer is **NEVER (1)** or **DO NOT KNOW (5)** please go to question **5a**.

4b. If so, was this…? (Tick one box only)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

5a. In the past 12 months, how often have you been verbally insulted, harassed and/or threatened? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1),** please go to question **6a**.

5b. If so, was this…? (Tick one box only.)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

6a. In the last 12 months, how often have you been physically harassed and/or threatened? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1),** please go to question **7a**.

6b. If so, was this…? (Tick one box only.)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

7a. In the last 12 months, how often have you been physically assaulted? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1)**, please go to question **8**.

7b. If so, was this…? (Tick one box only)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

7c. If so, who physically assaulted you? (Tick one box only)

My husband/wife/partner ☐ 1
Another member of the household ☐ 2
Person(s) outside the household who is/are known to me ☐ 3
Unknown person(s) ☐ 4

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8. In the last 12 months, how often have you been subjected to psychological pressure or manipulation by your husband/wife or partner in which your HIV-positive status was used against you? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

---

9. In the last 12 months, how often have you experienced sexual rejection as a result of your HIV positive status? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

---

10. In the last 12 months, how often have you been discriminated against by other people living with HIV? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

---

11. In the last 12 months, how often has your wife/husband or partner, or any members of your household experienced discrimination as a result of your HIV-positive status?
(Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

12. If you have experienced some forms of HIV-related stigma and/or discrimination in the last 12 months, why do you think this is? (Tick more than one box if appropriate)

People are afraid of getting infected with HIV from me ☐ 1
People don't understand how HIV is transmitted ☐ 2
People think that having HIV is shameful and they should not be associated with me ☐ 3
Religious beliefs or "moral" judgments ☐ 4
People disapprove of my lifestyle or behavior ☐ 5
I look sick with symptoms associated with HIV ☐ 6
I don't know/I am not sure of the reason(s) ☐ 7
I never been stigmatized or discriminated ☐ 8

SECTION 2B YOUR ACCESS TO WORK AND HEALTH AND EDUCATION SERVICES

1a. In the last 12 months, how often have you been forced to change your place of residence or been unable to rent accommodation? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1)**, please go to question **2a**.

1b. If so, was this…? (Tick one box only)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

NOTE: *If interviewee* **has not been earning an income** *(either through some form of formal employment or on a casual or part-time basis) or* **has not been self-employed** *during the last 12 months, go to question* **5***.*

2a. In the last 12 months, how often have you lost a job (if employed) or another source of income(if self-employed or an informal/casual worker)? (Tick one box only.)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

NOTE: If the answer is **NEVER (1)**, please go to question **3**.

2b. If so, was this…? (Tick one box only.)

Because of your HIV status? ☐ 1
For (an)other reason(s)? ☐ 2
Both because of your HIV status and other reason(s)? ☐ 3
Not sure why ☐ 4

NOTE: If the answer is **FOR (AN) OTHER REASON(S) [1]** or **NOT SURE WHY [4]**, please go to question **3**

2c. Because of HIV status, did you (wholly or partly) lose your work/income? (Tick one box only.)

Because of discrimination by your employer or co-workers ☐ 1
Because you felt obliged to stop working due to poor health ☐ 2
Because of a combination of discrimination and poor health ☐ 3
Because of another reason ☐ 4

3. In the last 12 months, have you been refused employment or a work opportunity because of your HIV status?

Yes ☐ 1
No ☐ 2

4a. In the last 12 months, how often has your job description or the nature of your work changed, or have you been refused promotion, as a result of your HIV status? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4

<u>**NOTE**</u>: If the answer is **NEVER (1)**, please go to question **5**.

4b. If so, did this happen…? (Tick one box only.)

Because of discrimination by your employer or co-workers ☐ 1
Because poor health prevented you from doing certain things ☐ 2
Because of a combination of discrimination and poor health ☐ 3
Other reason ☐ 4

5. In the last 12 months, how often have you been dismissed, suspended or prevented from attending an educational institution because of your HIV status? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4
Not applicable ☐ 5

6. In the last 12 months, how often has your child/children been dismissed, suspended or prevented from attending an educational institution because of your HIV status? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4
Not applicable ☐ 5

---

7. In the last 12 months, how often have you been denied health services, including dental care, because of your HIV status? (Tick one box only)

Never ☐ 1
Once ☐ 2
A few times ☐ 3
Often ☐ 4
Not applicable ☐ 5

---

8. In the last 12 months, have you been denied family planning services because of your HIV status? (Tick one box only)

Yes ☐ 1
No ☐ 2
Not applicable ☐ 3

---

9. In the last 12 months, have you been denied sexual and reproductive health services because of your HIV status? (Tick one box only.)

Yes ☐ 1
No ☐ 2

SECTION 2C INTERNAL STIGMA (THE WAY YOU FEEL ABOUT YOURSELF) AND YOUR FEARS

1. In the last 12 months, have you experienced any of the following feelings because of your HIV status? (Tick one box for each category)

I feel ashamed	Yes ☐ 1	No ☐ 2
I feel guilty	Yes ☐ 1	No ☐ 2
I blame myself	Yes ☐ 1	No ☐ 2
I blame others	Yes ☐ 1	No ☐ 2
I have low self-esteem	Yes ☐ 1	No ☐ 2
I feel I should be punished	Yes ☐ 1	No ☐ 2
I feel suicidal	Yes ☐ 1	No ☐ 2

2. In the last 12 months, have you done any of the following things because of your HIV status? (Tick one box for each category)

I have chosen not to attend social gathering(s)	Yes ☐ 1	No ☐2
I have isolated myself from my family and/or friends	Yes ☐ 1	No ☐2
I took the decision to stop working	Yes ☐ 1	No ☐2
I decided not to apply for a job/work or for a promotion	Yes ☐ 1	No ☐2
I withdrew from education/training or did not take up an opportunity for education/training	Yes ☐ 1	No ☐2
I decided not to get married	Yes ☐ 1	No ☐2
I decided not to have sex	Yes ☐ 1	No ☐2
I decided not to have (more) children	Yes ☐ 1	No ☐2
I avoided going to a local clinic when I needed to	Yes ☐ 1	No ☐2
I avoided going to a hospital when I needed to	Yes ☐ 1	No ☐2

3. In the last 12 months, have you been fearful of any of the following things happening to you –whether or not they actually have happened to you?

Being gossiped about	Yes ☐1	No ☐2
Being verbally insulted, harassed and/or threatened	Yes ☐1	No ☐2
Being physically harassed and/or threatened	Yes ☐1	No ☐2
Being physically assaulted	Yes ☐1	No ☐2

4. In the last 12 months, have you been afraid that someone would not want to be sexually intimate with you because of your HIV-positive status?

Yes ☐ 1
No ☐ 2

SECTION 2D RIGHTS, LAWS AND POLICIES

1a. Have you heard of the Declaration of Commitment on HIV/AIDS, which protects the rights of people living with HIV?

Yes ☐ 1
No ☐ 2

1b. If yes, have you ever read or discussed the content of this Declaration?

Yes ☐ 1
No ☐ 2

2a. Have you heard of The law on prevention and the fight against the spread of HIV/AIDS?

Yes ☐ 1
No ☐ 2

2b. If yes, have you ever read or discussed the content of this law?

Yes ☐ 1
No ☐ 2

---

3. In the last 12 months, have any of the following things happened to you because of your HIV status? (Tick more than one box if appropriate)

I was forced to submit to a medical or health procedure (including HIV testing) ☐ 1
I was denied health insurance or life insurance because of my HIV status ☐ 2
I was arrested or taken to court on a charge related to my HIV status ☐ 3
I had to disclose my HIV status in order to enter another country ☐ 4
I had to disclose my HIV status to apply for residence or nationality ☐ 5
I was detained, quarantined, isolated or segregated ☐ 6
None of these things happened to me ☐ 7

4a. In the last 12 months, have any of your rights as a person living with HIV been abused?

Yes ☐ 1
No ☐ 2
Not sure ☐ 3

NOTE: If the answer is **NO (2)** or **NOT SURE (3)**, please go to the next section (**Section 2E: Effecting change**).

4b. If yes, have you tried to get legal assistant for any abuse of your rights as a person living with HIV?

Yes ☐ 1
No ☐ 2
Not sure ☐ 3

NOTE: If the answer is **NO (2)** or **NOT SURE (3)**, please go to question **4e**.

4c. Has this process begun in the last 12 months?

Yes ☐ 1
No ☐ 2

NOTE: If the answer is NO (2), please go to question 4e.

4d. What was the result?

The matter has been dealt with ☐ 1
The matter is still in the process of being dealt with ☐ 2
Nothing happened/the matter was not dealt with ☐ 3

4e. If the response to question 4b was **NO** or **NOT SURE**, what was the reason for not trying to get legal assistant?

Don't know where to go or whom to ask ☐ 1
Insufficient financial resources to take action ☐ 2
Process of addressing the problem appeared too bureaucratic ☐ 3
Felt intimidated or scared to take action ☐ 4
Advised against taking action by someone else ☐ 5
No/little confidence that the outcome would be successful ☐ 6
None of the above ☐ 7

SECTION 2E EFFECTING CHANGE

---

1. In the last 12 months, have you confronted, challenged or educated someone who was stigmatizing and/or discriminating against you?

Yes ☐ 1
No ☐ 2

2a. Do you know of any organizations or groups that you can go to for help if you experience stigma or discrimination?

Yes ☐ 1
No ☐ 2

NOTE : If the answer is **NO (2)**, please go to question **3**.

2b. If yes, which kinds of organizations or groups do you know about? (Tick more than one box if appropriate.)

People living with HIV support group ☐ 1
Network of people living with HIV ☐ 2
Local non-governmental organization ☐ 3
Faith-based organization ☐ 4
A legal practice ☐ 5
A human rights organization ☐ 6
National AIDS council or committee ☐ 7
International non-governmental organization ☐ 8
UN organization ☐ 9
Other ☐10

---

3. Have you sought help from any of the above organizations or groups to resolve an issue of stigma or discrimination?

Yes ☐ 1
No ☐ 2

4a. In the last 12 months, have you supported other people living with HIV?

Yes ☐ 1
No ☐ 2

NOTE : If the answer is **NO (2)**, please go to question **5**.

4b. If YES, what types of support did you provide? (Tick more than one box if appropriate.)

Emotional support (e.g. counseling, sharing personal stories and experiences) ☐ 1
Physical support (e.g. providing money or food, doing an errand for them) ☐ 2
Referral to other services ☐ 3

5. Are you currently a member of a people living with HIV support group and/or network?

Yes ☐ 1
No ☐ 2

---

6. In the last 12 months, have you been involved, either as a volunteer or as an employee, in any program or project (either government or non-governmental) that provides assistance to people living with HIV?

Yes ☐ 1
No ☐ 2

---

7. In the last 12 months have you been involved in any efforts to develop legislation, policies or guidelines related to HIV?

