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O.S. Shevchenko[1], V.P. Kiba[2], R.S. Shevchenko[1], T.O. Chumachenko[1], I.A. Ovcharenko[3], O.O. Pohorielova[2]

[1] Kharkiv National Medical University, Kharkiv, Ukraine
[2] Non-Profit Communal Enterprise of the Kharkiv Regional Council «Regional Clinical Psychiatric Hospital No. 3», Kharkiv, Ukraine
[3] College of Medicine of Bălți, Bălți, Republic of Moldova

Assessment of Stigmatisation of Tuberculosis Patients, People Living with HIV, and Individuals with Mental and Behavioural Disorders Among Higher Medical Education Students

Social determinants, including prejudice and social labelling (stigmatisation), exert a profound impact on population health outcomes and equity in healthcare. Stigmatisation leads to severe psychological, social, and financial repercussions for patients – fostering low self-esteem, depression, social isolation, and compromised treatment adherence. Despite its recognised burden on healthcare systems, detecting and controlling stigmatisation remains a complex task. Evaluating attitudes among future medical professionals is crucial to identifying latent biases and developing effective destigmatisation strategies.

Objective — to evaluate the level of stigmatisation, tolerance, and social distance towards tuberculosis (TB) patients, people living with HIV (PLHIV), and individuals with mental and behavioral disorders among higher medical education students.

Materials and methods. The study was conducted within the research project «Development of Innovative Methods for Improving the Information and Diagnostic Component of Infectious Disease Surveillance to Enhance the Biosecurity of Ukraine». A total of 158 medical students completed an anonymous online survey via Google Forms consisting of 30 questions (10 per diagnostic category). The questionnaire was developed by the authors based on frequently reported clinical instances of stigma and discrimination, utilising dichotomous and Likert scale responses.

Results and discussion. The findings demonstrate a high baseline level of theoretical knowledge and legal awareness among students. Respondents overwhelmingly recognised equal societal rights. Tuberculosis: 94.8 % agreed to work alongside a recovered colleague, 98.3 % rejected a past TB diagnosis as valid grounds for employment denial, and 96.6 % debunked the myth that TB exclusively affects socially vulnerable populations. HIV/AIDS: 87.9 % affirmed equal educational rights without forced isolation, 75.9 % reported their attitude towards a classmate would remain unchanged upon learning of an HIV-positive status, and 81.0 % identified a desire to help as their primary reaction to a friend's diagnosis. Mental health: 96.6 % rejected the belief that mental disorders stem solely from hereditary factors or antisocial lifestyles, and 89.7 % opposed employment discrimination based on psychiatric history. However, a marked paradox emerged between theoretical declarations and everyday domestic or personal behaviours: 55.2 % of students would attempt to conceal a family member's TB diagnosis out of fear of social judgment. 53.4 % would refuse to share utensils or household items with an HIV-positive individual, and only 10.3 % would unequivocally agree to a romantic relationship with a person living with HIV. 58.6 % would refuse to share housing with a person diagnosed with bipolar affective disorder, and only 39.7 % felt comfortable in the company of someone open about psychiatric disorders. Furthermore, only 25.9 % to 29.3 % of students expressed complete confidence in their practical knowledge regarding infection prevention or psychological first aid.

Conclusions. Future healthcare professionals exhibit strong theoretical tolerance and support for civil rights in administrative and academic settings. Nevertheless, latent stigma, subconscious wariness, and fear of public disapproval remain prevalent in private and everyday life scenarios. These results highlight an urgent necessity to modernise medical curricula by shifting focus from purely theoretical instruction towards interactive destigmatisation programmes, practical infection control training, and psychological preparation for clinical practice.

Keywords

Stigmatisation, discrimination, tuberculosis, HIV, mental disorders.

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Life circumstances, as well as conditions within society, the community, and interpersonal relationships, constitute social determinants that directly affect our health [17]. Prejudice and social labelling (i.e. stigma), shaped by laws, societal norms, and personal attitudes, also act as a powerful determinant [10]. This process is triggered when a certain characteristic or trait of an individual or a group begins to be perceived by society as undesirable or inferior [14]. Consequently, the individual feels devalued and begins to view their own characteristic negatively, experiencing shame, self-disgust, and guilt [7]. Such a self-destructive stance forces the individual to hide their problem from others, withdraw into themselves, avoid communication, or even risk their own life [16].

It is essential to understand that stigmatisation differs from discrimination (another major factor detrimental to health) [4]. The primary objective of restricting rights (discrimination) is to exclude an individual from society and deprive them of opportunities, which does not necessarily require making them feel guilty [4]. However, individuals subjected to «labelling» often suffer from both afflictions simultaneously: they experience both psychological pressure and a loss of status or actual restriction of rights by a society that perceives them as «different» [14]. Despite being recognised as a massive problem that generates inequality in healthcare, it remains difficult to detect, measure, and control, which significantly complicates its resolution.

