

GENDER BASED VIOLENCE AND HIV/AIDS IN GEORGIA: LINKS, OPPORTUNITIES AND POTENTIAL RESPONSES



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United Nations Entity for Gender Equality
and the Empowerment of Women



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This research has been carried out by ACT Research for UN WOMEN Georgia, in cooperation with UNAIDS



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Technical editor: Mzia Tabatadze

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LIST OF ABBREVIATIONS:

- AIDS** – Acquired Immunodeficiency Syndrome
- ATIPFUND** – State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking
- BSS** – Behavioural Surveillance Survey
- DEVAW** – The Declaration on the Elimination of Violence Against Women
- DV** – Domestic Violence
- EECA** – Eastern Europe and Central Asia
- GBV** – Gender Based Violence
- GHRN** – Georgia Harm Reduction Network
- GoG** – government of Georgia
- HIV** - Human Immunodeficiency Virus
- IDI** – in-depth interview
- IDU** – injecting drug user
- NGO** – Non-Governmental Organization
- PLHIV** – people living with HIV
- PWID** – people who inject drugs
- RTI** – Research Triangle Institute International
- STI** – sexually transmitted infection
- SW** – sex worker
- TGF** – The Global Fund
- UNAIDS** - The Joint United Nations Programme on HIV/AIDS

1. INTRODUCTION

“I wanted to protect myself, but he was often against it. I sometimes resisted and refused to have sex with him, however he always insulted me and in order to avoid further violation, I agreed...” (Irma, HIV positive woman from Samegrelo region, Georgia)

“Everyone is pointing the finger at me because I am infected; everyone is talking about this... When other people found out... I locked myself in the house and have no courage to go out. (Lika, HIV positive woman from Imereti region, Georgia)

“I should have used contraception as long as my husband was a drug addict... But I could not imagine something like that could have happened to me.” (Lela, HIV positive woman from Adjara region, Georgia)

There is growing evidence from different countries, including the countries in the EECA region, that gender based violence can increase the risk of HIV/AIDS as well as be an outcome of HIV/AIDS. Georgia is among the countries with a low prevalence of HIV/AIDS among general population (0.05%) with concentrated HIV epidemic among men who have sex with men.¹ According to updated estimates (Spectrum EPP) the number of people living with HIV/AIDS in the country

was estimated at 4400 in 2010 and 5000 in 2011.² Georgia is one of the nine countries in the world where the incidence rate of HIV among adults 15-49 years old has increased by more than 25% over the past decade, 2001-2011.³ There is growing evidence that the epidemics of HIV and GBV may overlap and interact in several complex ways. Many studies have shown the increasing links between violence against women and HIV and demonstrated that HIV-infected women are more likely to have experienced violence and, that women who have experienced violence are at higher risk for HIV/AIDS.⁴

As both, research and programming at the intersection of GBV and HIV expand, there is need to further examine the complex aspects of the relationship between the two issues, including their association with vulnerability and risk-taking behaviours.⁵ Given the absence of any reliable information about the intersection of HIV and GBV in Georgia, a study - “Gender Based Violence (GBV) and HIV in Georgia: Links, Opportunities and Potential Responses” was conducted in 2012 year within the frames of the UN WOMEN Georgia. For the sake of brevity and simplicity, hereafter the study will be referred to as GBV & HIV in Georgia study.

¹Global AIDS Response Progress Report, Georgia, January 2010-December 2011, p.3 Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/> [Accessed 24.04.2013].

²Ibid., p.4

³UNAIDS Report on the Global AIDS Epidemic 2012, State of the Epidemic, p.11

⁴UN Women RFP, Research on GBV and HIV/AIDS, 2011, p.20

⁵HIV/AIDS and GBV; Literature Review; Harvard School of Public Health, p.8. Available at: <https://www.google.com/#q=Harvard+school+HIV+GBV> (Accessed 19.09.2013).

2. RESEARCH DESIGN

2.1. Research Goal and Objectives

The major goal of the GBV and HIV in Georgia study was to examine and analyze the links between Gender Based Violence and HIV infection in the country. The study focused on the following objectives:

- To evaluate how gender based violence can influence prevalence of HIV infection;
- To evaluate how HIV infection can fuel gender based violence;
- To study the services in terms of gender based violence and HIV prevention and, study the barriers to accessibility of these services.

Research General Overview

The GBV & HIV in Georgia study was conducted by local research agency- ACT Research in close collaboration with the Infectious Diseases, AIDS and Clinical Immunology Research Centre (AIDS Centre in Tbilisi). Skilled doctor epidemiologists from the AIDS Center served as independent consultants for the study. The process of development of study design, selection of target groups, and refining research instruments was participatory and involved consultations with partner organizations and key experts as well as representatives of UN Women and UNAIDS in Georgia.

The GBV & HIV in Georgia study involved several components with various research methodologies and different target groups. The study can be divided into three major components:

Component I: initial phase of the study was desk research that involved reviewing of available policy documents and reports of the researches conducted in the area of HIV, GBV and women's reproductive health in Georgia.

Component II: The qualitative research involved in-depth and narrative interviews with three different thematic groups of study population:

1. Representatives of NGOs working in the field of either GBV or HIV/AIDS;
2. Representatives of key populations attending the GBV support centres and HIV/AIDS prevention and treatment services: women survivors of GBV, female sex workers and women who inject drugs;
3. Women living with HIV and attending services at the AIDS Centres in Tbilisi, Batumi, Kutaisi, Zugdidi

Component III: The quantitative research among women living with HIV and attending services at the AIDS Centres in Tbilisi, Batumi, Kutaisi and Zugdidi.

Based on study findings, a set of policy recommendations was elaborated to strengthen coordination and integration between the GBV prevention and HIV prevention national policies in Georgia. The draft of the research report, major findings and recommendations were presented to and discussed with the stakeholders (governmental and non-governmental organizations) at the dissemination meeting. Comments provided by stakeholders were incorporated into the final version of the study report.

¹Global AIDS Response Progress Report, Georgia, January 2010-December 2011, p.3 Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/> [Accessed 24.04.2013].

²Ibid., p.4

³UNAIDS Report on the Global AIDS Epidemic 2012, State of the Epidemic, p.11

⁴UN Women RFP, Research on GBV and HIV/AIDS, 2011, p.20

⁵HIV/AIDS and GBV; Literature Review; Harvard School of Public Health, p.8. Available at: <https://www.google.com/#q=Harvard+school+HIV+GBV> (Accessed 19.09.2013).

2.2. Research Methods, Target Groups and Sampling

In the process of research project planning, a complex design has been elaborated which consisted of desk review as well as qualitative and quantitative researches.

The table below presents brief description of all study components.

Research Design			
Qualitative Research			
Technique	In-depth Interview	In-depth Interview	In-depth Interview
Target Groups	Representatives of NGOs /Experts	Female victims of GBV (N=3) Female sex workers (N=2) Women who inject drugs (N=5)	Women living with HIV (N=11)
Sample Size	21 interviews	10 interviews	11 interviews
Sampling Method	Purposive Sampling	Purposive Sampling	Purposive Sampling
Study Area	Tbilisi	Tbilisi	Tbilisi, Batumi, Kutaisi, Zugdidi
Length of Interview	1-2 hours	1-2 hours	40-60 minutes
Quantitative Research			
Technique	Face-to-face interview		
Target Groups	Women living with HIV		
Sample Size	206 respondents		
Sampling Method	Purposive Sampling		
Study Area	Tbilisi (N=121), Kutaisi (N=25), Zugdidi (N=30), Batumi (N=30)		
Length of Interview	30 minutes		

Each component of the study is briefly described in the next sections.

2.3. Desk Research

Desk Research gave the opportunity to have an in-depth glimpse in the subject of the study and facilitated the process of planning further phases of the research project. Desk research findings were used in development of study design for the quantitative research including selection of target populations and development of survey instrument.

2.4. Quantitative Surveys

Target group: Women living with HIV

Eligibility: HIV positive women, 18 years and older, seeking services at the AIDS Centres (in Tbilisi, Batumi, Kutaisi and Zugdidi) during October-December 2012.

Sampling: A purposive sampling was used to recruit and enrol study participants.

Sample size: As of September 2012, a total of 807 women living with HIV were registered at the AIDS Center. Based on the official statistics, a desired sample size was set at 200 women respondents (sampling error – 6.0%; reliability – 95%).

Limitations of sampling methodologies: the applied sampling method can be defined as non-probability sampling and, therefore, research results should be interpreted with cautions and cannot be generalized to all HIV positive women in Georgia. Women living with HIV and not seeking services at the AIDS Centres were omitted from the sample. The study does not capture those women who are at early stage of HIV infection and do not need frequent follow-up visits to the Centres; or those women who might be in need of services but cannot or do not seek medical services due to self-stigma and/or coercion. They could represent the most vulnerable segment of HIV positive women. Due to sampling limitations, data disaggregation by age, regions, and other characteristics was not possible and thus, is not presented in the study.

Sadly, female partners of male IDUs in Georgia were not included in the survey even though they are at increased risk of both, GBV and contracting HIV due to several reasons: injecting drug use is prevalent in Georgia; HIV prevalence among people who inject drugs (PWID) is increasing (9.1% in Zugdidi; 5.6% in Batumi);⁶ prevalence of Hepatitis C among male IDUs is alarmingly high (57%);⁷ condom use among male IDUs with their female partners remains low (under 40% at last sex with regular partners in 6 cities of Georgia)⁵. Low condom use suggests that female partners of male IDUs in Georgia either are not aware of their high risk of contracting HIV and other blood-borne diseases through unprotected sex, or they lack the ability to demand/negotiate condom use with their male IDU partners. Due to above mentioned, female partners of male IDUs should become part of the target populations for any GBV & HIV prevention programs, and recruitment of this group in future researches should be highly encouraged.