Yes ☐ 1
No ☐ 2

---

8. There are a number of organizations of people living with HIV working against stigma and discrimination. If one of them asked you, “What is the most important thing we should be doing as an organization to address stigma and discrimination?” what would you recommend? (Tick one box only)

Advocating for the rights of all people living with HIV ☐ 1
Providing support to people living with HIV by providing emotional, physical and referral support ☐ 2
Advocating for the rights and/or providing support to particularly marginalized groups (men who have sex with men, injecting drug users, sex workers) ☐ 3
Educating people living with HIV about living with HIV (including treatment literacy) ☐ 4
Raising the awareness and knowledge of the public about AIDS ☐ 5

SECTION 3A TESTING/DIAGNOSIS

---

1. Why were you tested for HIV? (Tick one or more boxes as appropriate)

Employment ☐ 1
Pregnancy ☐ 2
To prepare for a marriage/sexual relationship ☐ 3
Referred by a clinic for sexually transmitted infections ☐ 4
Referred due to suspected HIV-related symptoms (e.g. tuberculosis) ☐ 5
Husband/wife/partner/family member tested positive ☐ 6
Illness or the death of husband/wife/partner/family member ☐ 7
I just wanted to know ☐ 8
Others (specify)………… ☐ 9

---

2. Was the decision to be tested for HIV up to you? (Tick one box only)

Yes, I took the decision myself to be tested (i.e. it was voluntary) ☐ 1
I took the decision to be tested, but it was under pressure from others ☐ 2
I was made to take an HIV test (coercion) ☐ 3
I was tested without my knowledge – I only found out after the test had been done ☐ 4

---

3. Did you receive counseling when you were tested for HIV? (Tick one box only)

I received both pre- and post-HIV test counseling ☐ 1
I only received pre-test HIV counseling ☐ 2
I only received post-test HIV counseling ☐ 3
I did not receive any counseling when I had an HIV test ☐ 4

SECTION 3B DISCLOSURE AND CONFIDENTIALITY

1. For each of the following people or groups of people, please describe how they were first told about your HIV status, if they have been told.
(Please tick your answers. Only tick more than one box in each line if the answer is different for different individuals.)

	I told them	Someone else told them, WITH my consent	Someone else told them, WITHOUT my consent	They don't know my HIV status	Not Applicable
Your husband/wife/partner	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other adult family members	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Children in your family	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Neighbors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other PLHIV	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
People who you work with (your co-workers)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Your employer(s)/boss(es)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Your clients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Injecting drug partners	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Religious leaders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Community leaders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Health care workers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Social workers/counselors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Teachers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Government officials	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
The media	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2a. How often did you feel pressure from other individuals living with HIV or from groups/networks of people living with HIV to disclose your HIV status?

Often ☐ 1
A few times ☐ 2
Once ☐ 3
Never ☐ 4

2b. How often did you feel pressure from other individuals not living with HIV (e.g. family members, social workers, non-governmental organization employees) to disclose your HIV status?

Often ☐ 1
A few times ☐ 2
Once ☐ 3

Never 4

---

3. Has a health care professional (for example, a doctor, nurse, counselor, laboratory technician) ever told other people about your HIV status without your consent?

Yes ☐ 1
No ☐ 2
Not sure ☐ 3

---

4. How confidential do you think the medical records relating to your HIV status are? (Tick one box only)

I am sure that my medical records will be kept completely confidential ☐ 1
I don’t know if my medical records are confidential ☐ 2
It is clear to me that my medical records are not being kept confidential ☐ 3

---

5. How would you describe the reactions of these people (in general) when they first knew about your HIV status? (Tick one box only for each category of people.)
(Tick **Not applicable** if these people do not know your HIV status or you don’t know what their reaction was.)

	Very Discriminatory	**Discriminatory**	**No different**	**Supportive**	**Very Supportive**	**Not Applicable**
Your husband/wife/partner	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Other adult family members	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Children in your family	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Neighbors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Other PLHIV	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
People who you work with (your co-workers)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Your employer(s)/boss(es)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Your clients	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Injecting drug partners	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Religious leaders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Community leaders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Health care workers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Social workers/counselors	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Government officials	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Teacher	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

---

6. Did you find the disclosure of your HIV status an empowering experience?
(Tick Not applicable if you have not disclosed your HIV status.)

Yes ☐ 1
No ☐ 2
Not applicable ☐ 3

SECTION 3C TREATMENT

1. In general, how would you describe your health at the moment? (Tick one box only)

Excellent ☐ 1
Very good ☐ 2
Good ☐ 3
Fair ☐ 4
Poor ☐ 5

2a. Are you currently taking antiretroviral treatment? (Tick one box only)

Yes ☐ 1
No ☐ 2

2b. Do you have access* to antiretroviral treatment, even if you are not currently taking it? (Tick one box only)

Yes ☐ 1
No ☐ 2
Don’t know ☐ 3

** In this context access means that antiretroviral treatment is available and free or you can afford it.*

3a. Are you currently taking any medication to prevent or to treat opportunistic infections? (Tick one box only)

Yes ☐ 1
No ☐ 2

3b. Do you have access* to medication for opportunistic infections, even if you are not currently taking it? (Tick one box only.)

Yes ☐ 1
No ☐ 2
Don’t know ☐ 3

** In this context access means that treatment is available and free or you can afford it.*

---

4. In the last 12 months, have you had a constructive discussion with a health care professional(s) on the subject of your HIV-related treatment options?

Yes ☐ 1
No ☐ 2

---

5. In the last 12 months, have you had a constructive discussion with a health care professional(s) on other subjects such as your sexual and reproductive health, sexual relationship(s), emotional well-being, drug use, etc?

Yes ☐ 1
No ☐ 2

SECTION 3D HAVING CHILDREN

Questions 1–5 can be completed by both male and female interviewees.

1a. Do you have a child/children?

Yes ☐
No ☐

1b. If Yes, are any of these children known to be HIV-positive?

Yes ☐
No ☐
No HIV+ Child ☐

---

2. Since being diagnosed as HIV-positive, have you ever received counseling about your reproductive options?

Yes ☐
No ☐

---

3. Has a health care professional ever advised you not to have a child since you were diagnosed as HIV-positive?

Yes ☐
No ☐

---

4. Has a health care professional ever recommended you into being sterilized since you were diagnosed as HIV-positive?

Yes ☐
No ☐

---

5. Is your ability to obtain antiretroviral treatment conditional on the use of certain forms of contraception?

Yes ☐
No ☐
Don’t know ☐

NOTE: Questions 6 and 7 should be completed by female interviewees only.

6. In the last 12 months, have you been strong advised by a health care professional in relation to any of the following because of your HIV status?

	Yes		No		N/A	
Termination of pregnancy (abortion)	☐	1	☐	2	☐	3
Method of giving birth	☐	1	☐	2	☐	3
Infant feeding practices	☐	1	☐	2	☐	3

7a. Have you ever been given antiretroviral treatment to prevent mother-to-child transmission of HIV during pregnancy? (Tick one box only)

Yes – I have received such treatment (ARV)	☐	1
No – I did not know that such treatment existed	☐	2
No – I was refused such treatment	☐	3
No – I did not have access to such treatment	☐	4
No – I was not HIV-positive when pregnant	☐	5

NOTE: If the answer is **NO**, please end the interview.

7b. If yes, were you also given information about healthy pregnancy and motherhood as part of the program to prevent mother-to-child transmission of HIV?

Yes	☐	1
No	☐	2

NOTE: Please go to page 2 on Referrals and Follow-Up.
-End the interview by thanks the participant-

8.2. Quantitative Data

Section 1- Information about respondents

Question 1. Sex of participants

S1Q1	Total (n=397)	
Variables	Freq	%
Male	114	28.7
Female	280	70.5
Transgender	3	0.8
Total	*397*	*100*

Question 2. How old are you? (years)

S1Q2	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
15-19	0	0.0	2	0.7	2	0.5
20-24	0	0.0	8	2.9	8	2.0
25-29	6	5.3	23	8.2	29	7.4
30-39	56	49.1	131	46.8	187	47.5
40-49	42	36.8	86	30.7	128	32.5
≥50	10	8.8	30	10.7	40	10.2
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 3. For how long have you been living with HIV? (years)

S1Q3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
<1	3	2.6	16	5.7	19	4.8
1-4	47	41.2	92	32.9	139	35.3
5-9	52	45.6	119	42.5	171	43.4
10-14	10	8.8	46	16.4	56	14.2
≥15	2	1.8	7	2.5	9	2.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 4. Current relationship status

S1Q4	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Married and non-married but live together	93	81.6	132	47.1	225	57.1
Married but partner live away from household	1	0.9	8	2.9	9	2.3
In a relationship but not living together	2	1.8	3	1.1	5	1.3
Single	1	0.9	10	3.6	11	2.8
Divorced, separated	2	1.8	14	5.0	16	4.1
Widow, widower	15	13.2	113	40.4	128	32.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 5. If you are currently in a relationship, for how long have you been involved with your spouse/partner? (years)

S1Q5	Men (n=96)		Women (n=143)		Total (n=239)	
Variables	Freq	%	Freq	%	Freq	%
<1	2	2.1	4	2.8	6	2.5
1-4	14	14.6	34	23.8	48	20.1
5-9	31	32.3	38	26.6	69	28.9
10-14	31	32.3	47	32.9	78	32.6
≥15	18	18.8	20	14.0	38	15.9
Total	*96*	*100.0*	*143*	*100.0*	*239*	*100.0*

Question 6. Are you sexually active in the past 3 months?

S1Q6	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	88	77.2	125	44.6	213	54.1
No	26	22.8	155	55.4	181	45.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 7. Do you belong to, or have you in the past belonged to, any of the following categories? (more than one answer is possible).

S1Q8	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	14	12.3	13	4.6	27	6.9
No	100	87.7	267	95.4	367	93.1
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 8. Do you have a physical disability of any kind (not including general ill health related to HIV)?

S1Q8	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	14	12.3	13	4.6	27	6.9
No	100	87.7	267	95.4	367	93.1
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 9. What is the highest level of formal education you have completed?

S1Q9	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
No schooling	12	10.5	89	31.8	101	25.6
Primary school	55	48.2	139	49.6	194	49.2
Secondary school	45	39.5	52	18.6	97	24.6
Technical college/university	2	1.8	0	0.0	2	0.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 10. Which one of these statements best describes your current employment status?

S1Q10	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Unemployed	11	9.6	46	16.4	57	14.5
Moto-taxi driver	20	17.5	1	0.4	21	5.3
military, police or military police	5	4.4	1	0.4	6	1.5
Public servant (government staff)	2	1.8	3	1.1	5	1.3
Seller, vendor	21	18.4	101	36.1	122	31.0
Farmer	49	43.0	116	41.4	165	41.9
Civil servant (NGO staff)	4	3.5	7	2.5	11	2.8
Private company worker	1	0.9	1	0.4	2	0.5
Others	1	0.9	4	1.4	5	1.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 11. How many people currently live in your household in each of these age categories? (in years

S1Q11	1 PLHIV		2 PLHIV		≥3 PLHIV	
Variables (n=394)	Freq	%	Freq	%	Freq	%
0-14	141	35.8	100	25.4	47	11.9
15-19	96	24.4	41	10.4	11	2.8
20-24	64	16.2	34	8.6	7	1.8
25-29	78	19.8	20	5.1	0	0.0
30-39	171	43.4	74	18.8	5	1.3
40-49	154	39.1	33	8.4	0	0.0
≥50	91	23.1	40	10.2	3	0.8

Question 12. How many of the children and youth in your household are AIDS orphans?