Drawing upon the classic definition by sociologist Erving Goffman, this unfair process consists of five steps:

1. People notice a difference between themselves and someone else and place a «label» on this difference.
2. This trait is linked to negative stereotypes and something unpleasant.
3. Labelled individuals are separated from the rest of society, dividing the world into «us» and «them».
4. The individual loses social status and faces discrimination.
5. Those who stigmatise possess real power and advantage over those who are stigmatised [14].

Stigmatisation can be either intentional or unconscious, but the outcome is always the same — rejection and injustice. When it comes to illnesses, the root cause of such attitudes is most frequently a basic lack of knowledge about the disease and a panic-driven fear of contagion [5]. Therefore, it is crucial for destigmatisation to take place within society — meaning education, debunking myths, and restoring respect and support to patients.

Today, three main forms of this phenomenon are identified:

- Anticipated stigma — occurs when a patient, upon learning of their diagnosis, already fears and expects contempt from others.
- Experienced stigma — refers to the actual experience where an individual has personally encountered worse treatment due to their illness [8].
- Internalised stigma (self-stigma) — happens when an individual internalises negative myths about themselves and begins to engage in self-blame [1].

All of this leads to severe psychological, social, and financial consequences that ruin the quality of life [11]. The individual suffers from low self-esteem, falls into depression, and experiences suicidal ideation and constant anxiety. They withdraw from the world, lose their job, income sources, and any opportunities for normal development [6].

Objective — to assess the stigmatisation of tuberculosis patients, people living with HIV, and individuals with mental and behavioural disorders among higher medical education students.

Materials and methods

The study was performed within the framework of the research project «Development of Innovative Methods for Improving the Information and Diagnostic Component of Infectious Disease Surveillance to Enhance the Biosecurity of Ukraine». A total of 158 higher medical education students participated in the study. Utilising Google Forms, the students completed an anonymous survey consisting of 30 questions regarding the stigmatisation of tuberculosis (TB) patients, people living with HIV, and individuals with mental and behavioral disorders. The questionnaire was developed by the authors of this article based on the most frequent reports of stigmatisation and discrimination encountered by patients in clinical practice. Both dichotomous and Likert scale questions were employed. The questionnaires are presented in Tables 1—3.

Results

The survey conducted among higher medical education students allowed for an assessment of the actual level of stigmatisation and tolerance of future healthcare professionals towards people who are currently ill with or have recovered from tuberculosis (Fig. 1).

The results demonstrate a high level of professional awareness and legal culture among the students. The vast majority of respondents are free from basic biases in the field of employment:

- 94.8 % of respondents would have no problem agreeing to work in the same team with a colleague who has successfully completed their anti-tuberculosis treatment course.

Table 1. **Questionnaire on the Stigmatisation of Tuberculosis Patients**

№	Question	Answer options
1	Would you agree to work in the same team with a person who has successfully completed a course of anti-tuberculosis treatment?	Yes; No
2	Would you maintain a friendly relationship with a person if you learned that they are currently receiving outpatient treatment for tuberculosis (and are non-infectious)?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
3	Do you believe that tuberculosis exclusively affects vulnerable segments of the population (homeless individuals, people with alcohol/drug addiction)?	Yes; No
4	Would you feel uncomfortable sharing public transport with someone who has recovered from tuberculosis?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
5	Would you be willing to buy groceries at a store where the shop assistant has recovered from tuberculosis (and has a medical certificate stating they currently do not have active TB)?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
6	If a close relative or family member were diagnosed with tuberculosis, would you attempt to conceal this fact from acquaintances and neighbours?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
7	Do you believe that individuals with a history of tuberculosis should have the right to be employed in educational or healthcare facilities?	Yes; No
8	Would you be willing to share a meal at the same table with someone who has a certificate proving full recovery from tuberculosis?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
9	Do you think that a past diagnosis of tuberculosis should be a reason to deny someone employment?	Yes; No
10	Do you feel you have enough knowledge about how to protect yourself from tuberculosis and prevent its spread in society?	Yes; Somewhat agree; Undecided; Somewhat disagree; No