All HIV positive women who visited AIDS Centres (in Tbilisi, Batumi, Kutaisi and Zugdidi) in the period of October-December 2012 were approached by study team and invited to participate in the survey. A total of 206 women agreed to take part in the face-to-face interview.

2.5. Qualitative Study

The qualitative study has utilized two types of data collection methods: in-depth and narrative interviews. The qualitative study focused on three main target groups:

1. Representatives of NGOs working in the field of either GBV or HIV prevention;
2. Representatives of key populations attending GBV & HIV/AIDS prevention and treatment services: female survivors of gender-based violence, female sex workers and women who inject drugs;
3. Women living with HIV and attending services at the AIDS Centres in Tbilisi, Batumi, Kutaisi, Zugdidi

Each target group participating in the qualitative study is briefly described below:

1. Governmental and Non-governmental Organizations/Independent Experts

In-depth interviews were held with the representatives of the NGO's and other organizations working with the key populations: actual victims of gender based violence, people at higher risk of contracting HIV (sex workers, injecting drug users) and people living with HIV. In total 21 interviews with representatives of 19 organizations were conducted. The list below provides the information regarding the NGO's and other organizations participating in the survey. In two of the organizations, (1) Georgian Harm Reduction Network, and ATIP FUND GEORGIA the interviews were conducted with two employees.

⁶HIV risk and prevention behaviors among People Who Inject Drugs in six cities of Georgia. Bio-behavioral surveillance survey in Tbilisi, Batumi, Zugdidi, Telavi, Gori, Kutaisi in 2012. The Global Fund project in Georgia; Study report. Prepared by: Curatio International Foundation. Public Union Bemoni. February 2013

⁷Behavioral Surveillance Survey among IDUs with a biomarker component; 2009, USAID funded STI/HIV Prevention Project; 2010 Study report

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List Of Participating Organizations / Independent Experts	
1	Infectious Diseases, AIDS and Clinical Immunology Research Centre, Tbilisi, Georgia
2	Union Sakhli
3	Women's Information Centre (WIC)
4	UN Women in Georgia - The United Nations Entity for Gender Equality and the Empowerment of Women
5	UNAIDS - The Joint United Nations Programme on HIV and AIDS
6	Georgian Young Lawyer's Association
7	Alternative Georgia
8	Bemoni Public Union (BPU)
9	Georgian Harm Reduction Network (GHRN) – 2 interviews
10	ATIPFUND - State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking – 2 interviews
11	RTI International
12	Women's Fund in Georgia
13	Association Tanadgoma
14	Anti-Violence Network of Georgia
15	Centre of Social Sciences
16	Union of Democrat Women of Samtskhe-Javakheti
17	Real People, Real Vision
18	HIV/AIDS Patients Support Foundation
19	Independent Expert, Psychiatrist

The purposive sampling was used while choosing the participant organizations. The initial list of participating organizations was developed together with UN Women. Throughout the fieldwork the list was filled with additional organizations, selected using snowball technique.

NGOs for participation in qualitative research were selected based on their work experience and expertise in the field of GBV or HIV prevention in Georgia. Some respondent organizations focus on gender issues and/or implement projects about gender equality and women's empowerment; while other organizations have been actively involved in providing HIV prevention services to vulnerable populations, such as people who inject drugs; sex workers, MSM and people living with HIV.

2. Study populations for qualitative research

Study populations were selected based on the findings of desk review and through consultations with UN Women and other experts in the field.

In-depth interviews were conducted with the victims of domestic violence and with groups at high risk of being infected with HIV. In total 10 in-depth interviews were conducted with key target groups:

- 5 interviews with female IDUs,
- 3 – with female sex workers, and
- 2- with female victims of domestic violence.

The respondents were recruited by the NGOs and/or governmental organizations from their beneficiaries.

Narrative interviews were conducted with 11 women living with HIV at the AIDS Centres in Tbilisi and regional cities: Tbilisi (N=5); Kutaisi (N=2); Batumi (N=2) and Zugdidi (N=2). All interviewees were recruited by the Infectious Diseases, AIDS and Clinical Immunology Research Center, and local NGO- HIV/AIDS Patients' Support Foundation.

2.6. Ethical Considerations

Ethical considerations of the research involved precise exploration of (1) the nature of the target groups and (2) the research topics from ethical perspective.

All target groups of the research, except NGO representatives/experts, can be defined as members of the vulnerable and/or stigmatized populations based on their HIV status, life experience (victims of GBV), and past or current behaviour (SWs, IDUs). The intention of the study is not to stigmatize them further but to reveal some of the key challenges that the majority of these key groups are facing in terms of being more susceptible to HIV infection and more exposed to violence.

Topics discussed with key affected populations within the frames of the study, are clearly considered as very sensitive, because they focused on participant's life stories, which were mostly connected with their risky sexual behaviour and/or illegal activities, their abuse or exploitation, thus could provoke powerful emotional responses in some respondents. Reliving painful and insulting life events could be distressing. To minimize the risk and discomfort to study populations, interviewers were selected from the AIDS Center staff who are knowledgeable of personal and societal problems associated with the

GBV & HIV. Expert from the AIDS Center treat all HIV positive patients with respect and dignity, and have gained trust among PLWH receiving medical services at the AIDS Centres. Furthermore, interviewers were retrained on sensitive topics by the ACT research team. In addition, all interviews took place at the premises of the AIDS Centres either in Tbilisi or in regional cities, in the environment that was familiar to study populations.

Study participants received detailed information about the study; their participation was voluntary; no personal identifiable information was recorded; confidentiality of respondents was guaranteed. Participants were also aware that they could skip any questions causing discomfort and could stop participation in the survey at any time. After communicating this information to respondents, verbal informed consent form was obtained.

As for the data handling procedures, the interviews were transcribed verbatim to preserve the exact ideas of the respondents. To ensure anonymity and confidentiality of the data, filled questionnaires were stored together with recordings without any identifiers in locked cabinets. It should be noted that pseudonyms for every respondent have been used throughout the report.

2.7. Study Limitation

There are growing evidences that women are both, biologically and socially more vulnerable to HIV than men. In most societies, girls and women face heavier risks of HIV infection than men because their diminished economic and social status compromises their ability to choose safer and healthier life strategies.⁸ However, it should be mentioned that since 1989, when the first case of HIV was registered in Georgia, adult men have been predominantly affected by the infection. HIV epidemic in Georgia, as in most Eastern European countries was driven by injecting drug use, and the share of male population among all HIV registered cases has remained to be around 75% for almost a decade.⁹ Since 2010, HIV transmission has shifted toward the heterosexual mode that became dominant by 2011 when the proportion of HIV cases transmitted through drug use decreased to 44.6% while heterosexual transmission rose to 47.4%.¹⁰ Majority of women living with HIV are sexual partners of men who inject drugs. Therefore, one of the most vulnerable populations who are at increased risk of contracting HIV in Georgia, is female sexual partners of male injecting drug users.

Behavioural Surveillance Surveys (BSSs)¹¹ conducted among IDUs in Georgia revealed that the majority of the PWIDs (from 68.3% in Telavi to 90.3% in Tbilisi) reported having regular sex partners. Many male IDUs surveyed during the BSSs mentioned having regular as well as occasional sex partners. Despite practicing risky behaviours (injecting drugs and having more than one partner), male IDU respondents do not perceive that they are at increased risk of HIV. Due to low HIV awareness and low risk perception among male IDUs, they do not use condom with their spouses/regular partners. The level of condom with regular sex partners is extremely low: less than one third of male IDUs participating in the BSSs reported using condom at last sex with female regular partners, with the lowest level of condom use found in Batumi (13.1%).¹¹

Due to unavailability of reliable data, it is unknown what are the underlying reasons for practicing risk behaviours within marital relationship and how these behaviours are evolving. More studies should be conducted to identify the risks that injecting drug user men pose to their low-risk, non-injecting female spouses and/or regular sexual partners, to examine all potential factors contributing to risk behaviours: low HIV awareness among both partners, low risk perception among people who inject drugs and their female partners, negligence or gender based violence.

It should be noted that like female partners of male IDUs, women, who are spouses of married men who have sex with men (MSM) are at elevated risk of acquiring HIV. Due to high level of stigma and discrimination against MSM in Georgia, men follow prevailing social standards of marriage to the opposite sex to hide their sexual orientation and/or homosexual behaviour, satisfy social norms and avoid judgmental and discriminatory attitudes from the society. The BSS conducted among MSM in Tbilisi¹² has found that one third of MSM reported having female sex partners.

⁸UNGASS; Fact Sheet, Gender and HIV http://www.un.org/ga/aids/ungassfactsheets/html/fsgender_en.htm; accessed on September 21, 2013

⁹Monitoring the Declaration of Commitment on HIV/AIDS: Georgia Country Progress report 2006 y. United Nations General Assembly Special Session on HIV/AIDS; p.4

¹⁰Modes of Transmission Study; HIV Data Triangulation in Georgia, 2012; p.3

¹¹HIV Risk and Prevention Behaviors among People Who Inject Drug in Six Cities of Georgia; 2012 y. The Global Fund Project in Georgia; study report; Curatio International Foundation and Bemoni Public Union; published in 2013; p.43

¹²HIV Risk and Prevention Behaviors' among Men who Have Sex with Men in Tbilisi, 2012 y. The Global Fund Project in Georgia; study report; Curatio International Foundation, and Tanadgoma; published in 2013

Interestingly, only 43% of MSM having regular female sex partners reported regular condom use with them; regular condom use is relatively higher with female sex workers (57%) and female occasional sex partners (60%). It should be stressed that MSM is the only group in Georgia with concentrated HIV epidemic: HIV prevalence among MSM population has been increasing steadily over the past few years (3.7% in 2007; 7% in 2010 and 13% in 2012).¹²

Due to above-mentioned, female sex partners of MSM should be considered as one of the key populations, and special attention needs to be paid to their vulnerability to both, HIV and GBV.