S1Q12	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
1	12	10.5	40	14.3	52	13.2
2	4	3.5	41	14.6	45	11.4
3	3	2.6	17	6.1	20	5.1
4	0	0.0	3	1.1	3	0.8
5	0	0.0	2	0.7	2	0.5
6	2	1.8	0	0.0	2	0.5

Question 13. Is your household in:

S1Q13	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Rural	78	68.4	147	52.5	225	57.1
Urban/City	36	31.6	133	47.5	169	42.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 14. What was the average income of your household per month over the last 12 months?

S1Q14	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
No income	13	11.4	19	6.8	32	8.1
≤$30	32	28.1	95	33.9	127	32.2
$31- 70	37	32.5	88	31.4	125	31.7
>$70	32	28.1	78	27.9	110	27.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 15. In the last month, how many days has any member of your household hot had enough food to eat

S1Q15	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Enough	18	15.8	38	13.6	56	14.2
Food shortage 1-7 days	59	51.8	116	41.4	175	44.4
Food shortage 8-14 days	24	21.1	79	28.2	103	26.1
Food shortage ≥15 days	13	11.4	47	16.8	60	15.2
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Section 2A – Your experience of stigma and discrimination from other people

Question 1a. In the last 12 months, how often have you been excluded from social gatherings or activities (e.g. weddings, funerals, parties, clubs)?

S2aQ1a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	104	91.2	249	88.9	353	89.6
Once	3	2.6	4	1.4	7	1.8
A few times	4	3.5	14	5.0	18	4.6
Often	3	2.6	13	4.6	16	4.1
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 1b. If so, was this…?

S2aQ1b	Men (n=10)		Women (n=31)		Total (n=41)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	5	50.0	12	38.7	17	41.5
For (an)other reason(s)	0	0.0	7	22.6	7	17.1
Both because of your HIV status and other reason(s)	1	10.0	4	12.9	5	12.2
Not sure why	4	40.0	8	25.8	12	29.3
Total	*10*	*100.0*	*31*	*100.0*	*41*	*100.0*

Question 2a. In the last 12 months, how often have you been excluded from religious activities or places of worship?

S2aQ2a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	104	91.2	264	94.3	368	93.4
Once	4	3.5	3	1.1	7	1.8
A few times	5	4.4	5	1.8	10	2.5
Often	1	0.9	8	2.9	9	2.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 2b. If so, was this…?

S2aQ2b	Men (n=10)		Women (n=16)		Total (n=26)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	4	40.0	8	50.0	12	46.2
For (an)other reason(s)	2	20.0	1	6.3	3	11.5
Both because of your HIV status and other reason(s)	1	10.0	2	12.5	3	11.5
Not sure why	3	30.0	5	31.3	8	30.8
Total	*10*	*100.0*	*16*	*100.0*	*26*	*100.0*

Question 3a. In the last 12 months, how often have you been excluded from family activities (e.g. cooking, eating together, sleeping in the same room?)

S2aQ3a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	107	93.9	268	95.7	375	95.2
Once	1	0.9	2	0.7	3	0.8
A few times	5	4.4	3	1.1	8	2.0
Often	1	0.9	7	2.5	8	2.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 3b. If so, was this…?

S2aQ3b	Men (n=7)		Women (n=12)		Total (n=19)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	5	71.4	8	66.7	13	68.4
For (an)other reason(s)	1	14.3	1	8.3	2	10.5
Both because of your HIV status and other reason(s)	0	0.0	3	25.0	3	15.8
Not sure why	1	14.3	0	0.0	1	5.3
Total	*7*	*100.0*	*12*	*100.0*	*19*	*100.0*

Question 4a. In the past 12 months, how often have you been aware of being gossiped about?

S2aQ4a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	51	44.7	108	38.6	159	40.4
Once	5	4.4	15	5.4	20	5.1
A few times	15	13.2	50	17.9	65	16.5
Often	13	11.4	50	17.9	63	16.0
Don't know	30	26.3	57	20.4	87	22.1
Total	*114*	*100.0*	*280*	*100.0*	*307*	*100.0*

Question 4b. If so, was this…?

S2aQ4b	Men (n=33)		Women (n=115)		Total (n=148)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	21	63.6	88	76.5	109	73.6
For (an)other reason(s)	3	9.1	6	5.2	9	6.1
Both because of your HIV status and other reason(s)	7	21.2	18	15.7	25	16.9
Not sure why	2	6.1	3	2.6	5	3.4
Total	*33*	*100.0*	*115*	*100.0*	*148*	*100.0*

Question 5a. In the past 12 months, how often have you been verbally insulted, harassed and/or threatened?

S2aQ5a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	93	81.6	204	72.9	297	75.4
Once	5	4.4	25	8.9	30	7.6
A few times	12	10.5	25	8.9	37	9.4
Often	4	3.5	26	9.3	30	7.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 5b. If so, was this…?

S2aQ5b	Men (n=21)		Women (n=76)		Total (n=97)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	12	57.1	45	59.2	57	58.8
For (an)other reason(s)	2	9.5	13	17.1	15	15.5
Both because of your HIV status and other reason(s)	6	28.6	15	19.7	21	21.6
Not sure why	1	4.8	3	3.9	4	4.1
Total	*21*	*100.0*	*76*	*100.0*	*97*	*100.0*

Question 6a. In the last 12 months, how often have you been physically harassed and/or threatened?

S2aQ6a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	106	93.0	244	87.1	350	88.8
Once	3	2.6	10	3.6	13	3.3
A few times	5	4.4	18	6.4	23	5.8
Often	0	0.0	8	2.9	8	2.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 6b. If so, was this…?

S2aQ6b	Men (n=8)		Women (n=36)		Total (n=44)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	1	12.5	14	38.9	15	34.1
For (an)other reason(s)	1	12.5	10	27.8	11	25.0
Both because of your HIV status and other reason(s)	5	62.5	7	19.4	12	27.3
Not sure why	1	12.5	5	13.9	6	13.6
Total	*8*	*100.0*	*36*	*100.0*	*44*	*100.0*

Question 7a. In the last 12 months, how often have you been physically assaulted?

S2aQ7a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	110	96.5	262	93.6	372	94.4
Once	2	1.8	11	3.9	13	3.3
A few times	2	1.8	4	1.4	6	1.5
Often	0	0.0	3	1.1	3	0.8
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 7b. If so, was this…?

S2aQ7b	Men (n=4)		Women (n=18)		Total (n=22)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	0	0.0	2	11.1	2	9.1
For (an)other reason(s)	0	0.0	8	44.4	8	36.4
Both because of your HIV status and other reason(s)	3	75.0	5	27.8	8	36.4
Not sure why	1	25.0	3	16.7	4	18.2
Total	*4*	*100.0*	*18*	*100.0*	*22*	*100.0*

Question 7c. If so, who physically assaulted you?

S2aQ7c	Men (n=4)		Women (n=18)		Total (n=22)	
Variables	Freq	%	Freq	%	Freq	%
My spouse/partner	0	0.0	6	33.3	6	27.3
Another member of the household	0	0.0	9	50.0	9	40.9
Person outside the household who is known to me	3	75.0	1	5.6	4	18.2
Unknown person	1	25.0	2	11.1	3	13.6
Total	*4*	*100.0*	*18*	*100.0*	*22*	*100.0*

Question 8. In the last 12 months, how often have you been subjected to psychological pressure or manipulation by your husband/wife or partner in which your HIV-positive status was used against you?

S2aQ8	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	97	85.1	216	77.1	313	79.4
Once	4	3.5	19	6.8	23	5.8
A few times	9	7.9	26	9.3	35	8.9
Often	4	3.5	19	6.8	23	5.8
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 9. In the last 12 months, how often have you experienced sexual rejection as a result of your HIV positive status?

S2aQ9	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Never	104	91.2	262	93.6	366	92.9
Once	1	0.9	3	1.1	4	1.0
A few times	7	6.1	11	3.9	18	4.6
Often	2	1.8	4	1.4	6	1.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 9. In the last 12 months, how often have you experienced sexual rejection as a result of your HIV positive status?

S2aQ9	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Never	104	91.2	262	93.6	366	92.9
Once	1	0.9	3	1.1	4	1.0
A few times	7	6.1	11	3.9	18	4.6
Often	2	1.8	4	1.4	6	1.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 10. In the last 12 months, how often have you been discriminated against by other people living with HIV?

S2aQ10	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Never	103	90.4	242	86.4	345	87.6
Once	6	5.3	10	3.6	16	4.1
A few times	3	2.6	16	5.7	19	4.8
Often	2	1.8	12	4.3	14	3.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 11. In the last 12 months, how often has your wife/husband or partner, or any members of your household experienced discrimination as a result of your HIV-positive status?

S2aQ11	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Never	108	94.7	266	95.0	374	94.9
Once	3	2.6	2	0.7	5	1.3
A few times	2	1.8	7	2.5	9	2.3
Often	1	0.9	5	1.8	6	1.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 12. If you have experienced some forms of HIV-related stigma and/or discrimination in the last 12 months, why do you think this is? (more than 1 answer is possible)

S2aQ12	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
People are afraid of getting infected with HIV from me	35	30.7	92	32.9	127	32.2
People don't understand how HIV is transmitted	34	29.8	89	31.8	123	31.2
People think that having HIV is shameful and they should not be associated with me	6	5.3	37	13.2	43	10.9
Religious beliefs or "moral" judgements	1	0.9	8	2.9	9	2.3
People disapprove of my lifestyle or behaviour	6	5.3	12	4.3	18	4.6
I look sick with symptoms associated with HIV	4	3.5	9	3.2	13	3.3
I don't know/I am not sure	10	8.8	27	9.6	37	9.4
Never been stigmatized or discriminated against	72	63.2	159	56.8	231	58.6

Section 2B –Access to work and health and education services

Question 1a. In the last 12 months, how often have you been forced to change your place of residence or been unable to rent accommodation?

S2bQ1a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Never	104	91.2	244	87.1	348	88.3
Once	6	5.3	18	6.4	24	6.1
A few times	2	1.8	11	3.9	13	3.3
Often	2	1.8	7	2.5	9	2.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 1b. If so, was this…?

S2bQ1b	Men (n=10)		Women (n=36)		Total (n=46)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	5	50.0	15	41.7	20	43.5
For (an)other reason(s)	0	0.0	9	25.0	9	19.6
Both because of your HIV status and other reason(s)	4	40.0	7	19.4	11	23.9
Not sure why	1	10.0	5	13.9	6	13.0
Total	*10*	*100.0*	*36*	*100.0*	*46*	*100.0*

Question 2a. In the last 12 months, how often have you lost a job (if employed) or another source of income(if self-employed or an informal/casual worker)?