Table 2. **Questionnaire on the Stigmatisation of People Living with HIV**

№	Question	Answer options
1	Would you be willing to be friends with someone living with HIV?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
2	Would you feel uncomfortable sharing a classroom with an HIV-positive person?	Would not feel any discomfort at all; Would feel slight discomfort; Would feel uncomfortable; Would absolutely not want to be near them
3	Would you be willing to share dishes or household items with someone who has HIV?	Yes; No
4	If you found out that a classmate of yours was HIV-positive, would your attitude towards them change?	No, my attitude would remain the same; I would become more cautious around them; I would try to limit my interaction with them; I would cut off all contact
5	Do you think that students living with HIV should study in separate groups or via remote learning to avoid putting others at risk?	Yes, this would be an appropriate safety measure; Rather yes; No, they have the same right to education as everyone else; Hard to say
6	Would you be open to a romantic relationship with someone knowing they are HIV-positive (provided that protection and antiretroviral therapy are used)?	Yes; Maybe, if I had full information; No, this is unacceptable to me; Hard to say
7	Do you think that a person should be required to disclose their HIV status to friends or colleagues?	Yes, it should be mandatory; Only if there is a risk of transmission; No, it is a personal matter and everyone's right; Hard to say
8	Does the thought of casual contact with someone living with HIV cause you to feel fear or anxiety?	Yes, constantly; Sometimes, when I am unsure about the modes of transmission; No, I understand how the virus is transmitted and how to protect myself
9	If a close friend of yours told you they were HIV-positive, what would your first reaction be?	Support and a desire to help; Shock and confusion; Fear for my own health
10	Do you think that in our society, people living with HIV face unfair treatment and discrimination?	Yes, very often; No, people are accepting of it now; It happens sometimes; Hard to say

Table 3. **Mental and Behavioral Behavioural Stigma Questionnaire**

№	Questions	Answer options
1	Would you be willing to work in the same team with someone who has been diagnosed with a mental disorder but is in stable remission?	Yes; No
2	Would you continue being friends with someone if you found out they were seeing a psychiatrist or taking antidepressants?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
3	Do you believe that mental disorders only affect people with a family history of mental illness or those who lead an antisocial lifestyle?	Yes; No
4	Would it make you feel uncomfortable to spend time with a person who is open about their past psychiatric hospitalisation?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
5	Would you be willing to use the services of a professional (such as a lawyer, hairstylist, or tutor) if you knew they had a behavioural disorder that does not interfere with their professional activities?	Yes; No
6	If a loved one of yours had a mental disorder, would you try to hide this fact from acquaintances and neighbours out of fear of judgment?	Yes; Somewhat agree; Undecided; Somewhat disagree; No
7	Do you believe that a person who is successfully managing a mental disorder has the right to work in educational institutions or hold high-level government positions?	Yes; No
8	Would you be willing to share housing with someone who has a formally diagnosed condition (such as bipolar affective disorder) but follows their doctor's recommendations?	Yes; No
9	Do you believe that a history of a psychiatric diagnosis should be grounds for denying employment?	Yes; No
10	Do you feel you have enough knowledge on how to provide psychological first aid and where to seek help if mental health issues arise?	Yes; Somewhat agree; Undecided; Somewhat disagree; No

- 98.3 % clearly understand that a past diagnosis of tuberculosis cannot serve as grounds for denying employment.
- 93.1 % confirm the right of individuals who have recovered from the disease to work in educational or healthcare institutions.

Notably, there is a readiness to interact with such individuals in everyday life: over 84 % of respondents are willing to buy groceries from a vendor who holds a medical certificate proving the absence of an active form of TB (the sum of «Yes» — 58.6 % and «Rather yes» — 25.9 % responses).

Despite general legal tolerance, the analysis of the responses revealed hidden psychological barriers and manifestations of everyday stigma:

- Shared daily life: only 58.6 % of students would have no hesitation in sharing a lunch at the same table with a fully recovered person. The remaining cohort (specifically 32.8 % for «Rather yes» and the rest who hesitated) demonstrates a certain subconscious wariness.
- Public transport: over 80 % of respondents noted that they would not feel uncomfortable sharing public transport with a recovered individual (51.7 % «Rather no», 29.3 % «No»). However, nearly one in seven students (13.8 %) still experiences internal anxiety («Rather yes»).
- Outpatient treatment: in a scenario where a loved one is undergoing outpatient treatment and is non-infectious (does not spread mycobacteria), the absolute majority would continue their friendly relationship (a combined 81.1 % of «Rather yes» and «Yes» responses). At the same time, 13.8 % of future doctors found it hard to answer this question, indicating a lack of confidence in the epidemiological safety of such patients.

The primary paradox lies in the correlation between theoretical knowledge and its practical perception. An overwhelming 96.6 % of students completely and rightfully debunk the social myth, stating that TB does not solely affect representatives of «socially vulnerable» segments of the population. However, if TB were detected in their own loved one, more than half of the respondents (55.2 % — the sum of «Yes» and «Rather yes» answers) would try to hide this fact from acquaintances and neighbours. This indicates a high level of fear of social disapproval (internalised stigma). The underlying cause of such behaviour may be dissatisfaction with their own knowledge: only 25.9 % of respondents are firmly confident that they have sufficient knowledge regarding TB protection and halting its spread, while the majority (58.6 %) answered only «Rather yes».