Even though the two key populations described above were not included in the study, the research has managed to involve four other key groups of most marginalized women: female IDUs; female sex workers, women living with HIV, and female victims of GBV. Obviously, the study, first ever in Georgia, has generated valuable information about crosscutting issues of HIV and GBV in Georgia. Study findings will serve as a starting point and baseline data for further researches in the country. The research results will lay the groundwork for development of integrated GBV and HIV prevention strategies in Georgia.

3. MAIN CONCEPTS AND DEFINITIONS

In the scope of the study particular concepts were employed, the definitions of which are presented below.

Gender Based Violence / Violence against Women

The Declaration on the Elimination of Violence Against Women (DEVAW) defines violence against women as ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’. Article #2 of DEVAW states that violence against women shall be understood to encompass, but not be limited to, the following:

- (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

This conceptual understanding of GBV proposed by UN underlies this research. In addition to this definition, it is worth mentioning how Georgian legislation defines violence against women, particularly the specific case of domestic violence, especially since, as research results suggest, in Georgia this type of violence predominantly is directed to women.

Domestic Violence (Georgian Law)

Georgian law on prevention of domestic violence, protection and support to its victims defines domestic violence as follows: Domestic violence stands for violation of constitutional rights and freedoms of one family member by the other, in conjunction with physical, psychological or sexual violence, coercion or threat to undertake such actions.

According to the same law the types of domestic violence are defined as follows:

- a. Physical violence- battery, torture, injury, illegal restriction of liberty or any other action that causes physical pain or suffering, failure to meet requirements concerning state of health that may cause harm to the health or lead to death of family member.
- b. Psychological violence- offence, blackmail, degrading treatment, threat or any other act that violates pride and dignity of the human being;

- c. Coercion- physical or psychological coercion of the person to perform or to abstain from performing an act, performance or non-performance of which represents the right of the person, or coercion to stand certain influence against his/her will;
- c. Sexual violence- an act that violates sexual liberty and integrity of the person, as well as sexual intercourse with or other act of sexual nature or immoral act against the minor;
- d. Economic violence- restriction of right of ensuring with food, accommodation and other terms for normal development, right to property, right to engage in labour activities and right to enjoy property in joint possession.

4. RESEARCH RESULTS

The main aim of this research project was to study potential intersections between GBV and HIV/AIDS in Georgia. The report is thematically divided into four major parts.

Chapter I: Topics related to GBV is the starting point of the analysis, and the issues of HIV infection are viewed in relation to gender-based violence. The chapter discusses the association between gender-based violence and increased risk of contracting HIV.

Chapter II: The second part of the report focuses on HIV as a potential cause and reinforcing factor of violence against women. Study attempts to find out whether or not HIV positive status can increase the risk of GBV; and why women living with HIV are more vulnerable to GBV. Socio-demographic profile of women living with HIV who participated in the quantitative research is presented in the chapter.

Chapter III: This part of the report provides brief overview of services available in Georgia to address needs of both, women victims of gender based violence and women living with HIV.

Chapter IV: In the final chapter, major findings of the study and key recommendations are presented.

CHAPTER I. GENDER BASED VIOLENCE AS A FACTOR INCREASING THE RISK OF HIV/AIDS INFECTION

Chapter I is dedicated to discussing gender based violence as a factor increasing the risk of HIV infection. Initially, we will discuss different forms of violence against women, and possible reasons of GBV for different target groups. Experts' opinion on the subject is presented based on the in-depth interviews conducted among key stakeholders. In addition, as defined in the research design, study population is also presented by women who have experienced GBV; and the groups at high risk of HIV transmission (female IDUs and SWs). The chapter also discusses risks of HIV infection among these groups in light of gender based violence and finally, provides an analysis of what impact the GBV may have on the spread of HIV within these target groups.

1.1. Violence against Women – Dominant Forms and Causes

According to the data generated through the qualitative research conducted among key experts (N=21, representatives of 19 agencies/organizations), various forms of gender based violence occur in Georgia: psychological (psychological pressure, verbal humiliation, emotional pressure), physical (beating, restricting the right to treatment), sexual (rape, unwanted sexual intercourse), economic (restricting the right to work), and coercion. Experts drew upon the DV law that defines most dominant five forms of domestic violence. Representatives of the participant organizations working with different target segments discussed the forms of violence their beneficiaries face, though they noted that in general, apart from some exceptions, forms of violence against women can be similar in every segment of vulnerable populations. Different segments of women (married women, female sex workers, women who inject drugs, or women living with HIV) may overlap and they might have to deal with more complex violent circumstances. For example, a female sex worker might experience violence not only from her partner or her client, but also from a pimp; she also might be exposed to various forms of violence simultaneously (sexual violence together with physical and/or psychological violence). Some experts also highlighted that different forms of violence and different behaviours put women at different levels of risk for getting HIV or for becoming victims of VAW.

Opinions of study participants are split regarding the dominant form of gender based violence in Georgia. Some experts think that psychological violence is more prevalent in Georgia than other forms of GBV. They draw upon the recent study by the UNFPA, which states that psychological violence is the most widespread form of gender-based violence, followed by physical violence. According to this study, a relatively small number of women acknowledge being victims of physical or sexual violence. Overall, 6.9% of women reported having experienced physical violence and 3.9% of women confess having experienced sexual violence, while 14.3% of women declare having experienced emotional violence.¹³ Some respondents argue that while psychological violence might be the one reported most frequently, victims of other forms of violence may be reluctant to report violence acts due to fear of retaliation, and/or stigma. Experts also state that sometimes women feel confused and ashamed of being beaten or sexually assaulted, and prefer not to share their problems with anyone.

According to our observation, psychological violence is more common. Women are more likely to confess that they are victims of psychological violence [...] In our opinion, low index of sexual violence does not accurately reflects the reality. Women just don't report or even cannot realize they might be victims of sexual violence from husbands; this is absolutely vague for them. (WIC)

The Georgian society is not aware of this phenomenon [...] If you ask a woman whether she had been a victim of violence, she would start recalling whether she has been beaten or not. So, if the woman is not beaten in her family, she might think that she has never been violated. Even if a woman is permanently oppressed, psychologically stressed and she must suppress her wishes and opinions because she is a woman, it would not be perceived as a violence. (Women's Fund in Georgia)

Majority of experts participating in IDIs, think that low index of certain forms of violence might be connected to perceptions and attitudes of victims. For instance, a relatively low incidence of forms of sexual violence might be caused by the fact that a married woman may not think that coercion from her husband to have sex may be qualified as a form of sexual violence. A source of such attitudes comes from the widespread perception in Georgia that having sexual intercourse with a husband is the “duty” of a wife. At the same time, experts admit that a pronounced double standard regarding sexual behaviour is still prevalent in Georgia: married men are much more likely to engage in extramarital sex than married women, and men are not judged by the society because of having sexual contacts with other women. Experts mention that reliable statistics on whether men use condoms during every sexual contact or not do not exist, however most respondents think that condom use traditionally is very low in the country. Therefore, married women, sometimes even without acknowledging it, can be at increased risk of contracting HIV and other STIs through having unprotected sex with their husband.

Most respondents acknowledged the complex nature of GBV and discussed the social and cultural norms as well as economic factors contributing to the violence against women. Experts think that reasons for violence must be examined by considering a broad picture and studying underlying root causes of violence, such as gender inequalities, social norms and standards, power dynamics between men and women, poverty, etc. Moreover, examining evidences for links and casual pathways between the HIV and GBV should further continue.

1.1.1. Domestic Violence – Forms and Causes

While speaking about domestic violence, experts participating in the research distinguished psychological, physical and sexual violence perpetrated by a partner/spouse or other family members. Respondents discussed first the causes and motives of perpetrator(s)'s violent behaviour in the family and secondly, society's attitude towards DV, which either causes this problem (“woman must obey”) or does not prevent it from happening (“it is okay, it happens everywhere,” “it is not our business”).

Perpetrator individuals – partner/spouse or other family members

Based on the opinions of almost all respondents, in most cases domestic violence against women is committed by their male sex partners or ex-partners.

Violence is the phenomenon that takes place in every society. Our society is no exception. According to the world statistics, 95% of victims are women and children, and vast majority of perpetrators are men. Same thing happens

¹³Javakhishvili, 2010. Prevalence of violence against women. In National Research on Domestic Violence Against Women in Georgia, 2010, UNFPA and Government of Norway, pp.33-35.

in our society [...] As the statistics show, conflicts between wife and husband occurs most frequently, then comes the conflict between mother-in-law and daughter-in-law, and then mother-in-law and son-in-law. (Sakhli)

In Georgian reality, forms of domestic violence committed by men/spouses against women can be verbal, physical, and sexual. As the experts note, different forms of violence often appear simultaneously. Apparently, sexual violence on female domestic partners can directly increase the risk of contracting HIV and other sexually transmitted infections; however, experts stressed that if psychological and verbal violence take place in a family, there is a high probability that other violent actions will follow.

When there is a resistance from the female victim, other forms of violence are involved afterwards. Everything starts with psychological violence and if the victim opposes, other forms of violence occur. (ATIP)

Based on experts' opinions, domestic violence may often have a latent character and gender-based discrimination may not be evident. Sometimes the victims of DV do not recognize that they have been violated. In some cases, the society either does not perceive certain behaviours as violence, or tries to justify it. This happens particularly in cases of psychological violence and sometimes in cases of sexual and physical violence within the family. The problem is rooted in Georgian cultural norms and perceptions.