S2bQ2a	Men (n=110)		Women (n=266)		Total (n=376)	
Variables	Freq	%	Freq	%	Freq	%
Never	57	51.8	137	51.5	194	51.6
Once	21	19.1	31	11.7	52	13.8
A few times	21	19.1	52	19.5	73	19.4
Often	11	10.0	46	17.3	57	15.2
Total	*110*	*100.0*	*266*	*100.0*	*376*	*100.0*

Question 2b. If so, was this…?

S2bQ2b	Men (n=53)		Women (n=129)		Total (n=182)	
Variables	Freq	%	Freq	%	Freq	%
Because of your HIV status	27	50.9	66	51.2	93	51.1
For (an)other reason(s)	11	20.8	27	20.9	38	20.9
Both because of your HIV status and other reason(s)	12	22.6	31	24.0	43	23.6
Not sure why	3	5.7	5	3.9	8	4.4
Total	*53*	*100.0*	*129*	*100.0*	*182*	*100.0*

Question 2c. Because of HIV status, did you (wholly or partly) lose your work/income?

S2bQ2c	Men (n=40)		Women (n=99)		Total (n=139)	
Variables	Freq	%	Freq	%	Freq	%
Discrimination by your employer or co-workers	1	2.5	6	6.1	7	5.0
Due to poor health	30	75.0	68	68.7	98	70.5
Combination of discrimination and poor health	6	15.0	17	17.2	23	16.5
Another reason	3	7.5	8	8.1	11	7.9
Total	*40*	*100.0*	*99*	*100.0*	*139*	*100.0*

Question 3. In the last 12 months, have you been refused employment or a work opportunity because of your HIV status?

S2bQ3	Men (n=110)		Women (n=266)		Total (n=376)	
Variables	Freq	%	Freq	%	Freq	%
Yes	10	9.1	38	14.3	48	12.8
No	99	90.0	228	85.7	327	87.0
Total	*109*	*99.1*	*266*	*100.0*	*375*	*99.7*

*There is male respondent whose data was not recorded.

Question 4a. In the last 12 months, how often has your job description or the nature of your work changed, or have you been refused promotion, as a result of your HIV status?

S2bQ4a	Men (n=110)		Women (n=266)		Total (n=376)	
Variables	Freq	%	Freq	%	Freq	%
Never	102	92.7	244	91.7	346	92.0
Once	5	4.5	14	5.3	19	5.1
A few times	2	1.8	2	0.8	4	1.1
Often	0	0.0	6	2.3	6	1.6
Total	*109*	*99.1*	*266*	*100.0*	*375*	*99.7*

Question 4b. If so, did this happen…?

S2bQ4b	Men (n=7)		Women (n=22)		Total (n=29)	
Variables	Freq	%	Freq	%	Freq	%
Discrimination by your employer or co-workers	0	0.0	6	27.3	6	20.7
Due to poor health	3	42.9	8	36.4	11	37.9
Combination of discrimination and poor health	2	28.6	4	18.2	6	20.7
Another reason	2	28.6	4	18.2	6	20.7
Total	*7*	*100.0*	*22*	*100.0*	*29*	*100.0*

Question 5. In the last 12 months, how often have you been dismissed, suspended or prevented from attending an educational institution because of your HIV status?

S2bQ5	Men (n=100)		Women (n=220)		Total (n=320)	
Variables	Freq	%	Freq	%	Freq	%
Never	99	99.0	214	97.3	313	97.8
Once	1	1.0	2	0.9	3	0.9
A few times	0	0.0	3	1.4	3	0.9
Often	0	0.0	1	0.5	1	0.3
Not applicable	14		60		74	
Total	*100*	*100.0*	*220*	*100.0*	*320*	*100.0*

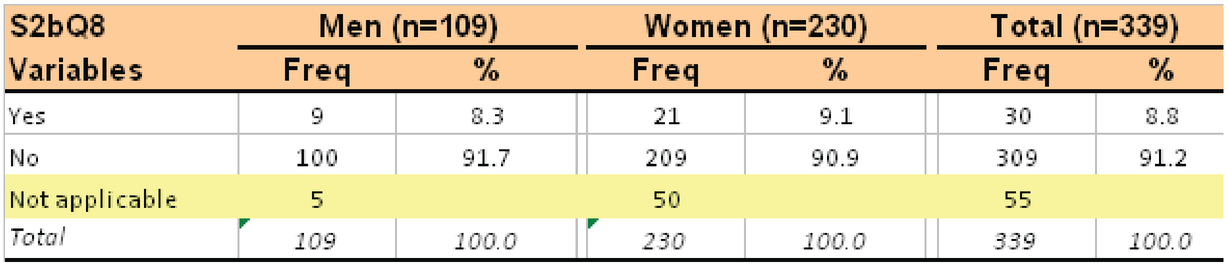
Question 6. In the last 12 months, how often has your child/children been dismissed, suspended or prevented from attending an educational institution because of your HIV status?

S2bQ6	Men (n=109)		Women (n=263)		Total (n=372)	
Variables	Freq	%	Freq	%	Freq	%
Never	107	98.2	252	95.8	359	96.5
Once	1	0.9	3	1.1	4	1.1
A few times	0	0.0	2	0.8	2	0.5
Often	1	0.9	6	2.3	7	1.9
Not applicable	5		17		22	
Total	*109*	*100.0*	*263*	*100.0*	*372*	*100.0*

Question 7. In the last 12 months, how often have you been denied health services, including dental care, because of your HIV status?

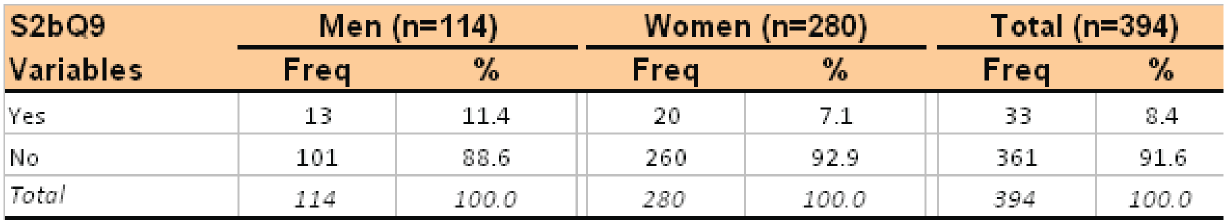
S2bQ7	Men (n=113)		Women (n=277)		Total (n=390)	
Variables	Freq	%	Freq	%	Freq	%
Never	110	97.3	267	96.4	377	96.7
Once	3	2.7	6	2.2	9	2.3
A few times	0	0.0	4	1.4	4	1.0
Often	0	0.0	0	0.0	0	0.0
Not applicable	1		3		4	
Total	*113*	*100.0*	*277*	*100.0*	*390*	*100.0*

Question 8. In the last 12 months, have you been denied family planning services because of your HIV status?



S2bQ8	Men (n=109)		Women (n=230)		Total (n=339)	
Variables	Freq	%	Freq	%	Freq	%
Yes	9	8.3	21	9.1	30	8.8
No	100	91.7	209	90.9	309	91.2
Not applicable	5		50		55	
Total	*109*	*100.0*	*230*	*100.0*	*339*	*100.0*

Question 9. In the last 12 months, have you been denied sexual and reproductive health services because of your HIV status?



S2bQ9	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	13	11.4	20	7.1	33	8.4
No	101	88.6	260	92.9	361	91.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Section 2C – Internal stigma and fears

Question 1. In the last 12 months, have you experienced any of the following feelings because of your HIV status?

S2cQ1	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Feel ashamed						
Yes	70	61.4	177	63.2	247	62.7
No	44	38.6	103	36.8	147	37.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Feel guilty						
Yes	83	72.8	210	75.0	293	74.4
No	31	27.2	70	25.0	101	25.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Blame myself						
Yes	74	64.9	104	37.1	178	45.2
No	40	35.1	140	50.0	180	45.7
Total	*114*	*100.0*	*244*	*87.1*	*358*	*90.9*
Blame others						
Yes	10	8.8	73	26.1	83	21.1
No	104	91.2	207	73.9	311	78.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Have low self-esteem						
Yes	47	41.2	143	51.1	190	48.2
No	67	58.8	137	48.9	204	51.8
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Feel that I should be punished						
Yes	44	38.6	110	39.3	154	39.1
No	70	61.4	170	60.7	240	60.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Feel suicidal						
Yes	7	6.1	55	19.6	62	15.7
No	107	93.9	225	80.4	332	84.3
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 2. In the last 12 months, have you done any of the following things because of your HIV status?

S2cQ2	**Men (n=114)**		**Women (n=280)**		**Total (n=394)**	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Have chosen not to attend social gathering(s)						
Yes	34	29.8	71	25.4	105	26.6
No	80	70.2	209	74.6	289	73.4
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Have isolated from my family and/or friends						
Yes	29	25.4	57	20.4	86	21.8
No	85	74.6	223	79.6	308	78.2
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Took the decision to stop working						
Yes	17	14.9	42	15.0	59	15.0
No	97	85.1	238	85.0	335	85.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Decided not to apply for a job/work or for a promotion						
Yes	27	23.7	77	27.5	104	26.4
No	87	76.3	203	72.5	290	73.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Withdrew from education/training or did not take up an opportunity for education/training						
Yes	35	30.7	94	33.6	129	32.7
No	79	69.3	186	66.4	265	67.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Decided not to get married						
Yes	41	36.0	123	43.9	164	41.6
No	73	64.0	157	56.1	230	58.4
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Decided not to have sex						
Yes	26	22.8	103	36.8	129	32.7
No	88	77.2	177	63.2	265	67.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Decided not to have (more) children						
Yes	64	56.1	164	58.6	228	57.9
No	50	43.9	116	41.4	166	42.1
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Avoided going to a local clinic when needed to						
Yes	30	26.3	65	23.2	95	24.1
No	84	73.7	215	76.8	299	75.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Avoided going to a hospital when needed to						
Yes	20	17.5	43	15.4	63	16.0
No	94	82.5	237	84.6	331	84.0
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 3. In the last 12 months, have you been fearful of any of the following things happening to you –whether or not they actually have happened to you?

S2cQ3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Being gossiped about						
Yes	49	43.0	135	48.2	184	46.7
No	65	57.0	145	51.8	210	53.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Being verbally insulted, harassed and/or threatened						
Yes	42	36.8	114	40.7	156	39.6
No	72	63.2	166	59.3	238	60.4
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Being physically harassed and/or threatened						
Yes	31	27.2	97	34.6	128	32.5
No	83	72.8	183	65.4	266	67.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*
Being physically assaulted						
Yes	37	32.5	102	36.4	139	35.3
No	77	67.5	178	63.6	255	64.7
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 4. In the last 12 months, have you been afraid that someone would not want to be sexually intimate with you because of your HIV-positive status?

S2cQ4	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	20	17.5	45	16.1	65	16.5
No	94	82.5	235	83.9	329	83.5
Total	*114*	*100*	*280*	*100*	*394*	*100*

Section 2D – Rights, laws and policies

Question 1a. Have you heard of the Declaration of Commitment on HIV/AIDS, which protects the rights of people living with HIV?