The analysis conducted among higher medical education students to assess the level of tolerance and identify potential manifestations of stigmatisation towards people living with HIV (PLHIV) indicates a generally high level of baseline tolerance and a humanistic attitude among future doctors towards this patient group (Fig. 2). Specifically, the vast majority of respondents (74.2 %) declare a

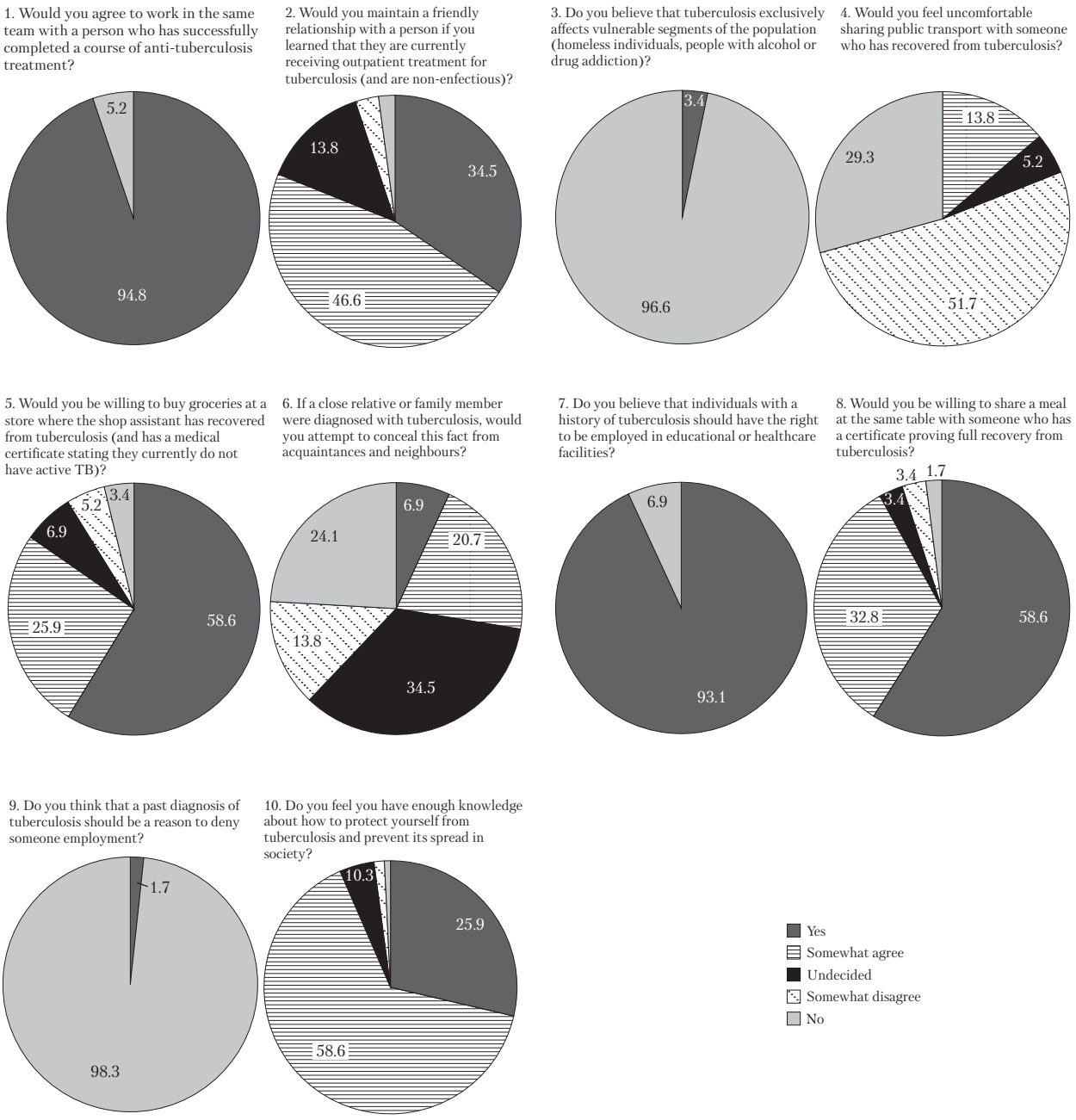

Fig. 1. **Survey results on higher medical education students' «attitudes towards tuberculosis patients», %**

readiness for friendly relationships with PLHIV (the sum of «Yes» and «Rather yes» responses). The absolute majority of those surveyed (72.4 %) would not feel any discomfort sharing a classroom with an HIV-positive individual, and 75.9 % of students noted that their attitude towards a classmate would not change if they discovered their positive HIV status. Furthermore, 87.9 % of respondents are firmly convinced that students living with HIV have the same rights to education as everyone else and should not be isolated into separate groups or transferred to remote learning.

Another indicator of high empathy within the micro-social environment is the willingness to support a loved one: 81 % of respondents stated that if a friend were diagnosed with HIV, their primary reaction would be a desire to help, whereas fear for their own health as an initial reaction was chosen by only a few isolated respondents. Moreover, 84.5 % of future doctors clearly understand the routes of viral transmission and protective measures, which eliminates feelings of casual anxiety or fear during routine daily contact.