There is a cultural norm in Georgia that considers a man as a dominant person in the family, and so, he might express this dominance by the means of violence. If you ask men, they might say that if a woman deserves, being rude to her and beating her a little bit is completely normal. (GHRN)

Study respondents declared that forms of sexual violence might also be connected with cultural perceptions. Sexual violence may have two forms in a family. Commonly, the sexual violence when the penetrator uses physical force is classified as a rape. However, sexual intercourse against the woman's will through the verbal or other types of psychological pressure is not commonly perceived as a rape. Ultimately, despite the fact that a woman may not want to have sex and may suffer from undesirable sexual intercourse, she may not even think that she is violated. Respondents mentioned that some women in Georgia think it is acceptable if a husband demands that a wife fulfils "her duty." Obviously, some women have a subordinate self-perception and display submissive behaviours. Obviously, such women will not be able to protect themselves by negotiating condom use even if they acknowledge the risk of contracting HIV.

Awareness is so low that women can't even acknowledge that this is violence and she is a victim [...] This is how she understands marital relationship [...] Women often note that wife must tolerate even if husband is wrong. [...] There are many similar examples around her, and she thinks that this is not violence. (Women's Fund in Georgia)

Experts admit that women may face psychological violence from other family members as well. Most frequently, parents of married couples interfere in marital relationship. It is common in Georgia when meddling mother-in-laws try to control and intrude into the lives of married couples. Such forms of psychological violence may often cause problems in the marital relationship and may further reduce self-esteem and confidence of married women.

CASES OF GBV REPORTED BY EXPERTS

GBV Case #1: Violence from Partner and other Family Members

Sakhli: A young girl referred our service for help, she was not from Tbilisi. She escaped from home. This girl was abducted when she was 17. When the girl's relatives went there, the person who kidnapped her, became very aggressive and threatened them he would burn and destroy everything, if the girl was taken by the family. She was 17 then, she thought that it would be reasonable for her to stay and avoid problems for her relatives, mother and sister. Her father was dead. So, her married life started. This girl used to live with spouse, mother-in-law, father-in-law and brother-in-law. She gave birth to two children. This girl was a victim of sexual violence from her husband. Maybe she was not beaten every day but she reached the condition when she self-harmed herself and tried to commit a suicide. It took her several months to recover from this episode. Besides, her father-in-law and brother-in-law were beating and physically violating her [...] This girl appeared to be very brave and through the help of her mother, she managed to leave the house and move to another place; she built her own house and started living there. She was very lucky to be young enough to start new life.

1.1.2. Societal Violence

During the in-depth-interviews, many respondents discussed societal norms that become a source of violence. The study shows that the society's perceptions, stereotypes and norms underlying sexuality, gender relations and gender roles in Georgia might be the factors reinforcing GBV and can be seen as the obstacles to prevention. This issue can be analyzed from the perspective of both the society and the victim as the societal perceptions may influence the self-perception of individual woman.

Society's viewpoint – demand of obedience of women, apathy and ignorance

Society's attitude regarding domestic violence is often viewed as a deterring factor in the prevention of violence against women. While speaking about attitudes of society towards GBV, two main issues can be identified: (1) traditional cultural viewpoints in terms of the role and function of woman in society and (2) neglecting and ignoring acts of violence.

Generally, power relations between men and women in Georgian society can be characterized as quite unequal. Various Georgian traditional perceptions and practices reinforce the traditional image of a woman as an obedient wife and mother. Her job and career are considered to be of secondary importance. Correspondingly, society demands that women be obedient to men, act according to their will and suppress their own wishes and desires. As experts note, generally such perceptions are considered to be common in a male-dominated society such as Georgia.

Woman is a mother in the first place, then she is a housewife and everything else comes after it. Successful women often say that no one is interested in your success in career; when an acquaintance meets you, the first thing the person asks is - why don't you get married? They think that you are unhappy and unsuccessful unless you are married. You are nothing regardless the success you have reached; however this attitude is different in terms of men. It is important for man to be successful while success in case of woman is measured according to how many children does she have and how good housewife she is. (Women's Fund in Georgia)

Vast majority of study respondents mentioned that there is a double standard when it comes to judging the behaviour of men and women. For instance, while having sexual experience before marriage is acceptable for men, the same experience is unforgivable and shameful for women. One of the respondents also brought up the issue of virginity: according to cultural norms of Georgian society, women are obliged to have their first sexual intercourse on the wedding night, while premarital sex is regarded to be a very normal experience for men. Such attitudes are especially widespread in rural Georgia. In addition, some risky behaviours, e.g. drug abuse or adultery are tolerated by the society if performed by men, and are considered unacceptable and inappropriate if performed by women.

All of these types of gender discrimination reinforce the inferior and deprived position of women in Georgian society and, being a certain type of psychological violence by themselves, can be considered indirect factors that reinforce other types of violence against women.

Majority of respondents stressed that due to societal norms and stereotypes oftentimes domestic violence is not considered to be a crime which should be punishable by law. Society may not perceive verbal humiliation as violence and may even tolerate physical violence especially if a victim is not severely injured.

Only extreme cases are reported, when a woman is on the edge of death. Most women in Georgia do not even understand the notion of violence. (Bemoni)

Study participants acknowledge that even when people encounter the facts of domestic violence, they take no action. Ignorance, indifference and apathy in the larger society have resulted in a lower incidence of response to domestic and gender based violence. In some cases, society does not report cases of domestic violence because of the perception of family as a closed institution. There is a widespread view that family problems should not be discussed outside the family. As one NGO representative explains, apathy towards and ignorance of domestic violence by witnesses is justified by claims such as "it is their own business", "no one should interfere in family business" and therefore, reporting domestic violence might be considered as a violation of the family's privacy.

According to the results of national research on domestic violence against women in Georgia, 78.3% of women think that family problems should only be discussed within a family; 52.1% think that if a man mistreats his wife, others outside the family should not intervene; and 30.7% of women think that family abuse is a private affair and the law should not interfere. These results demonstrate that the problem is reinforced by the perceptions of women themselves.

Experts believe that involvement of a third person in family relations is disapproved by the society unless it is absolutely necessary and lifesaving. In addition, people do not expect that the police involvement, if reported, can be effective and justice can be found; furthermore, many think that police may complicate the situation even more. Another reason for

non-reporting domestic violence can be a fear of retaliation and further violence. It is likely that witnesses are afraid that the perpetrator will harm their family if they report the incident.

As a rule, unless woman is in extreme condition, neighbours think that they have no rights to get involved even if a woman cries and asks for help. They don't think it is appropriate to call the police [...] and on the other hand, neighbours are afraid of this abuser. (Bemoni)

Georgian society perceives the family as a sacral institute. According to this perception, it is more important to preserve the family than to ensure the happiness and well-being of its members. As suggested by some respondents, many people in Georgia, especially in rural areas, perceive divorce as the worst possible outcome of conflict in the family. Therefore, many married women violated by spouses or other family members might be under constant psychological pressure to endure domestic violence and preserve the marriage by all means. This pressure might come from the family members of the survivor (mother, father, siblings, other relatives) and/or from the community, predominantly in rural areas. The statement – preserving family is the best option and should be done for the sake of children – is perceived by the society as the truth.

Due to Georgian traditions, people pay attention to this, especially in regions where women endure everything as divorce is considered to be a tragedy. They try to preserve family despite the difficulties. [...] Mentality and tradition still play very important role. (GYLA)

Comments of victims of domestic violence:

Maya, Tbilisi: I was lucky that my husband made a decision to leave me, otherwise I would still be in that situation because everyone kept saying me that I could not ruin my family and I had to endure my husband by all means.

Victim's viewpoint - perception of women about female inferiority

The victims of GBV who participated in in-depth-interviews as well as study participants from NGOs argue that violence against women is linked with the perception of female inferiority by women themselves. Stereotypical gender roles dominant in the society and traditional practices women are obliged to follow negatively impact women's self-perception and self-esteem.

Research participant experts discussed the expectations of Georgian society regarding the role and function of women. An important cause of gender based discrimination is the societal perception of woman's role as housekeeper and mother, without considering whether or not women choose that role. Such attitudes place women in subordinated position and in some cases may cause decrease of their self-esteem. Women become obedient and they lack the ability to act according to their best interests and protect their own rights. The problem is the fact that victims do not realize that the behaviour of their husbands, intimate partners, mothers-in-law or other relatives is actually acts of violence.

The thing is that as proved by the studies, many women don't even understand that they are victims of violence; it is quite ordinary and normal when a victim says: he beats me every day; is it violence? She does not even want to acknowledge, or has no ability to identify the act as violence. (Alternative Georgia)

As research results show, both attitudes of society towards domestic violence and the female victim's self-perception decrease the chance to prevent violence. The societal norms and the perception of female inferiority encourage women to be subordinated to their husbands in everything. This stereotype impairs women's judgment and negotiation skills to avoid unwanted sex or request having protected sex even in cases when they are aware of their husbands' extramarital sexual activities and real risks of sexually transmitted diseases.

1.1.3. Violence against IDU Women – Forms and Causes

Based on expert opinions, a female IDU faces the greatest risk of harm from her partner or spouse. However, as drug use is considered a deviant behaviour, women who inject drugs are most stigmatized and marginalized by the society. The attitude of Georgian society towards female IDUs is more negative when compared to male IDUs. Culturally, Georgian society evaluates women according to a higher moral standard. Taking this fact into consideration, women become victims of a stronger stigma which may be viewed as a form of psychological violence.

Drug user women are thrown out of house, kept away from their children, they are being deprived a right of motherhood. These women are judged by even those men who use drugs themselves – they judge women for doing the same... (GHRN)

Experts state that female injecting drug users are most marginalized group in Georgia and they are at increased risk of being violated not only by their intimate partners, but also by other drug users, community members, family members, relatives, and other members of society. Double stigma attached to women who inject drugs makes them want to remain hidden and subordinate. Societal norms and judgemental attitudes toward female drug users reduce their self-esteem, confidence as well as the ability and desire to protect their rights. All these interrelated factors place female IDUs at increased risk of being infected with HIV or other STIs as they are more likely to have unwanted sexual intercourse, have intercourse with multiple, concurrent partners without using condoms.