S2dQ1a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	96	84.2	239	85.4	335	85.0
No	18	15.8	41	14.6	59	15.0
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 1b. If yes, have you ever read or discussed the content of this Declaration

S2dQ1b	Men (n=96)		Women (n=239)		Total (n=335)	
Variables	Freq	%	Freq	%	Freq	%
Yes	76	79.2	147	61.5	223	66.6
No	20	20.8	92	38.5	112	33.4
Total	*96*	*100*	*239*	*100*	*335*	*100*

Question 2a. Have you heard of the law on prevention and the fight against the spread of HIV/AIDS?

S2dQ2a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	95	83.3	226	80.7	321	81.5
No	19	16.7	54	19.3	73	18.5
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 2b. If yes, have you ever read or discussed the content of this law?

S2dQ2b	Men (n=95)		Women (n=226)		Total (n=321)	
Variables	Freq	%	Freq	%	Freq	%
Yes	76	79.2	144	63.7	220	68.5
No	19	19.8	82	36.3	101	31.5
Total	*95*	*99*	*226*	*100*	*321*	*100*

Question 3. In the last 12 months, have any of the following things happened to you because of your HIV status?

S2dQ3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Forced to receive health services (including HIV testing)	15	13.2	31	11.1	46	11.7
Denied health insurance or life insurance	7	6.1	9	3.2	16	4.1
Arrested or taken to court on a charge	3	2.6	2	0.7	5	1.3
Disclosed status in order to enter another country	2	1.8	5	1.8	7	1.8
Disclosed status to apply for residence or nationality	4	3.5	11	3.9	15	3.8
Detained, quarantined, isolated or segregated	5	4.4	8	2.9	13	3.3
None of these things have happened to me	101	88.6	243	86.8	344	87.3

Question 4a. In the last 12 months, have any of your rights as a person living with HIV been abused?

S2dQ4a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	11	9.6	32	11.4	43	10.9
No	100	87.7	235	83.9	335	85.0
Not sure	3	2.6	13	4.6	16	4.1
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 4b. If yes, have you tried to get legal assistant for any abuse of your rights as a person living with HIV?

S2dQ4b	Men (n=95)		Women (n=226)		Total (n=321)	
Variables	Freq	%	Freq	%	Freq	%
Yes	7	63.6	22	68.8	29	67.4
No	3	27.3	10	31.3	13	30.2
Not sure	1	9.1	0	0.0	1	2.3
Total	*11*	*100*	*32*	*100*	*43*	*100*

Question 4c. Has this process begun in the last 12 months?

S2dQ4c	Men (n=7)		Women (n=22)		Total (n=29)	
Variables	Freq	%	Freq	%	Freq	%
Yes	6	85.7	15	68.2	21	72.4
No	1	14.3	7	31.8	8	27.6
Total	*7*	*100*	*22*	*100*	*29*	*100*

Question 4d. What was the result?

S2dQ4d	Men (n=6)		Women (n=15)		Total (n=21)	
Variables	Freq	%	Freq	%	Freq	%
The matter has been solved	2	33.3	8	53.3	10	47.6
The matter is still in the process of being solved	3	50.0	2	13.3	5	23.8
Nothing happened or the matter was not solved	1	16.7	3	20.0	4	19.0
Total	*6*	*100*	*13*	*87*	*19*	*90*

*There were two female respondents whose data was not recorded.

Question 4e. What was the reason for not trying to get legal assistant

S2dQ4e	Men (n=17)		Women (n=40)		Total (n=57)	
Variables	Freq	%	Freq	%	Freq	%
Don't know where to go/whom to ask	5	29.4	7	17.5	12	21.1
Insufficient financial resources to take action	6	35.3	11	27.5	17	29.8
Process of addressing the problem appeared too bureaucratic	2	11.8	1	2.5	3	5.3
Felt intimidated or scared to take action	2	11.8	5	12.5	7	12.3
Advised against taking action by someone else	0	0.0	7	17.5	7	12.3
Little confidence that the outcome would be successful	1	5.9	3	7.5	4	7.0
None of the above	1	5.9	6	15.0	7	12.3
Total	*17*	*100*	*40*	*100*	*57*	*100*

Section 2E – Effecting change

Question 1. In the last 12 months, have you confronted, challenged or educated someone who was stigmatizing and/or discriminating against you?

S2eQ1	Men (n=114)		Women (n=280)		Total (n
Variables	Freq	%	Freq	%	Freq
Yes	38	33.3	109	38.9	147
No	76	66.7	171	61.1	247
Total	*114*	*100*	*280*	*100*	*394*

Question 2a. Do you know of any organizations or groups that you can go to for help if you experience stigma or discrimination?

S2eQ2a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	102	89.5	256	91.4	358	90.9
No	12	10.5	24	8.6	36	9.1
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 2b. If yes, which kinds of organizations or groups do you know about? (more than one answer is possible).

S2eQ2b	Men (n=102)		Women (n=256)		Total (n=358)	
Variables	Freq	%	Freq	%	Freq	%
People living with HIV support group	85	83.3	211	82.4	296	82.7
Network of people living with HIV	62	60.8	135	52.7	197	55.0
Local non-governmental organization	72	70.6	184	71.9	256	71.5
Faith-based organization	22	21.6	42	16.4	64	17.9
A legal practice	13	12.7	9	3.5	22	6.1
A human rights organization	13	12.7	16	6.3	29	8.1
National AIDS council or committee 8	14	13.7	18	7.0	32	8.9
International non-governmental organization	10	9.8	18	7.0	28	7.8
UN organization	4	3.9	9	3.5	13	3.6
Other	5	4.9	6	2.3	11	3.1

Question 3. Have you sought help from any of the above organizations or groups to resolve an issue of stigma or discrimination?

S2eQ3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	47	41.2	100	35.7	147	37.3
No	67	58.8	180	64.3	247	62.7
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 4a. In the last 12 months, have you supported other people living with HIV?

S2dQ4a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	11	9.6	32	11.4	43	10.9
No	100	87.7	235	83.9	335	85.0
Not sure	3	2.6	13	4.6	16	4.1
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 4b. If Yes, what types of support did you provide? (more than one answer is possible)

S2eQ4b	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Emotional support	66	57.9	153	54.6	219	55.6
Physical support	28	24.6	54	19.3	82	20.8
Referral to other services	52	45.6	100	35.7	152	38.6

Question 5. Are you currently a member of a people living with HIV support group and/or network?

S2eQ5	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	104	91.2	258	92.1	362	91.9
No	10	8.8	22	7.9	32	8.1
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 6. In the last 12 months, have you been involved, either as a volunteer or as an employee, in any program or project (either government or non-governmental) that provides assistance to people living with HIV?

S2eQ6	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	40	35.1	69	24.6	109	27.7
No	74	64.9	211	75.4	285	72.3
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 7. In the last 12 months have you been involved in any efforts to develop legislation, policies or guidelines related to HIV?

S2eQ7	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	11	9.6	17	6.1	28	7.1
No	103	90.4	263	93.9	366	92.9
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 8. There are a number of organizations of people living with HIV working against stigma and discrimination. If one of them asked you, “What is the most important thing we should be doing as an organization to address stigma and discrimination?” what would you recommend?

S2eQ8	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Advocating for the rights of all people living with HIV	49	43.0	96	34.3	145	36.8
Providing support to people living with HIV by providing emotional, physical and referral support	41	36.0	127	45.4	168	42.6
Advocting for the rights and/or providing support to particularly marginalized groups	0	0.0	3	1.1	3	0.8
Educating people living with HIV about living with HIV (including treatment literacy)	10	8.8	21	7.5	31	7.9
Raising the awareness and knowledge of the public about AIDS	14	12.3	33	11.8	47	11.9
Total	*114*	*100*	*280*	*100*	*394*	*100*

Question 3A – Testing/Diagnosis

Question 1. Why were you tested for HIV? (more than one answer is possible)

S3aQ1	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Employment	0	0.0	2	0.7	2	0.5
Pregnancy	0	0.0	16	5.7	16	4.1
Marriage/sexual relationship	3	2.6	7	2.5	10	2.5
Referred by a clinic for STI	14	12.3	16	5.7	30	7.6
Suspected HIV-related symptoms	54	47.4	93	33.2	147	37.3
Partner/family member tested positive	19	16.7	72	25.7	91	23.1
Illness or the death of partner/family member	23	20.2	115	41.1	138	35.0
I just wanted to know	30	26.3	64	22.9	94	23.9
Other reasons	4	3.5	3	1.1	7	1.8

Question 2. Was the decision to be tested for HIV up to you?

S3aQ2	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
I took the decision myself to be tested (voluntary)	106	93.0	254	90.7	360	91.4
I took the decision to be tested, but it was under pressure from others	5	4.4	16	5.7	21	5.3
I was made to take an HIV test (coercion)	1	0.9	7	2.5	8	2.0
I was tested without my knowledge	2	1.8	3	1.1	5	1.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 3. Did you receive counseling when you were tested for HIV?

S3aQ3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
I received both pre- and post-HIV test counselling	105	92.1	260	92.9	365	92.6
I only received pre-test HIV counselling	2	1.8	3	1.1	5	1.3
I only received post-test HIV counselling	6	5.3	10	3.6	16	4.1
I did not receive any counselling when I had an HIV test	1	0.9	7	2.5	8	2.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Section 3B – Disclosure and confidentiality

Question 1. For each of the following people or groups of people, please describe how they were first told about your HIV status, if they have been told.

Co-workers						
I told them	42	65.6	93	62.8	135	63.7
Someone else told them, WITH my consent	4	6.3	7	4.7	11	5.2
Someone else told them, WITHOUT my consent	5	7.8	8	5.4	13	6.1
They don't know my HIV status	13	20.3	40	27.0	53	25.0
Not applicable	50		132		182	
Total	*64*	*100.0*	*148*	*100.0*	*212*	*100.0*
Employers						
I told them	31	63.3	65	66.3	96	65.3
Someone else told them, WITH my consent	4	8.2	3	3.1	7	4.8
Someone else told them, WITHOUT my consent	3	6.1	7	7.1	10	6.8
They don't know my HIV status	11	22.4	23	23.5	34	23.1
Not applicable	65		182		247	
Total	*49*	*100.0*	*98*	*100.0*	*147*	*100.0*
Clients						
I told them	9	21.4	36	33.6	45	30.2
Someone else told them, WITH my consent	3	7.1	5	4.7	8	5.4
Someone else told them, WITHOUT my consent	2	4.8	13	12.1	15	10.1
They don't know my HIV status	28	66.7	53	49.5	81	54.4
Not applicable	72		173		245	
Total	*42*	*100.0*	*107*	*100.0*	*149*	*100.0*
Injecting drug partners						
I told them	2	50.0	2	15.4	4	23.5
Someone else told them, WITH my consent	0	0.0	1	7.7	1	5.9
Someone else told them, WITHOUT my consent	0	0.0	1	7.7	1	5.9
They don't know my HIV status	2	50.0	9	69.2	11	64.7
Not applicable	110		267		377	
Total	*4*	*100.0*	*13*	*100.0*	*17*	*100.0*
Religious leaders						
I told them	50	54.9	107	55.4	157	55.3
Someone else told them, WITH my consent	6	6.6	12	6.2	18	6.3
Someone else told them, WITHOUT my consent	9	9.9	15	7.8	24	8.5
They don't know my HIV status	26	28.6	59	30.6	85	29.9
Not applicable	23		87		110	
Total	*91*	*100.0*	*193*	*100.0*	*284*	*100.0*
Community leaders						
I told them	81	77.1	206	78.0	287	77.8
Someone else told them, WITH my consent	8	7.6	17	6.4	25	6.8
Someone else told them, WITHOUT my consent	12	11.4	28	10.6	40	10.8
They don't know my HIV status	4	3.8	13	4.9	17	4.6
Not applicable	9		16		25	
Total	*105*	*100.0*	*264*	*100.0*	*369*	*100.0*
Teachers						
I told them	30	55.6	74	49.7	104	51.2
Someone else told them, WITH my consent	4	7.4	5	3.4	9	4.4
Someone else told them, WITHOUT my consent	5	9.3	17	11.4	22	10.8
They don't know my HIV status	15	27.8	53	35.6	68	33.5
Not applicable	60		131		191	
Total	*54*	*100.0*	*149*	*100.0*	*203*	*100.0*