At the same time, the study revealed certain areas of psychological discomfort and wariness associated with a deeper domestic or personal level of interaction, which may indicate the presence of so-called «hidden» or latent stigma.

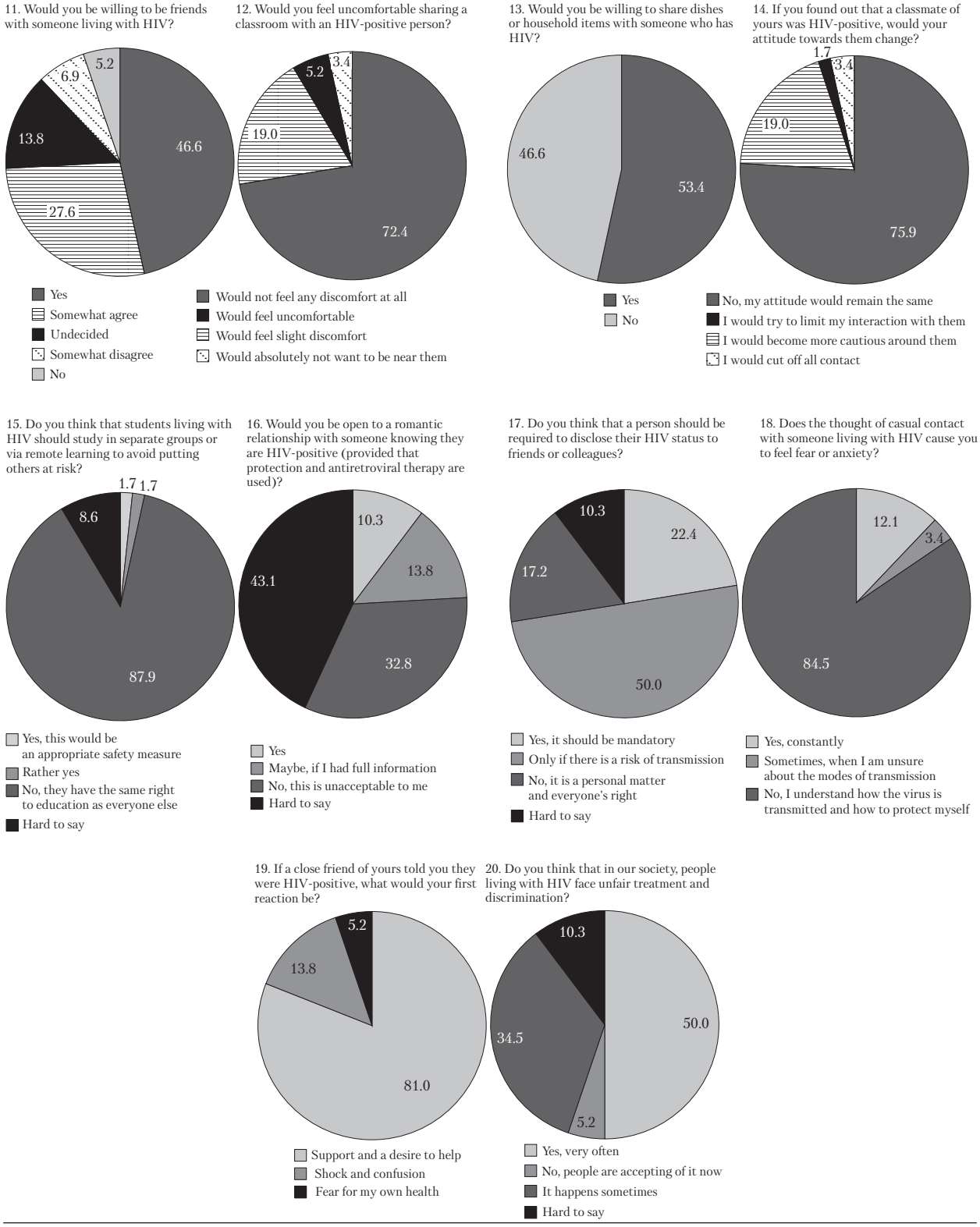

Fig. 2. **Results of the survey of higher education applicants at medical universities on their attitudes towards people living with HIV, %**

Domestic level: more than half of those surveyed (53.4 %) would refuse to share utensils or household items with a person living with HIV. This points to a certain gap between theoretical knowledge regarding the safety of casual contact and actual behavioural mindsets.

Personal level: only 10.3 % of respondents would unequivocally agree to a romantic relationship with an HIV-positive person (even under the condition of using protection and antiretroviral treatment), whereas a significant portion (32.8 %) considers this unacceptable, and 43.1 % were unable to give a clear answer.