However, it should be noted that reliable data about the vulnerability of female IDUs to GBV or HIV is very limited in Georgia. Every attempt of Georgian experts to recruit female IDUs as study respondents for Behavioural Surveillance Surveys that have been carried out among PWIDs in major cities of Georgia biennially, was unsuccessful.

Perpetrator partner/spouse and police

Experts focus largely on psychological pressure and coercion when discussing sexual violence committed against female IDUs. For instance, female IDUs may be manipulated into having sexual intercourse so their partner can get money or drugs. The expert working with drug user women in Georgia, thinks that drug dependence may lead female IDUs to exchange sex for money or drug in unprotected environment.

Having unwanted sex with undesirable person occurs frequently in the lives of female IDUs. Sexual intercourse may take place in exchange of money [...] The might have unwanted sex with police for different reasons, for instance, woman has to do this in order to avoid prison or fine. (Alternative Georgia)

Women are often engaged in sex industry in order to earn money and get the drugs. They usually depend on men as it is difficult for them to get drugs independently. (GHRN)

Representatives from NGOs working with female IDUs note that men have networks and know easier ways to get drugs unobtrusively from police, but female IDUs face obstacles in acquiring drugs. Respectively, women who use drugs are easy targets for the police and oftentimes are coerced to cooperate with them. In some cases, cooperation is legal, but in other cases violent action may occur. Blackmail of female IDUs, psychological violence and manipulation take place not only by threatening to deprive liberty, but also by using their children. Fear of losing the right of motherhood forces IDU women to do many things against their will and personal interests.

Due to the fact that she is engaged in illegal activity, the woman becomes easily manageable from everyone starting with her partner and his friends, ending with her own spouse or other family members, every member of society she is in touch with [...]. If she is caught by the police and taken for drug testing and the results appear to be positive [...] she will have to pay penalty, or may appear in prison. Let us imagine: she has a minor child and does not want to go to prison; so what else can she do? She agrees to denounce information about drug dealers and/or user drug users. So, police is motivated to catch women drug users. It is a perfect deal for them! A police officer fulfils his duty - detects more people who use drugs, discovers another shelter and seizes 2, 3 or even more people. And, the woman gets liberty in exchange of it. She is ready to do everything for personal freedom. She agrees on sexual intercourse even on oral sex, anything. It does not matter whether you want this or not, you do it if you want freedom and that's it! (Alternative Georgia)

The obstacles female IDUs encounter while getting drugs, and their dependence on male partners increase their vulnerability, make them easier to manipulate, and increase their risk of being violated by partners or police. Experts also mentioned that male IDUs might manipulate their female partners to engage them in drug use and make them addicted in order to get money from them and have easier access to drugs.

Perpetrator family members and society

Female IDUs are victims of double stigma and endure stronger psychological pressure from family and society when compared to male IDUs. As stated above, Georgian society has higher moral standards for women than for men. As research participant experts note, family might be more tolerant towards IDU men and forgive him abusing drugs, while IDU women are more often rejected from their families. According to experts' opinion, such psychological violence takes place in regions more frequently than in urban areas.

Drug addict women become undesirable for family while [drug user] men might be tolerated and their family members may try to ensure treatment for them. It is different in case of women; family members might not help them at all. It also depends on family's culture, how advanced it is. Families in regions, in most cases tend to isolate such women, however there are cases when they forgive and do their best to take care of them. [...] But in any case, double stigma against drug user women is very severe in Georgia. (Alternative Georgia)

Comments of IDU women:

Maia, Tbilisi: When your sister cannot understand you and scolds you, she has beaten me once [...] At the school my kid was told that I should not come to the parents meeting and that the grandmother should come instead. And this was obvious what the reason was. The society avoids you.

Being isolated and rejected by family and the society increase the vulnerability of female IDUs. They become fully dependent on and easily manipulated by their drug user partners that increase their risk for both, experiencing violence and being infected.

1.1.4. Violence against Commercial Sex Workers – Forms and Causes

Interviews conducted during the qualitative study with experts as well as sex workers find that sex workers may become victims of verbal, physical and sexual violence. Vast majority of respondents think that sex workers are more likely to be violated from their permanent partners, clients, and society.

Commercial sex workers participating in the research note that their work implies permanent risk of sexual, physical and verbal violence. Due to high level of stigma attached to commercial sex and fear of being ostracized, women sex workers often hide information regarding their lifestyle to friends and relatives.

Perpetrator police and clients

Within the desk review of available research data in Georgia, reliable information about the violence on female sex workers in the country were analyzed. Major sources of information have been Behavioural Surveillance Surveys conducted among FSWs in Tbilisi and Batumi biennially (2002; 2004, 2006 and 2008-2009 years).

The BSSs (2008-2009 years)¹⁵ among Female Sex Workers in Tbilisi and Batumi have found that small proportion (4.2%) of FSWs in Batumi were victims of physical violence (beating, smothering, etc) during last 12 months; however this rate was about 3 times higher among FSWs in Tbilisi (14.4%). In about half of the cases of physical violence sex workers named the clients as perpetrators. Small proportion of FSWs in Tbilisi (2.5%) and Batumi (5%) reported being victims of sexual violence through blackmailing or threatening that is still associated with their clients. About 2% in Tbilisi and less than 1% in Batumi told they were forced for sexual intercourse by strangers. Overall, the BSS found 15.6% of FSWs in Tbilisi and 8.3% in Batumi who experienced any types of violence during last year. In most cases of violent acts reported by sex workers, the clients of SWs were named as perpetrators.

In many countries, especially in those where sex work is criminalized, the violence against female sex workers by police occurs frequently; and a couple of years ago Georgia was not an exception to the general pattern of violence against women in sex business.

Police used to commit different types of violence against sex workers. They conducted raids, pushed sex workers in cars after verbal and physical violence, and forced to render sexual service for free and it was happening rather regularly. However, after the rose revolution and police reform in Georgia, sex workers are less likely to complain about being victims of violence from the police. (RTI International)

The expert's opinion is proven by the research data available in the country. The BSS among FSWs carried out in 2002¹⁶ has

¹⁵Bio-behavioral surveillance surveys among female sex workers in Georgia; Tbilisi, Batumi, 2008 – 2009; The Global Fund Project in Georgia; study report; prepared by Curatio International Foundation and Tanadgoma Center for Information and Counseling on Reproductive Health; p 24

¹⁶Characteristics, High-Risk Behaviors and Knowledge of STI/HIV/AIDS and STI/HIV Prevalence of Street-based Female Sex Workers in Tbilisi, Georgia: 2002 – 2006; funded by USAID; Report on Three Behavioral Surveillance Surveys with a Biomarker Component for the SHIP Project; p.4

revealed that often the police were involved in apprehending FSWs for compulsory testing and sex workers could avoid this forced testing by paying bribes or with sexual favors to the police. However, since the introduction of a new police force in 2004 in Georgia in the last two years this situation has substantially improved. BSSs among FSWs in Tbilisi found that in 2002, eleven FSWs (N=158) reported being sexually violated by policemen; this number decreased to 3 women (N=160) in 2004; and it should be noted that none of the 160 FSWs participated in BSSs in 2006 as well as in 2008 reported being sexually assaulted/raped by police.

Study respondents state that sex workers have developed their own protection strategies to minimize the risk of violence by clients. They avoid risky behaviour, for instance, following a client to his home or another place of his preference. Sex workers participating in the research declare, women who work in hotels or saunas feel safer than street-based sex workers. SWs commonly try to work mainly at one facility where they know the administration and have some hopes for their support in case of violence and conflict with a client. As our respondent sex workers noted, women who work outside hotels face a higher risk of violence. Sex workers also try not to oppose their clients not to make them upset, that impedes their ability to negotiate condom use.

Comments of female commercial sex worker respondents:

Lika, Adjara: *Yes, I work only in one hotel, rarely in another hotel, very rarely. No, I don't follow them at their homes, in nature or otherwise, I can't. [...] Hotel administrator helps us, so does hotel manager. They tell us to call them in case of violence, theft. [...] Clients beat women who work outside. I don't know that girl, but I was told that she was insulted and beaten by her client.*

Mari, Adjara: *I always try to avoid conflicts. I don't follow a client to home, there is a chance of violence, I avoid it.*

Sex workers also try to keep their relationships with regular clients for a long time as they feel safer with them. On the other hand, sex workers are less likely to use condoms with regular partners than with paying clients.

The BSSs¹⁷ among female sex workers in Batumi found that the percentages of FSWs who used a condom at last their last sexual encounter with their regular partner remained unchanged (18%) in 2004 and 2006 years. When asked why they did not use a condom with the regular sexual partner, the most frequent responses for all age groups were "I trust him" or "didn't think it was needed." Having unprotected sex with clients may place female sex workers at increased risk of sexually transmitted infections.

Societal Violence

Apart from the risk of violence from their clients, sex workers may become victims of strong public stigma. Society considers sex work to be deviant behaviour, which results in increased aggression and more legitimized violence. Insulting a woman becomes more acceptable if she is involved in sex business. These societal attitudes negatively affect the self-esteem of sex workers and increase their vulnerability to violence.

Sex work is major financial source for many female sex workers enabling them to support their families. The only way for them to get money is to keep their clients satisfied even if their rights are neglected. This financial factor makes them obedient and they often suffer from physical, verbal and sexual violence. Protest is less expressed because of stigma and fear of further violation. No matter how humiliated she is, it is very rare from sex worker to report cases of violence to the police. (RTI International)

Most expert respondents mention that female SWs are unlikely to oppose the violence and report abuse to the police as they lack confidence, suffer from low self-esteem and have little hope that the society will support them and law enforcement agencies will treat them with dignity and fairness. Some female sex workers may even think that they "deserve" to be mistreated and violated because of their lifestyles.