Government officials						
I told them	28	52.8	81	55.5	109	54.8
Someone else told them, WITH my consent	3	5.7	6	4.1	9	4.5
Someone else told them, WITHOUT my consent	6	11.3	12	8.2	18	9.0
They don't know my HIV status	16	30.2	47	32.2	63	31.7
Not applicable	61		134		195	
Total	*53*	*100.0*	*146*	*100.0*	*199*	*100.0*
Health care workers						
I told them	99	88.4	250	91.2	349	90.4
Someone else told them, WITH my consent	7	6.3	9	3.3	16	4.1
Someone else told them, WITHOUT my consent	4	3.6	11	4.0	15	3.9
They don't know my HIV status	2	1.8	4	1.5	6	1.6
Not applicable	2		6		8	
Total	*112*	*100.0*	*274*	*100.0*	*386*	*100.0*
Social workers/counsellors						
I told them	75	84.3	192	82.8	267	83.2
Someone else told them, WITH my consent	8	9.0	8	3.4	16	5.0
Someone else told them, WITHOUT my consent	3	3.4	14	6.0	17	5.3
They don't know my HIV status	3	3.4	18	7.8	21	6.5
Not applicable	25		48		73	
Total	*89*	*100.0*	*232*	*100.0*	*321*	*100.0*
The media						
I told them	11	50.0	26	34.7	37	38.1
Someone else told them, WITH my consent	0	0.0	1	1.3	1	1.0
Someone else told them, WITHOUT my consent	1	4.5	5	6.7	6	6.2
They don't know my HIV status	10	45.5	43	57.3	53	54.6
Not applicable	92		205		297	
Total	*22*	*100.0*	*75*	*100.0*	*97*	*100.0*

Question 2a. How often did you feel pressure from other individuals living with HIV or from groups/networks of people living with HIV to disclose your HIV status?

S3bQ2a	**Men (n=114)**		**Women (n=280)**		**Total (n=394)**	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Often	4	3.5	7	2.5	11	2.8
A few times	3	2.6	13	4.6	16	4.1
Once	6	5.3	12	4.3	18	4.6
Never	101	88.6	248	88.6	349	88.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 2b. How often did you feel pressure from other individuals not living with HIV (e.g. family members, social workers, non-governmental organization employees) to disclose your HIV status?

S3bQ2b	**Men (n=114)**		**Women (n=280)**		**Total (n=394)**	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Often	4	3.5	7	2.5	11	2.8
A few times	7	6.1	20	7.1	16	4.1
Once	6	5.3	9	3.2	18	4.6
Never	97	85.1	244	87.1	349	88.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 3. Has a health care professional (for example, a doctor, nurse, counselor, laboratory technician) ever told other people about your HIV status without your consent?

S3bQ3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	7	6.1	15	5.4	22	5.6
No	86	75.4	210	75.0	296	75.1
Not sure	21	18.4	55	19.6	76	19.3
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 4. How confidential do you think the medical records relating to your HIV status are?

S3bQ4	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
I am sure that my medical records will be kept completely confidential	98	86.0	241	86.1	339	86.0
I don't know if my medical records are confidential	11	9.6	21	7.5	32	8.1
It is clear to me that my medical records are not being kept confidential	5	4.4	18	6.4	23	5.8
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Questions 5. How would you describe the reactions of these people (in general) when they first knew about your HIV status?

S3bQ5	Men		Women		Total	
Variables	Freq	%	Freq	%	Freq	%
Spouse/partner						
Very discriminatory	3	2.8	9	3.9	12	3.6
Discriminatory	7	6.6	4	1.7	11	3.3
No different	15	14.2	46	20.0	61	18.2
Supportive	49	46.2	96	41.7	145	43.2
Very supportive	32	30.2	75	32.6	107	31.8
Not applicable	8		50		58	
Total	*106*	*100.0*	*230*	*100.0*	*336*	*100.0*
Other adult family members						
Very discriminatory	3	2.8	5	1.9	8	2.1
Discriminatory	3	2.8	13	4.8	16	4.2
No different	26	24.3	47	17.4	73	19.4
Supportive	51	47.7	133	49.3	184	48.8
Very supportive	24	22.4	72	26.7	96	25.5
Not applicable	7		10		17	
Total	*107*	*100.0*	*270*	*100.0*	*377*	*100.0*
Children in the family						
Very discriminatory	1	1.0	2	0.8	3	0.9
Discriminatory	5	4.9	6	2.5	11	3.2
No different	34	33.0	62	25.8	96	28.0
Supportive	50	48.5	117	48.8	167	48.7
Very supportive	13	12.6	53	22.1	66	19.2
Not applicable	11		40		51	
Total	*103*	*100.0*	*240*	*100.0*	*343*	*100.0*

Friends						
Very discriminatory	2	1.9	7	2.8	9	2.5
Discriminatory	14	13.1	24	9.6	38	10.7
No different	31	29.0	98	39.4	129	36.2
Supportive	51	47.7	107	43.0	158	44.4
Very supportive	9	8.4	13	5.2	22	6.2
Not applicable	7		31		38	
Total	*107*	*100.0*	*249*	*100.0*	*356*	*100.0*
Neighbours						
Very discriminatory	10	9.8	24	9.2	34	9.4
Discriminatory	16	15.7	34	13.1	50	13.8
No different	42	41.2	101	38.8	143	39.5
Supportive	32	31.4	88	33.8	120	33.1
Very supportive	2	2.0	13	5.0	15	4.1
Not applicable	12		20		32	
Total	*102*	*100.0*	*260*	*100.0*	*362*	*100.0*
Other PLHIV						
Very discriminatory	0	0.0	1	0.4	1	0.3
Discriminatory	1	0.9	2	0.8	3	0.8
No different	33	30.6	69	26.0	102	27.3
Supportive	63	58.3	159	60.0	222	59.5
Very supportive	11	10.2	34	12.8	45	12.1
Not applicable	6		15		21	
Total	*108*	*100.0*	*265*	*100.0*	*373*	*100.0*
Co-workers						
Very discriminatory	0	0.0	6	3.8	6	2.5
Discriminatory	11	14.3	8	5.0	19	8.0
No different	28	36.4	79	49.4	107	45.1
Supportive	38	49.4	61	38.1	99	41.8
Very supportive	0	0.0	6	3.8	6	2.5
Not applicable	37		120		157	
Total	*77*	*100.0*	*160*	*100.0*	*237*	*100.0*
Employers						
Very discriminatory	0	0.0	2	2.4	2	1.5
Discriminatory	3	6.7	6	7.1	9	6.9
No different	21	46.7	31	36.5	52	40.0
Supportive	20	44.4	39	45.9	59	45.4
Very supportive	1	2.2	7	8.2	8	6.2
Not applicable	69		195		264	
Total	*45*	*100.0*	*85*	*100.0*	*130*	*100.0*
Clients						
Very discriminatory	1	2.4	3	2.8	4	2.6
Discriminatory	2	4.8	10	9.2	12	7.9
No different	26	61.9	67	61.5	93	61.6
Supportive	13	31.0	29	26.6	42	27.8
Very supportive	0	0.0	0	0.0	0	0.0
Not applicable	72		171		243	
Total	*42*	*100.0*	*109*	*100.0*	*151*	*100.0*

Injecting drug partners						
Very discriminatory	1	9.1	0	0.0	1	5.0
Discriminatory	1	9.1	2	22.2	3	15.0
No different	5	45.5	3	33.3	8	40.0
Supportive	4	36.4	4	44.4	8	40.0
Very supportive	0	0.0	0	0.0	0	0.0
Not applicable	103		271		374	
Total	*11*	*100.0*	*9*	*100.0*	*20*	*100.0*
Religious leaders						
Very discriminatory	2	2.2	2	0.9	4	1.3
Discriminatory	3	3.4	2	0.9	5	1.7
No different	28	31.5	66	31.1	94	31.2
Supportive	52	58.4	115	54.2	167	55.5
Very supportive	4	4.5	27	12.7	31	10.3
Not applicable	25		68		93	
Total	*89*	*100.0*	*212*	*100.0*	*301*	*100.0*
Community leaders						
Very discriminatory	3	2.8	2	0.7	5	1.3
Discriminatory	5	4.7	7	2.6	12	3.2
No different	23	21.5	51	19.1	74	19.8
Supportive	66	61.7	167	62.5	233	62.3
Very supportive	10	9.3	40	15.0	50	13.4
Not applicable	7		13		20	
Total	*107*	*100.0*	*267*	*100.0*	*374*	*100.0*
Teachers						
Very discriminatory	2	3.1	2	1.3	4	1.8
Discriminatory	7	10.8	5	3.1	12	5.3
No different	36	55.4	86	53.8	122	54.2
Supportive	19	29.2	57	35.6	76	33.8
Very supportive	1	1.5	10	6.3	11	4.9
Not applicable	49		120		169	
Total	*65*	*100.0*	*160*	*100.0*	*225*	*100.0*
Health care workers						
Very discriminatory	1	0.9	1	0.4	2	0.5
Discriminatory	5	4.5	4	1.5	9	2.3
No different	19	17.3	32	11.6	51	13.2
Supportive	77	70.0	184	66.9	261	67.8
Very supportive	8	7.3	54	19.6	62	16.1
Not applicable	4		5		9	
Total	*110*	*100.0*	*275*	*100.0*	*385*	*100.0*
Social workers/counsellors						
Very discriminatory	1	1.2	2	0.9	3	1.0
Discriminatory	4	4.7	3	1.3	7	2.2
No different	19	22.1	47	20.6	66	21.0
Supportive	60	69.8	149	65.4	209	66.6
Very supportive	2	2.3	27	11.8	29	9.2
Not applicable	28		52		80	
Total	*86*	*100.0*	*228*	*100.0*	*314*	*100.0*

Question 6. Did you find the disclosure of your HIV status an empowering experience?

S3bQ6	Men (n=108)		Women (n=265)		Total (n=373)	
Variables	Freq	%	Freq	%	Freq	%
Yes	98	90.7	245	92.5	343	92.0
No	10	9.3	20	7.5	30	8.0
Not applicable	6		15		21	
Total	*108*	*100.0*	*265*	*100.0*	*373*	*100.0*

Section 3C – Treatment

Question 1. In general, how would you describe your health at the moment?