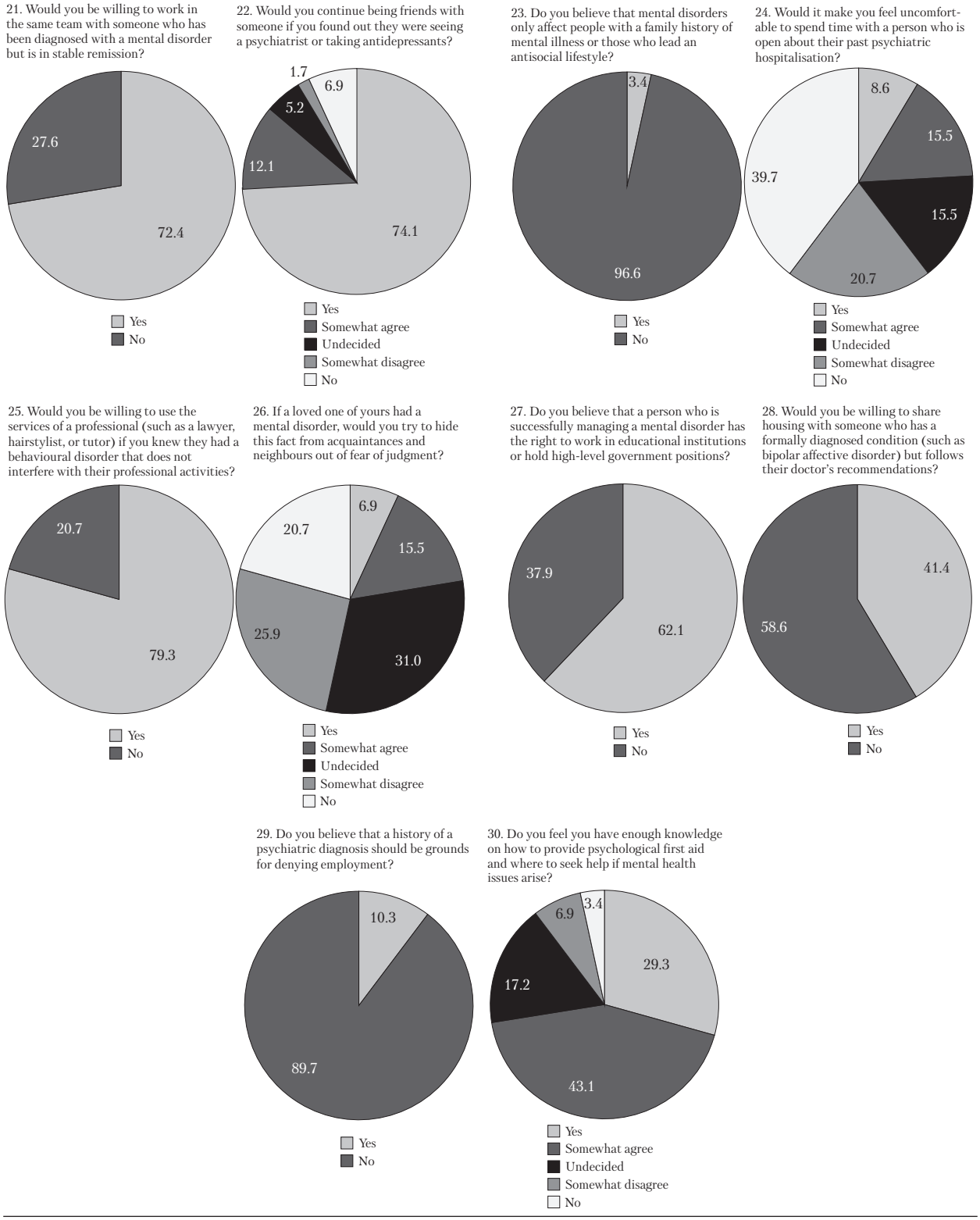

Fig. 3. **Survey results of higher medical education applicants regarding their attitudes towards individuals with mental and behavioural disorders, %**

Ethical aspect and destigmatisation: half of the respondents (50 %) believe that HIV status should only be disclosed to friends or colleagues if there is a risk of transmission, thereby recognising an individual's right to privacy. Meanwhile, exactly half of the students (50 %) state that in modern society, people living with HIV are still very frequently subjected to unfair treatment and discrimination.

An analysis of the results of the study on the level of stigmatisation of individuals with mental and behavioural disorders among higher medical education applicants (Fig. 3) demonstrates a generally

high level of theoretical tolerance and understanding of the nature of mental illness, yet reveals certain manifestations of social distance in practical life situations.

The debunking of fundamental myths about mental disorders is a highly positive trend. The vast majority of respondents (96.6 %) do not link the occurrence of mental disorders exclusively to «hereditary burden» or an antisocial lifestyle. Additionally, 89.7 % of those surveyed believe that a history of a psychiatric diagnosis should not be a ground for employment denial. Furthermore, the overwhelming majority of students (74.1 %) would continue their friendship without hesitation with a person who visits a psychiatrist or takes antidepressants.