¹⁷Behavioral Surveillance Survey among Female Sex Workers with a Biomarker Component for the USAID/HIV Prevention Project; p. 13

1.2. Gender Based Violence as a Factor Reinforcing Vulnerability to HIV Infection

As experts participating in the research note different types of risk-behaviours such as, drug abuse or involvement in the sex industry are not direct reasons of acquiring HIV if safety measures are taken. However, when such activities are accompanied by unsafe practices (for instance, sharing needles and syringes, using contaminated injecting paraphernalia, having unprotected sex) the risk of HIV infection significantly increases. Risk behaviours may be voluntary, or they may be the outcome of different types of violence. Not only physical and/or sexual violence can put people at risk of HIV infection, but also psychological pressure or fear of violence may lead women to feel disempowered to refuse unsafe sex, negotiate condom use, or refuse sharing injecting paraphernalia. In all these cases, violence should be viewed as a factor reinforcing women's vulnerability to HIV. Violence against women may increase the risk of HIV transmission both directly or indirectly.

As the GBV & HIV in Georgia study results suggest, target key populations (women who inject drugs, female sex workers) are running a higher risk of HIV infection, as they are much more likely to be engaged in risk behaviours. However, taking into account gender inequality and subordination within relationships present in the Georgian society, every woman in a relationship or marriage can be considered vulnerable to HIV. Therefore, the research also studied the risk of HIV transmission among married women and women in intimate relationships.

The chapters below first discuss the opinions of research respondents regarding the HIV infection risks of married women and women in relationships. This discussion is followed by an evaluation of how GBV can increase risk. The report uses examples from Georgian reality, some of which are narrated by participant experts and others by victims of gender based violence.

1.2.1. Gender Based Violence as a Risk Factor for transmitting HIV– General Attitude of Experts

Experts expressed ambivalent opinions regarding the links between violence and HIV infection. The majority of participant experts confess that theoretically, violence can obviously be discussed as a significant risk factor for HIV infection. However, the lack of available official statistics on causal relationship between the GBV and HIV in Georgia, some experts are hesitant to draw explicit conclusions on the crosscutting nature of the causes and impact of GBV and HIV.

The evaluation of violence as a factor causing the risk of HIV infection varied in different sub-groups. Links between violence and HIV infection is more topical in key populations (sex workers, injected drug users).

We can think that violence is a risk factor. Sex workers are victims of violence for the first place because they don't have any ability to protect themselves from undesirable relationships; using a condom is either unavailable or it is unacceptable for the client. These are the factors that can cause the problem of infection. (Sakhli)

Of course, violence against woman is a risk factor for infection. When a person has no autonomy on her own sexual life, when a drug user woman has to get drugs for any price, it is not surprising that there may be shared syringe or sex without a condom. (GHRN)

Since there are no official statistics, some experts do not view the link between HIV infection and domestic violence as a serious and striking problem. However, all experts confess that violence may create conditions in the family that can reinforce the risk of transmitting STIs, including HIV. Beyond sexual and physical violence, experts place much emphasis on other aspects: psychological violence against women, gender inequality in Georgian society, and subordination in the family all make women more vulnerable to HIV.

1.2.2. Risk of HIV Infection among Women Married or in a Relationship, and Domestic Violence

Research participant experts underline several factors that may cause transmission of HIV to women who are married or in a relationship. Risk factors of contracting HIV infection might be HIV positive status of a spouse, or spouse's risk behaviour associated with HIV infection. These risk behaviours may include (1) having unprotected sex with sex workers, and/or (2) practicing unsafe drug injections. These unsafe practices may increase man's risk of being infected with HIV and correspondingly, the risk of transmitting the virus to their low-risk wives and/or sexual partners.

HIV positive status of a husband/partner clearly increases the risk for wife/female partner of being infected through unprotected sexual intercourse. High HIV vulnerability of married women is remarkable taking into account the societal norm about marriage according to which using condom in a married life is not “necessary”; moreover, to request husband/regular sex partner to use condom in marital/romantic relationship is perceived as insulting, lack of love, distrust, disrespect, or accusing in infidelity.

At the same time, extramarital sexual relationships or sexual contacts with female sex workers are relatively well tolerated by the society when practiced by men. Such attitudes, do not impede men to have sex outside of marriage that increases their risk of contracting STIs. Ultimately, a great number of married women are put at risk of HIV infection through unprotected sex with their unfaithful husbands.

I don't remember which organization conducted the research – women thought that it is normal if a man has fun and sometimes has another sex partner. This is somehow imprinted but I don't want to believe that this is a tradition of Georgian culture; to me this is just a mangled tradition. (RTI International)

Commonly, a woman in Georgia has no parallel relationship with other men and if she does, it is very disapproved by society. It is somehow supported in case of men; why only wife? Men should have someone else too [...] Accordingly, men have sex more frequently than women and that's why they are sources of infection and put their wives at risk. In most cases, men are infected first and women get infections from them. (Women's Fund in Georgia)

Having sex with sex workers is widely practiced behaviour among male population in Georgia. The Behaviour Surveillance Survey (BSS) conducted among school and university students aged 15–24 in Tbilisi¹⁸ demonstrates that the use of sex-worker services is quite common among Georgian young men. According to this study, 51.0% of never married male students 18–24 years of age (n=361) reported having their first sexual intercourse with a sex-worker; 33.4% with a random partner; and 14.2% with a girlfriend. As for the younger age category, 44.4% of sexually active young boys aged 15–17 (n=223) reported having first sex with a sex worker; 30.9% stated it was a random partner; and 19.3% reported it was a girlfriend.¹⁹ When asked, if they used condom during last sex, 86% of young men say they used condom at last sex with occasional sex partners, and this indicator increases to 94% for the last sex with female sex workers. These data demonstrate that Georgian young men are likely to have sex with female sex workers, including unprotected sex. This risk behaviour potentially increases young men's vulnerability to HIV, and, if infected they may become a source of transmitting the virus through marital and/or romantic relationship to women with low risk of HIV.

The risk of HIV for women who are married or in a relationship may increase as a result of not only physical or sexual, but also psychological violence in the family.

As discussed above, domestic violence may be encouraged by society's stereotypical views of the status and role of women. Even when there is no physical or sexual violence in a family, a woman under the psychological pressure from a spouse or sex partner may have difficulty discussing intimate issues and negotiate condom use that can increase the risk of HIV infection.

It is violence when men find it insulting to be asked to use condom during sex. [...] It is violence when unprotected sexual contact takes place against women's will. (WIC)

Discussions about condom use may be prevented because of a woman's fear of an aggressive reaction from her husband as well as cultural norms and viewpoints about marital relationships.

Based on researches, I can tell you that women, especially in regions do not dare to ask their husbands to use condom. [...] How can I dare it to my spouse – this problem is connected with the Georgian traditions and culture. Accordingly, women do not dare to say it, it is considered to be indecent behaviour. As it seems, women do not acknowledge the risk that their husband may transmit the infection got from sharing syringes to their spouses through unprotected sex. (Bemoni)

Comments of HIV positive respondents:

Natia, Samegrelo: *If I had information about HIV positive status of my husband, he would think it is normal [to discuss condom use], otherwise... it would be insulting for him...*

One woman in the study admitted that her sex partner was against treatment and did not allow her to take medications. (See Annex #1- story #6). The real story of a woman living with HIV proves that women may encounter not only physical or sexual violence, but also strong psychological pressures that prevent women from realizing their rights to autonomy and health.

¹⁸Georgia HIV Prevention Project. Youth Behavioral Surveillance Survey: HIV/AIDS Knowledge, Attitudes, and Practices Among School Pupils and University Students in Tbilisi, Georgia. 2012. RTI International and Save the Children.

¹⁹Ibid., p. 38

1.2.3. HIV Risk for Female IDUs and the violence that follows Drug Use

Organizations working with IDUs state that injecting drug use is an important driver of HIV epidemic in Georgia. Injecting drugs when practised safely is not considered to be a direct risk-factor for HIV infection, however sharing injecting paraphernalia that still takes place among drug users in Georgia creates real threats for spreading HIV infection through contaminated injection equipments. Experts also note that women under the influence of drugs may not be able to control their sex behaviour and may have unprotected sex with men with high risk of HIV (drug users or alcohol addicts). In addition, drug addict women hoping to get illegal drugs in exchange of sex, may be manipulated and coerced to have sex, including unprotected sex with multiple partners.

Experts emphasize that use of homemade drugs has become widespread practice, and is on rise in Georgia. Use of homemade involves the preparation of multiple doses of drugs that then are used in groups. Accordingly, the risk of sharing potentially contaminated instruments (syringes, container and other injection paraphernalia) is high. Some drug users are aware that sharing can lead to HIV infection but addiction makes them to neglect the risk and get high.

Some respondents note that there are cases when an HIV positive person confesses his status in the group of IDUs, and he is the last who injects and uses shared equipment. In such cases, everything depends on an infected drug user's honesty, and knowing your own status.