S3cQ1	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Excellent	5	4.4	11	3.9	16	4.1
Very good	36	31.6	87	31.1	123	31.2
Good	45	39.5	95	33.9	140	35.5
Not so good	25	21.9	82	29.3	107	27.2
Poor	3	2.6	5	1.8	8	2.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 2a. Are you currently taking antiretroviral treatment?

S3cQ2a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	105	92.1	243	86.8	348	88.3
No	9	7.9	37	13.2	46	11.7
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 2b. Do you have access to antiretroviral treatment, even if you are not currently taking

S3cQ2b	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	87	76.3	204	72.9	291	73.9
No	23	20.2	69	24.6	92	23.4
Don't know	4	3.5	7	2.5	11	2.8
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 3a. Are you currently taking any medication to prevent or to treat opportunistic infections?

S3cQ3a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	81	71.1	187	66.8	268	68.0
No	33	28.9	93	33.2	126	32.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 3b. Do you have access to medication for opportunistic infections, even if you are not currently taking it?

S3cQ3b	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Yes	95	83.3	238	85.0	333	84.5
No	16	14.0	39	13.9	55	14.0
Don't know	3	2.6	3	1.1	6	1.5
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 4. In the last 12 months, have you had a constructive discussion with a health care professional(s) on the subject of your HIV-related treatment options?

S3cQ4	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Yes	100	87.7	255	91.1	355	90.1
No	14	12.3	25	8.9	39	9.9
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 5. In the last 12 months, have you had a constructive discussion with a health care professional(s) on other subjects such as your sexual and reproductive health, sexual relationship(s), emotional well-being, drug use, etc?

S3cQ5	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Yes	92	80.7	227	81.1	319	81.0
No	22	19.3	53	18.9	75	19.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Section 3D – Having children

Question 1a. Do you have a child/children?

S3dQ1a	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	100	87.7	242	86.4	342	86.8
No	14	12.3	38	13.6	52	13.2
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 1b. If Yes, are any of these children known to be HIV-positive?

S3dQ1b	Men (n=100)		Women (n=242)		Total (n=342)	
Variables	Freq	%	Freq	%	Freq	%
Yes	26	26.0	77	31.8	103	30.1
No	20	20.0	40	16.5	60	17.5
No HIV+ Child	54	54.0	125	51.7	179	52.3
Total	*100*	*100.0*	*242*	*100.0*	*342*	*100.0*

Question 2. Since being diagnosed as HIV-positive, have you ever received counseling about your reproductive options?

S3dQ2	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	91	79.8	196	70.0	287	72.8
No	23	20.2	84	30.0	107	27.2
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

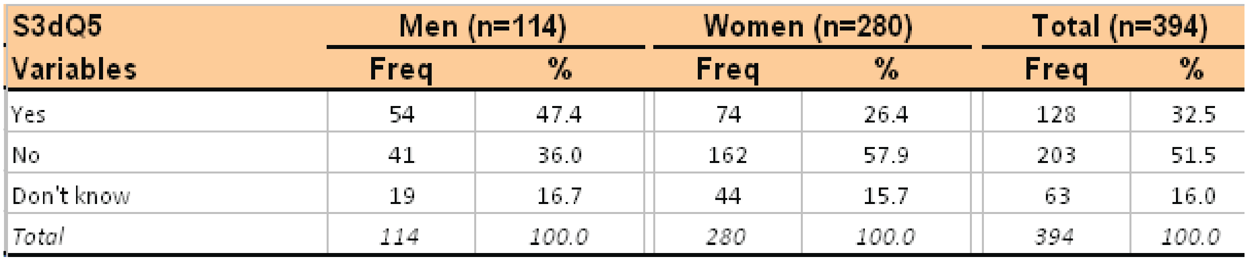
Question 3. Has a health care professional ever advised you not to have a child since you were diagnosed as HIV-positive?

S3dQ3	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	96	84.2	217	77.5	313	79.4
No	18	15.8	63	22.5	81	20.6
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 4. Has a health care professional ever recommended you into being sterilized since you were diagnosed as HIV-positive?

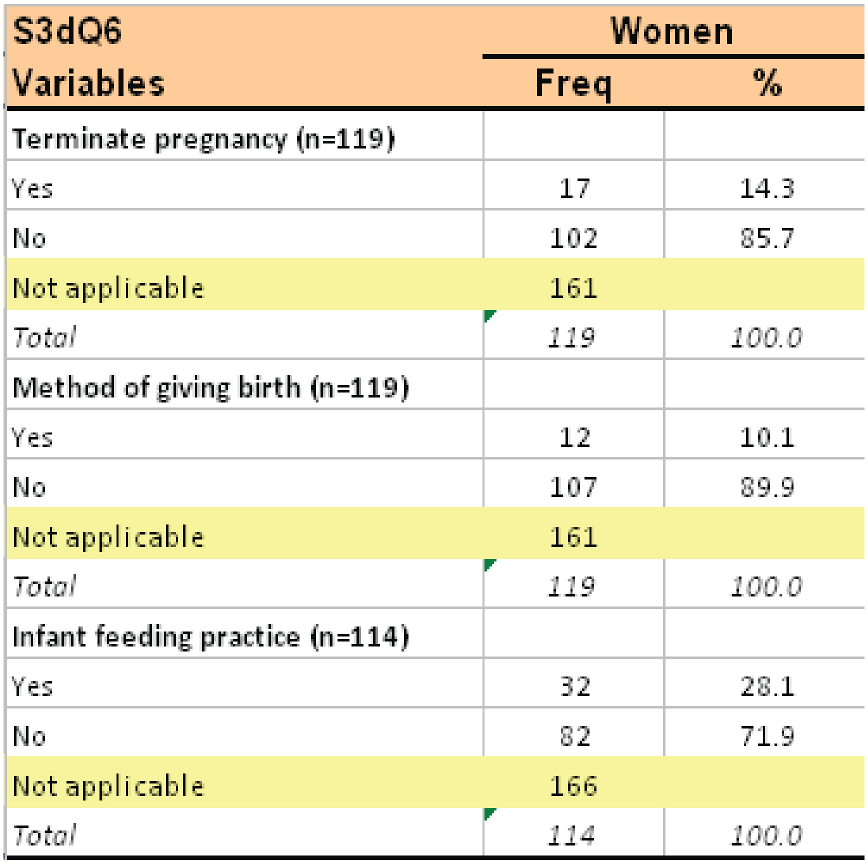
S3dQ4	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	Freq	%	Freq	%	Freq	%
Yes	25	21.9	51	18.2	76	19.3
No	89	78.1	229	81.8	318	80.7
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 5. Is your ability to obtain antiretroviral treatment conditional on the use of certain forms of contraception?



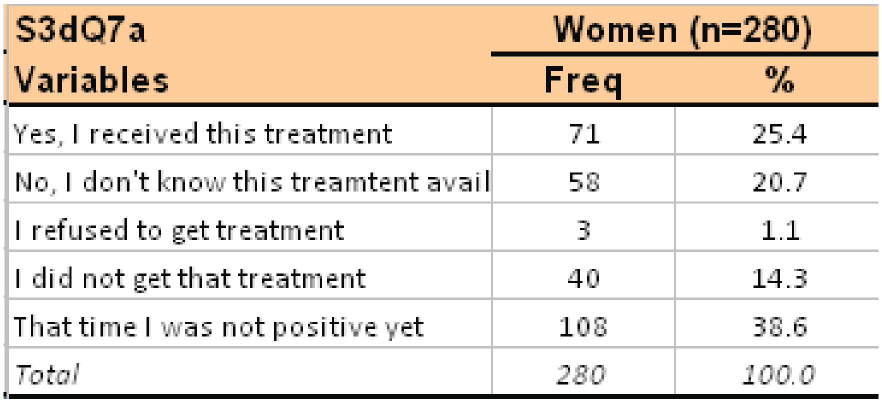
S3dQ5	Men (n=114)		Women (n=280)		Total (n=394)	
Variables	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**
Yes	54	47.4	74	26.4	128	32.5
No	41	36.0	162	57.9	203	51.5
Don't know	19	16.7	44	15.7	63	16.0
Total	*114*	*100.0*	*280*	*100.0*	*394*	*100.0*

Question 6. In the last 12 months, have you been strong advised by a health care professional in relation to any of the following because of your HIV status?



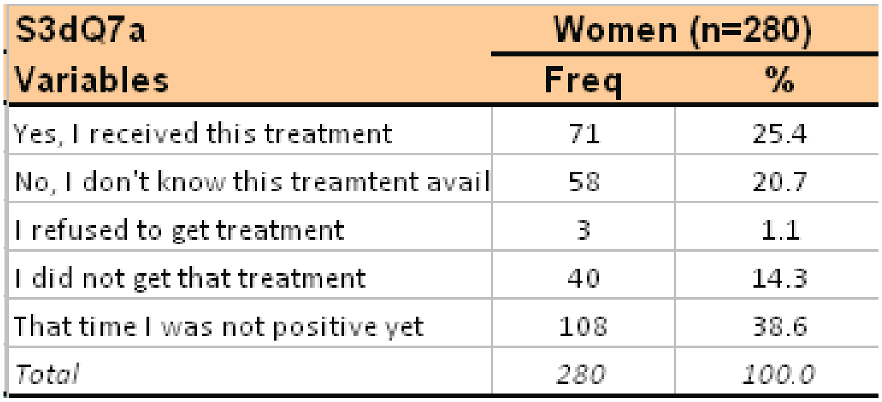
S3dQ6	Women	
Variables	**Freq**	**%**
Terminate pregnancy (n=119)		
Yes	17	14.3
No	102	85.7
Not applicable	161	
Total	*119*	*100.0*
Method of giving birth (n=119)		
Yes	12	10.1
No	107	89.9
Not applicable	161	
Total	*119*	*100.0*
Infant feeding practice (n=114)		
Yes	32	28.1
No	82	71.9
Not applicable	166	
Total	*114*	*100.0*

Question 7a. Have you ever been given antiretroviral treatment to prevent mother-to-child transmission of HIV during pregnancy?



S3dQ7a	Women (n=280)	
Variables	**Freq**	**%**
Yes, I received this treatment	71	25.4
No, I don't know this treamtent avail	58	20.7
I refused to get treatment	3	1.1
I did not get that treatment	40	14.3
That time I was not positive yet	108	38.6
Total	*280*	*100.0*

Question 7b. If yes, were you also given information about healthy pregnancy and motherhood as part of the program to prevent mother-to-child transmission of HIV?



S3dQ7a	Women (n=280)	
Variables	**Freq**	**%**
Yes, I received this treatment	71	25.4
No, I don't know this treamtent avail	58	20.7
I refused to get treatment	3	1.1
I did not get that treatment	40	14.3
That time I was not positive yet	108	38.6
Total	*280*	*100.0*

8.3. Field Guides

Focus Group Discussion with PLHIV

Introduction: The following is to be read by the moderator to the respondents: "The Cambodia People Living with HIV Network (CPN+), in collaboration with Khmer HIV/AIDS NGO Alliance (KHANA) is conducting a study on The PLHIV Stigma Index in five different provinces/municipality to understand about the care, supports, treatment, VCCT, works, experiences, rights and understanding of PLHIV in relation to stigma and discrimination.