Regarding joint professional activities, the medical community demonstrates a readiness for integration: 72.4 % of respondents would agree to work in the same team with a colleague in a state of stable remission of a mental disorder. Moreover, 79.3 % are ready to use the services of specialists (lawyers, hairdressers, etc.), knowing they have a behavioural disorder that does not interfere with their professional activities. At the same time, the question regarding the right of such individuals to work in educational institutions or hold responsible public office sparked some debate: although the majority (62.1 %) supports this right, over a third of respondents (37.9 %) opposed it, indicating the presence of certain apprehensions.

The most pronounced manifestations of stigma (specifically, internal and social distance) are observed in private life. Only 39.7 % of future doctors are confident that they would not feel discomfort in the company of a person who openly speaks about their experience of psychiatric hospitalisation. Less than half of the respondents (41.4 %) expressed a willingness to share accommodation (co-rent) with a person who has an official diagnosis (e.g., bipolar affective disorder), while 58.6 % refused. The level of fear of public condemnation is indicative: in the case of a mental disorder in a loved one, only 20.7 % of students would definitely not hide this fact from neighbours and acquaintances, while the remaining respondents would either try to conceal it (15.5 % — «rather yes», 5.2 % — «yes») or were unsure of their actions (31 % were hesitant to answer).

The obtained results may be partially due to the level of students' subjective preparedness: only 29.3 % of those surveyed were fully confident in their knowledge regarding the provision of psychological first aid and patient pathways. The majority (43.1 %) answered «rather yes»; however, a significant share of future specialists still felt a lack of clear algorithms or psychological uncertainty.

Discussion

Tuberculosis is known to cause many physical, social, economic, and mental problems in patients due to its long treatment period, affecting patients economically, socially, and psychologically, causing fear in society due to its contagious nature, and leading to social isolation, discrimination, and stigma [2]. This becomes one of the biggest obstacles in the fight against tuberculosis and can lead to the interruption and delay of treatment, affecting adherence to therapy [12].

Examples of unfounded stereotypes, myths, and misconceptions associated with people living with HIV are beliefs that these individuals are responsible for their illness due to their sexual behaviour and, therefore, bear full responsibility for their HIV-positive status. Negative attitudes include rejection, disgust, hostility, or anger, and manifest in the relationships between the majority and the negatively labelled minority. HIV-related stigma is a widespread phenomenon that manifests in many social settings, including healthcare facilities [3]. A number of meta-analyses have demonstrated a significant association between HIV stigma and depression, adherence to antiretroviral therapy, as well as access to and utilisation of medical and social services [15].

Mental illness-related stigma, including that existing within the healthcare system and among healthcare professionals, has been identified as a major barrier to treatment access and recovery, as well as a factor contributing to lower-quality physical care for individuals with mental illness [13]. People with lived experience of mental illness often report feeling humiliated, degraded, and dehumanised by many healthcare workers and other individuals they come into contact with [9].

The results of the conducted study indicate a high level of professional awareness, legal culture, and basic tolerance among future doctors. The vast majority of higher education students demonstrate a humanistic attitude towards vulnerable population groups and successfully debunk outdated social myths and prejudices. In particular, a clear understanding of the equality of patients' rights in the spheres of employment and education can be observed within the academic environment. Future doctors express readiness for collegial interaction and joint professional activity, which indicates the formation of a solid foundation of universal human values as early as during their studies at a higher education institution.

At the same time, the analysis of the responses revealed a deep paradox embedded in the gap between theoretical knowledge and its practical perception in real life. Despite general legal tolerance, hidden psychological barriers and elements of

social distance manifest in situations of direct everyday or personal interaction. This becomes evident when transitioning from public declarations to private space: the willingness to share housing, use common household items, or share a meal causes subconscious wariness and anxiety in a significant portion of respondents. Particularly telling is the high level of internal stigma and fear of public condemnation, as in the case of detecting a disease in a close relative, most respondents would try to conceal this fact from others.

Such contradictory behaviour among future professionals may be directly linked to the level of their subjective self-doubt. The obtained data highlight an urgent need to modernise the educational process in medical universities. The emphasis must shift from the purely informative presentation of clinical facts to the development of practical destigmatisation skills, overcoming internal fears, and fostering psychological readiness to work in real sociocultural conditions.

Conclusions

Medical students possess a high level of theoretical knowledge and declared tolerance towards patients with tuberculosis, HIV, and mental and behavioural disorders within professional and academic environments. However, at the everyday and personal levels, psychological discomfort, elements of social stigmatisation, and fear of public condemnation in close contacts with such individuals still persist. This justifies an urgent need to strengthen the practical and psychological training of future doctors, deepen their knowledge of infection control, and introduce specialised destigmatisation programmes and interactive classes to overcome internal biases.