The most used drugs are homemade drugs prepared on codeine so called "crocodile" and "vint". They are characterized with group consumption because it is boiled together for several people for 3, 4, 5, 6 people. It is divided then. So there are many conditions here to think that risks are significantly increased if anyone in group is infected. [...] They also buy ready-made drugs in syringes and who knows what it is. (Alternative Georgia)

Drug users who buy homemade drugs are under serious risk because these drugs are prepared with big doses; many people attend the process of drug preparation; drugs do not have long-term influence, thus a person needs to add new dosage in 2, 3 hours. So, people gather in one apartment for the whole day; there may be 5, 10 people and syringes often are messed up; it becomes impossible to distinguish your syringe when there are several more. (Bemoni)

Risk of being infected with HIV through unsafe injection of illicit drugs equally affects both men and women. However, in certain circumstances woman IDUs might be exposed to higher risk of HIV infection due several factors: Female drug users may have had transactional sex just to get the drugs and in such situation women lack the ability to negotiate condom use; even if female IDUs do not directly exchange sex for drugs or money, negotiating condom use might not be the first priority and intention of women under the influence of drugs. Experts say that even male drug users judge women who inject drugs, and treat them as inferior with no respect or compassion. It should be also noted that commonly, when drugs are used in groups, a drug user woman is the last person in the line waiting for her share, and as a rule, she uses the syringe that was used by other drug user men.

Drug addiction and commercial sex are linked to each other. If a woman is drug addict, she has to get money for drugs and she does everything whatever it takes. (GHRN)

It was also noted that public attitude and stigma can be viewed as a major factor reinforcing the risk of drug use driven HIV transmission in women. The Georgian legislation on drug use is extremely strict and based on punishments: high penalties and imprisonment. Therefore, the environment for expanding harm reduction programmes and promoting safe injection practices among injecting drug users remains challenging. While society accepts man's recognition of being drug addict and approves his decision to start treatment, women drug users typically experience severe stigma and aggression from society. Consequently, more barriers exist for women to disclose their drug addiction and seek treatment.

When a woman confesses that she is a drug user and wants to get enrolled in a Methadone program, they face very negative, judgmental attitude from everybody. Drug addiction is considered to be a disease for men and a crime for women. Accordingly, women cannot declare and cannot be treated. They are under permanent risk of infection. (Women's Fund in Georgia)

Gender based double standards and dual stigma attached to female IDUs as well as punitive drug legislation and fear of prejudice from people- all drive drug addict women further underground. Due to all above-listed reasons, female IDUs are least likely to seek medical services and be enrolled in harm reduction programs; therefore, they practice risk behaviours for a longer time and their susceptibility to HIV infection is augmented.

While speaking about the risk of HIV transmission through injecting drug use, experts focus on female partners/spouses of male drug users. As experts note, the problem of male IDUs infecting their partners/spouses is rather new trend in HIV epidemic in Georgia.

If we look at our country's statistics [...] it is obvious that HIV started to spread among females via heterosexual way. These women are wives, partners of drug addict men; and most of them are not drug users themselves. (Alternative Georgia)

All experts acknowledged that more women who are partners of male IDUs have been infected over the last few years in Georgia. The risk of HIV among female partners of male IDUs is augmented when domestic violence is involved. For instance, if a husband refuses to use condom, or he does not permit his female partner/wife to seek HIV counselling and testing services.

When we tell female partners of male IDUs that their partner may be infected and the risk of HIV and hepatitis C is high in case of unprotected sex, they often say that they would not dare to ask their spouses to use condom. This seems so unacceptable for them. (RTI International)

A male IDU may force his spouse or partner to use drugs by means of psychological violence. He might also be motivated to involve her in drug addiction, which will make it easier for him to manipulate her and extort money from her. The risk of HIV transmission among female partners of male IDUs is amplified if women start using drugs and become directly exposed to additional risk factors associated with drug use (sharing injection equipment; violence from the police; violence from other drug users, transactional sex, etc.)

Comments of IDU women:

Maia, Tbilisi: I got married very young. I got good education and had a job. After I got married I found out that my husband was drug addict. I myself tried drugs first when I was over 30. Probably, there is no excuse for that, I became curious, in addition I was tired fighting my husband's bad habit; I don't know what the main reason was but the fact is that it happened. Afterwards, as all drug addicts you didn't realize how I became addicted, I locked myself in the house. [...] Finally everything ended with the prison. [...] I was very upset with the family problems and I got the first injection from my husband. I agreed, however, it was kind of persuasion when you constantly are told over the years to try it. [...] I did experience violence from him, often he has beaten me, but not because he wanted me to consume drugs, just because he had some obvious mental problems.

Both forms of violence from male IDUs – forcing women to get involved in the sex industry and engaging her in drug use significantly increase the risk of HIV infection.

There was a drug addict man whose only purpose was to get money to buy drugs and forced his wife into prostitution. [...] When we discuss these issues with experts, they often say that IDU men make women addicted to drugs. [...] Men know that if women have job, income and they become drug users, they will spend money on drugs. In most cases women are engaged in drug use for this purpose. (WIC)

One female SW respondent also tells story about how a group of male drug addicts seduced a young girl to start using drugs intentionally to gain control over her and extort money from her.

Comments of respondent sex worker:

Lika, Adjara: It happened several times when such people wanted to seduce me. One very handsome boy told me that he likes me and so on. [...] I figured it out that he wanted to involve me in drugs. There was my friend who was involved and [...] she is dead now. They do this because of money. That girl, my friend became drug addict; they used to take money from her and made her addicted. All of them got in car accident one day; all of them were under drugs; everyone survived but my friend... the girl died.

1.2.4. Risk of HIV Infection of SWs and Violence in the Sex Industry

Since the beginning of the epidemic sex workers have experienced a heightened burden of HIV caused by combination of multiple risk factors: unsafe sex behavior; multiple sex partners and unprotected sex; sexual violence; violence from the po-

lice; psychological pressure and coercion. Besides, stigma and fear of discrimination are also considered to be among factors augmenting sex workers' risk of being infected.

Society's attitude is a form of violence and we encounter it often. Stigmatized attitude towards these women makes them more isolated. Their internal stigma, self-stigma is so strong that they avoid visiting different services offering prevention or treatment programs. The stigma creates a huge barrier to HIV prevention and testing services; low uptake of HIV testing can further fuel HIV transmission. (RTI International)

Sex workers in Georgia may face different forms of violence that directly or indirectly increase their HIV risk. Study participants emphasized that in most violent cases, clients of female SWs are perpetrators. Sex workers participating in the research declare, that there are cases when clients refuse to use a condom and they often argue regarding this issue. In such cases, a lot depends on the sex worker's confidence and ability to influence the client, particularly skills for condom negotiation. Study respondent sex workers discussed the strategies that they use to convince their clients to use a condom. In some cases, sex workers manage to persuade clients by means of calm negotiation and rational arguments, though some cases conflict with clients may arise.

Comments of respondent commercial sex workers:

Lika, Adjara: *We may argue about using a condom. [...] Rather many clients demand sex without condom. Sometimes you don't want tension, fight and you feel helpless... They are not afraid. I trust you, you seem to be a clean woman – they say. But it is not about cleanness and hygiene. Man or woman may look clean but not be clean, and vice versa. I explain this but they say: I am not afraid, why are you afraid? I respond: you must be afraid, I am a sex worker and you should protect to avoid unpleasant things. I explain this calmly, sometimes fondle him, and tickle him and so on. Sometimes that helps.*

Sex workers mention that sometimes their efforts to negotiate safe sex are unsuccessful. Some clients manage to persuade sex workers to have unprotected sex in exchange for additional payment. This is a coercive tactic, psychological violence on women as eventually, sex workers are coerced to agree and have unprotected sex against their real will and initial intention.

CHAPTER II. HIV INFECTION AS A FACTOR FUELLING GENDER BASED VIOLENCE

Major objective of GBV & HIV in Georgia study is to identify relationships between Gender Based Violence and HIV infection. The previous chapter discussed the risk of HIV transmission resulting from gender based violence. The Chapter II presents study findings that examine whether HIV positive status can fuel gender based violence.

The impact of HIV/AIDS on women is particularly acute. Women are often economically, culturally and socially disadvantaged and HIV positive status may further exacerbate their vulnerability to different types of violence and discrimination. Reliable data on HIV associated stigma and discrimination has been scarce in Georgia. The most recent study that assessed the attitudes towards PLHIV was conducted among school and university students, aged 15-24 in Tbilisi in 2011.²⁰ The youth BSS demonstrates that general attitude of Georgian youth is notably discriminative towards people living with HIV. Unfortunately, the survey does not ask questions on gender-based discrimination and, therefore the data whether women living with HIV are treated differently than HIV positive men do not exist in the country.

Below we present major findings proving that stigma attached to people living with HIV is prevailing among youth in Tbilisi. Only 68% of youth respondents believe that HIV positive people should not be isolated from the society, and 75% mention that students living with HIV should be allowed to continue attending schools. The percentage of youth with non-discriminatory attitudes reduces even further when asked the question about an HIV positive teacher: 58% of respondents say that an HIV positive teacher should be allowed to continue teaching in schools. Only half of respondents would not mind working with an HIV positive colleague.²¹ Importantly, larger proportions of males, especially those aged 15-17, expressed all three discriminatory attitudes, than did female respondents. For this study, pupils and students who held 2 or all 3 of the

²⁰Georgia HIV Prevention Project. Youth Behavioral Surveillance Survey: HIV/AIDS Knowledge, Attitudes, and Practices among School Pupils and University Students in Tbilisi, Georgia. 2012. RTI International and Save the Children

²¹Georgia HIV Prevention Project. Youth Behavioral Surveillance Survey: HIV/AIDS Knowledge, Attitudes, and Practices among School Pupils and University Students in Tbilisi, Georgia. 2012. RTI International and Save the Children. p.23.

discriminatory attitudes were considered to have a general discriminatory attitude towards people living with HIV. Overall, 28.2% of pupils and students fell into this category.¹⁹

As previously mentioned in the study report, women in Georgia are judged according to higher moral standards as men. Therefore, on the level of societal perceptions, men are more likely to be “excused” for practicing various risk behaviours that resulted in their infection, whereas women are not. In cases where a woman is infected with HIV/AIDS from her husband, the community and her immediate circles of interaction might feel compassion for her and not express aggression; however, if the woman’s intimate partner is not infected, she runs a high risk of a psychological violence from the community, starting from rumours and gossip, and ending with the expression of acute aggression. Experts think that women who presumably contracted HIV because of being involved in sex work or injecting drugs might be treated without any empathy.