We would like to request your cooperation for no more than 90 minutes to ask your participation with a focus group discussion. You are free to refuse to participate or to terminate your participation in the Focus Group Discussion at any time. Everything you say will be totally confidential. Your participation is very important. The information from this study will help the relevant stakeholders to improve the services: care, support, treatment and education including interventions in relation to rights promotion, capacity development, and participation of PLHIV in the society.

I would like to do a short game on trust – to help us think about what we mean by confidential

1. Trust

- Ask participants to sit in a circle (facilitator in a circle too)
- Ask the PLHIV to think of a secret that they would not want to tell anyone. Ask them to draw, make a shape, or write this down on a small piece of paper. Fold it up and do not show it to anyone
- Now ask the participants to pass their piece of paper to the person on their left
- Ask each person how if feels to have your secret in someone else hands (facilitator can record this on note book but only in a way all can understand (if literacy an issue this must be done with symbols)
- Now ask each person how it feels to have some ones secret in their hands. (facilitator can record feelings….as above)
- Now ask participants to give the paper back to the owner. Once done. All papers can be destroyed.
- Ask participants
    a. What does this tell us about confidentiality?
    b. What kind of things might people share with us that we should keep confidential?
    c. What rules should we have about confidentiality during this session?

2. Respondent's socio-demographic profile

No	Sex	Age	Marital Status	Household size	Job

3. Could you share with us how did you first find that you were positive? How long ago was that? And have been your experiences with the HIV status (relation with male and female members of families, male and female neighbor, male and female members of your community, place of religion, village chief, male and female health staff, male and female coworkers...)
4. What does the term "stigma and discrimination" mean to you?
5. What was the stigma and discrimination about?
6. Who help you to reduce the stigma and discrimination?
7. How did you and others try to solve the matter and what did you do?
8. Did you tell everyone that you are HIV positive? Who did you tell? Who did they react at that time? Did they tell to someone else about your status?
9. From your observation and experiences, how can you describe the differences (in term of living condition, business, health condition...) before and after your HIV status has been disclosed?
10. How do you get the care and treatment? How do you find the male and female health staff's attitude and behavior during your seeking for services (VCT, OI/ART, -adult or pediatric PMTCT, TB, SRH/FP, psychological support and home-based care) in terms of privacy, confidentiality, gossip, unfriendly behavior, and mistreatment? (Both supportive/helpful and/or unsupportive)
11. How do you experience in coping with your status (health care, medicine, living, children's schooling and spiritual support) What differences do you see, if any, in the way you experience health care, living, boys and girls, access and ability to cope in school to your neighbors' lives and their children?
12. What are problems and challenges in term of testing and diagnosis, disclosure and confidentiality, antiretroviral treatment and having children when you are HIV positive
13. Has your HIV status affected your employment status? Have you been fired or refused employment because of your HIV status?
14. Do you have anything else to discuss with us? or any Other comments and suggestions

Note: Clarifications or probes should be made if necessary for any question

Key informant interview with relevant service providers (health providers, community people,)

Introduction: The following is to be read by the interviewer to the respondent: "The Cambodia People Living with HIV Network (CPN+), in collaboration with Khmer HIV/AIDS NGO Alliance (KHANA) is conducting a study on Stigma Index of PLHIV in five different provinces/municipality to understand about the care, supports, treatment, VCCT, works, experiences, rights and understanding of PLHIV in relation to stigma and discrimination.

We would like to request your cooperation for no more than 60 minutes to ask you questions. You are free to refuse to participate or to terminate the interview at any time. All answers are totally confidential. Your participation is very important. The information from this study will help the relevant stakeholders to improve the services: care, support, treatment and education including interventions in relation to rights, promotion capacity development, and participation of PLHIV in the society.

1. General information of the respondent (age, sex, job and place of work)
2. Describe your services involving in HIV related (care, support and treatment, home & community based care)

- Privacy and confidentiality
- Attitude and behavior toward PLHIV
- Completeness of HIV information for the patients

3. How do you think or feel about your work? (Busy, unhappy, boring, workload…)
4. How do you think about the rights of PLHIV? Children living with HIV? MARP including MSM, ESW and DU
5. What does it mean to you the terms "stigma and discrimination" against PLHIV?
6. From your own perspective, is this issue still happening? (Community, workplace, health care settings, school…) and what are the form of stigma and discrimination that PLHIV (men/boys and women/girls/ESW/MSM/DU) typically experience?
7. From your thoughts, what are the problems and challenges faced by PLHIV and their families, including their children?
8. In your experience, have you observed anything positive that has come out of being HIV positive, any new appreciation of health? of living? Of making social contacts through HIV networks? Any benefits that you see that others with chronic illnesses do not get?
9. Are there any way to deal with stigma and discrimination against PLHIV? Are there any particular obstacles/issues facing men/boys more than women/girls? Women/girls more than men/boys? What are specific solutions for MARP?
10. What kind of support/assistance would make your job easier, and help you to better meet the needs of PLHIV?
11. Would you have anything else to share with us or and any other comments and suggestions

Note: Clarifications or probes should be made if necessary for any question

Thanks for your time and contribution!

8.4. Informed Consent Form

How do you do?

“The Cambodia People Living with HIV Network (CPN+), in collaboration with Khmer HIV/AIDS NGO Alliance (KHANA) is conducting a study on The PLHIV Stigma Index in five different provinces/municipality including Phnom Penh, Kampong Cham, Kampong Thom, Takeo and Battambang. This study aims to understand about the care, supports, treatment, VCCT, works, experiences, rights and understanding of PLHIV in relation to stigma and discrimination. The information from this study will help the relevant stakeholders to improve the services: education, care, treatment, and support, including interventions in relation to rights, promotion capacity development, and participation of PLHIV in the society.

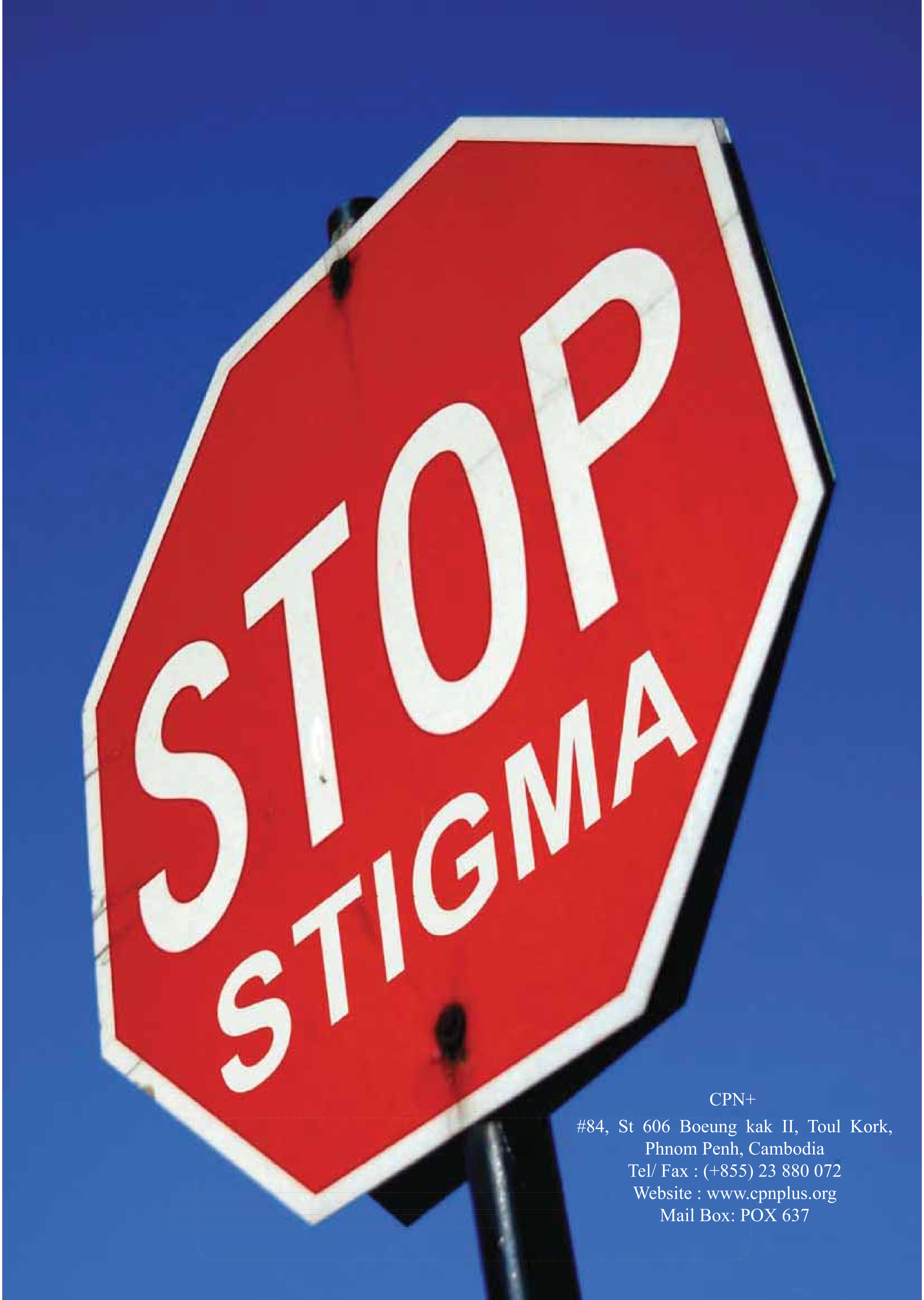
We are deeply grateful to you for your cooperation if you participate with us for about 45 minutes to ask you questions. All answers are totally confidential and guarantee that no one knows your response beside the study team. Your name will not be noted and you can refuse to answer to the question you do not want to. We do hope that you will participate and your participation is very important for this study.

Before starting the interview do you have any questions related to this study?

Date	Name and Signature of interviewer
....	………...

8.5. Advisory Committee Members

No.	Name	Sex	Organization/Agency
1	H.E Dr. Teng Kunthy	M	NAA
2	Kong Udom	M	CPN+
3	Leng Monyneath	M	BC
4	Tim Vora	M	HACC
5	Pen Mony	F	CCW
6	Pheng Pharozin	F	CACHA
7	Hean Senghorn	F	AUA
8	Klong Pichet	M	MoSVY
9	Sok Bunna	M	USAID
10	Tara Milani	F	USAID
11	Penelope Campbell	M	UNICEF
12	Keo Tha	F	WNU
13	Hout Totem	M	VC
14	Khiev Makara	M	RHAC
15	Savina Ammassari	F	UNAIDS
16	Sorn Sotheariddh	M	KHANA
17	Phon Yut Sakara	M	PACT CAMBODIA
18	Tek Vuthy	M	KORSANG
19	Katherine Moriarty	F	UNAIDS/UNDP



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