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О.С. Шевченко[1], В.П. Киба[2], Р.С. Шевченко[1], Т.О. Чумаченко[1], І.А. Овчаренко[3], О.О. Погорєлова[2]
[1]Харківський національний медичний університет, Харків
[2]Комунальне некомерційне підприємство Харківської обласної ради «Обласна клінічна психіатрична лікарня № 3», Харків
[3]Бєльцький медичний коледж, Бєльці, Республіка Молдова

Оцінка стигматизації пацієнтів із туберкульозом, людей, які живуть із ВІЛ, й осіб із розладами психіки та поведінки серед здобувачів вищої медичної освіти

Соціальні детермінанти, зокрема упередження та соціальне таврування (стигматизація), значним чином впливають на показники здоров'я населення та рівність у сфері охорони здоров'я. Стигматизація призводить до тяжких психологічних, соціальних і фінансових наслідків для пацієнтів, призводить до формування низької самооцінки, депресії, соціальної ізоляції та порушення прихильності до лікування. Попри визнаний тягар для систем охорони здоров'я, виявлення та контроль стигматизації залишаються складним за вданням. Оцінка ставлення майбутніх медичних лікарів є критично важливою для виявлення прихованих упереджень і розробки ефективних стратегій дестигматизації.

Мета роботи — оцінити рівень стигматизації, толерантності та соціальної дистанції щодо хворих на туберкульоз (ТБ), людей, які живуть з вірусом імунодефіциту людини (ВІЛ), та осіб із психічними та поведінковими розладами в здобувачів вищої медичної освіти.

Матеріали та методи. Дослідження проведено в межах науково-дослідного проєкту «Розробка інноваційних методів удосконалення інформаційно-діагностичного компонента епіднагляду за інфекційними хворобами для підвищення біобезпеки України». Проведено анонімне онлайн-опитування 158 студентів-медиків через Google Forms, що містило 30 запитань (по 10 на кожну діагностичну категорію). Анкету було розроблено авторами на основі часто описуваних клінічних випадків стигми та дискримінації з використанням дихотомічних відповідей та шкали Лайкерта.

Результати та обговорення. Отримані дані демонструють високий вихідний рівень теоретичних знань і правової обізнаності студентів. Більшість респондентів визнали рівність суспільних прав. Туберкульоз: 94,8 % погодилися працювати поряд із колегою, який одужав від ТБ, 98,3 % не вважають факт наявності ТБ у минулому законною підставою для відмови в прийнятті на роботу, 96,6 % спростували міф про те, що ТБ уражає лише соціально вразливі верстви населення; ВІЛ/синдром набутого імунодефіциту: 87,9 % погодилися з твердженням про однакові права на освіту без примусової ізоляції, 75,9 % зазначили, що їхнє ставлення до одногрупника не зміниться, якщо вони дізнаються про його ВІЛ-позитивний статус, 81,0 % назвали бажання допомогти своєю первинною реакцією на діагноз друга. Психічне здоров'я: 96,6 % не погодилися з тим, що психічні розлади зумовлені лише спадковими чинниками чи асоціальним способом життя, а 89,7 % проти дискримінації при працевлаштуванні через психіатричний анамнез. Однак виявлено парадокс між переконаннями та побутовою чи особистою поведінкою: 55,2 % студентів намагалися б приховати діагноз ТБ у члена родини через страх перед соціальним осудом, 53,4 % відмовилися б ділити посуд або побутові речі з ВІЛ-позитивною людиною, лише 10,3 % однозначно погодилися б на романтичні стосунки з людиною, яка живе з ВІЛ, 58,6 % відмовилися б проживати в одному помешканні з людиною з діагнозом «біполярний афективний розлад» і лише 39,7 % почувалися б комфортно в компанії особи, яка відверто розповідає про свої психічні розлади. Лише 25,9—29,3 % студентів висловили повну впевненість у своїх практичних знаннях щодо профілактики інфекцій або надання першої психологічної допомоги.

Висновки. Майбутні лікарі продемонстрували високу теоретичну толерантність і підтримку цивільних прав в адміністративному й академічному середовищах, але прихована стигма, підсвідома настороженість і страх громадського осуду залишаються поширеними в приватній і повсякденній сферах життя. Отримані результати свідчать про нагальну потребу модернізації медичних навчальних програм шляхом зміщення акценту із суто теоретичного навчання на інтерактивні програми дестигматизації, практичну підготовку з інфекційного контролю та психологічну готовність до клінічної практики.

Ключові слова: стигматизація, дискримінація, туберкульоз, ВІЛ, психічні розлади.

Контактна інформація / *Corresponding author*

Шевченко Ольга Станіславна, д. мед. н., професор кафедри інфекційних хвороб, дитячих інфекційних хвороб та фтизіатрії
https://orcid.org/0000-0002-5476-3981
E-mail: os.shevchenko@knmu.edu.ua

В.П. Киба, https://orcid.org/0009-0003-4806-5479
Р.С. Шевченко, https://orcid.org/0000-0002-6535-0939
Т.О. Чумаченко, https://orcid.org/0000-0002-4175-2941
І.А. Овчаренко, https://orcid.org/0000-0001-6953-9029
О.О. Погорєлова, https://orcid.org/0000-0003-4819-9373

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