2.1. HIV Infection as a factor Reinforcing Gender Based Violence

Representatives of NGOs and independent experts participating in the research believe that people living with HIV often become victims of different forms of violence solely because of their HIV positive status.

Basic human rights are violated when pregnant woman is refused to receive decent medical service; when bleeding woman is not served in hospital, when her child is refused to be accepted in school despite the fact that child might not be infected. Of course, these people have to deal with many difficulties. (Bemoni)

Yes, HIV positive status can cause different types of violence. If a woman with HIV is fired from work, she is a victim of violence; if a doctor refuses to serve her, she is a victim of violence; if society knows about her status and does not let her child into school, it is violence. (AIDS Centre)

HIV positive status intensifies violence against women – rejection, putting labels to person, refusing medical service and not hiring her for job – all are the forms of violence often faced by HIV positive women. (Bemoni)

Experts believe that HIV positive status does not only cause violence which is expressed in different forms of discrimination against people living with HIV, but also might be a factor reinforcing the existing violence. For instance, HIV positive women become more vulnerable to domestic violence, and there are different barriers for women to report acts of violence against them and seek help. The probability that HIV infected women will report violence to the police is considerably low as they avoid disclosing their HIV status to other people because of fear of further discrimination.

Of course, HIV infection intensifies violence against women. Women become more vulnerable; [...] This is conditioned by the fact that stereotypical viewpoints form stigma which worsens self-esteem of infected people; stigma also lowers the support from society. In general, a woman dares to report she is a victim of domestic violence, when she hopes she will be supported... but HIV positive people do not have this hope in most cases. (WIC)

Experts also focus on the higher degree of discrimination against unmarried women living with HIV. This is because HIV transmission is mostly associated with drug addiction and promiscuity, which society views as more acceptable if practiced by men than by women.

Society still perceives HIV as a disease of people with doubtful reputation and women are less likely to be forgiven by society for infidelity or drug abuse. People are more forgiving to men than women. Respectively, stigma is stronger and violence is more frequent against women (HIV/AIDS Patients’ Support Foundation)

2.2. Violence against HIV Positive Women – Dominant Forms and Causes

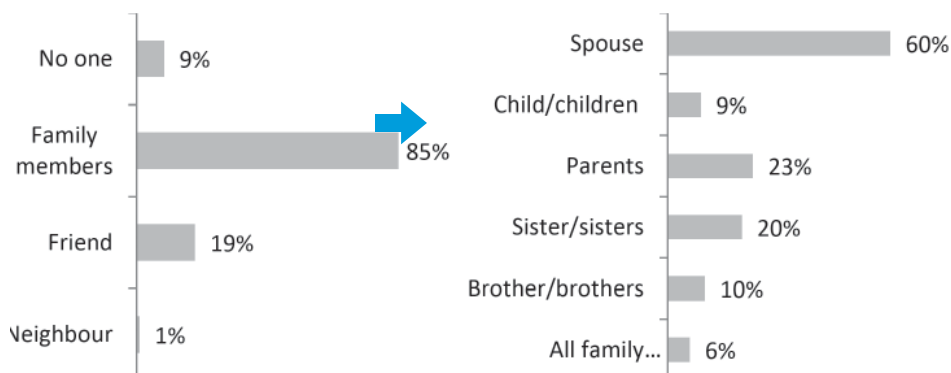
Study participants state that one of the major factors causing violence against HIV positive women is stigma, which leads to psychological violence manifested in various forms (insulting, isolation, ignorance, rejection, etc.) and might result in a violation of their basic human rights by restricting their access to healthcare, also, violation of their right to work by terminating or refusing employment to HIV positive women.

Qualitative as well as quantitative study results demonstrate that women living with HIV may face different forms of violence that include: emotional abuse, rejection, confidentiality breach, isolation, abandonment, restriction to the access to healthcare services.

GENDER BASED VIOLENCE AND HIV/AIDS IN GEORGIA: LINKS, OPPORTUNITIES AND POTENTIAL RESPONSES

Due to stigma and fear of discrimination, people living with HIV hide their status. Results of quantitative research among HIV positive women show that vast majority of women living with HIV prefer keeping their HIV positive status secret. Out of 206 participant women living with HIV, 19 (9%) did not disclose their HIV positive status with anybody. When disclosed, most women revealed their status with their spouse and fewer of them are open with their parents and siblings.

Figure 1: Did you disclose your HIV status with anyone? (N=206)
If yes, to whom? (N=176)



Note: multiple responses were possible!

When women who have not disclosed their HIV positive status with anybody (n=19) were asked about the reasons for non-disclosure, the following reasons were cited most frequently:

- The fear of people's reaction and negative attitude (68%),
- The fear of being isolated and rejected (37%), and
- The fear of being discriminated and mistreated due to HIV positive status (32%).

Women were asked if they have experienced certain types of discomfort, judgmental and/or discriminative attitudes from those people who were aware of their HIV positive status. More than one third of respondent women said they did.

Table 1: Have you ever felt the following because of your HIV positive status?

Have you ever felt the following because of your HIV positive status?	Yes %	No %
I felt rejected from society	56	44
I felt abandoned by my spouse/sex partner	41	59
I felt abandoned by my family	23	77
Family members and friends did not come to see me for a long time	17	83
People gossiped about me	40	60
Treated me disrespectfully	20	80
I receive low quality medical or other service	25	75
I felt humiliated	71	29
I was threatened	12	88
I lost my house	19	81
I am not allowed to rent apartment because of my status	5	95
I was a victim of physical violence	4	96
I was fired from work	5	95

N=75

(Women who say they face some types of problems because of their HIV positive status)

Note: multiple responses were possible!

Results of quantitative research also revealed that confidentiality of HIV status is not always guaranteed in Georgia. A total of 31 (15%) women complained their confidentiality was breached; respondents interviewed in regions were more likely to mention that their status was disclosed without their consent than women in Tbilisi.

HIV positive women who stated that their HIV status was disclosed without their consent name medical staff and their own family members as persons who violated the confidentiality: medical personnel (n=8); husband or ex-partner (n=4); mother in law (n=4); neighbours (n=3) or other family members from the husband's side (n=5).

Research revealed various contexts where HIV-related forms of violence occur in Georgian society. Cases of stigmatization and discrimination were reported by experts as well as by HIV positive persons participating in the study. Most striking is the variety of discriminating contexts, which includes (1) family, (2) society/local community, (3) workplace and (4) the health care system.

2.2.1. Family and Relatives

Considering the importance of family as a social institution in Georgian society, and the very close relationships most people have with close family members and relatives, family can be seen as a primary care-giver for an HIV positive woman. In many cases, ties with the family are not limited to relationships and emotional attachment, but also are of an economic character because relatives often support each other financially. Considering the above mentioned, family support is very important to HIV positive women.

Based on study participants, family attitudes towards HIV positive members may vary significantly. Sometimes, family becomes the major source of financial and emotional support for women living with HIV (see Annex #1- story #6). However, some respondents recall cases when women were rejected from their family because of their HIV positive status (see Annex #1-story #3). Experts as well as HIV positive respondents also mentioned that women sometimes are abandoned by their husbands after their HIV positive status becomes known (see Annex #1- story #4). Separation or divorce may lead women to psychological devastation as well as to a loss of financial resources, as in many cases men are the main breadwinners in the family. Feeling of loneliness, helplessness, low self-esteem and self-blame seriously impede women's ability to protect their rights.

Comments of HIV positive respondents:

Lika, Imereti: *I have a friend. When his son-in-law and daughter found out that my friend was HIV positive they humiliated, oppressed her and were aggressive. They made her leave the family. Later, her son-in-law even abandoned his wife and child because of the HIV positive status of his mother-in-law.*

Salome, Adjara: *It was terrifying for my relatives, they were afraid of me and my husband, and we were so isolated ... Then I made them read the leaflets and explained what it is, that no one is fully protected and everyone should have information about this disease. I talked to many people about HIV and many of them know much about this disease now.*

Interestingly, some women living with HIV complained that excessive care from family members may become annoying and cause serious discomfort to them. Few respondents emphasized that when HIV positive people try to overcome the disease psychologically, and adapt to changed environment, excessive care from family members accentuate their vulnerability and "different" status, and serves as a permanent reminder of their condition.

In the scope of quantitative study, the occurrence of violence among HIV/AIDS infected women both before and after infection was examined. Questions about being exposed to violence before and after HIV status were asked to those women who mentioned having spouses and or regular sex partners.

Results of quantitative research show that in most cases spouses' attitude does not change or even improves toward their HIV positive wives. However, 18% (25 out of 140) of women who were married or in serious relationship with male sex partners broke up after their HIV positive status was revealed. It should be noted, that 53% of such cases, HIV positive women were the initiators of divorce; in 27% of cases women were abandoned by their husbands; and 18% say that the decision was made together.

Table 2 : How has your spouse's attitude changed towards you after finding out about your HIV positive status?

How has your spouse's attitude changed towards you after finding out about your HIV positive status?	
Has not changed at all	21 %
Supported me	39 %
Has become more helpful	28 %
Has been alienated	9 %
We broke up	18 %
N=140	

Note: sum of results is not 100% as several answers were permissible.

More in-depth analysis is recommended to understand the reasons why women living with HIV appear to be the initiators of separation/divorce in the majority of cases. Interestingly, that all cases of separation/divorce occurred among concordant couples, where both partners were HIV positive that suggest that discordance in HIV status is not directly related to the marriage breakdown. Perhaps, in some cases women punish their husband for infidelity and transmitting the virus to them. Further research will be necessary to examine potential reasons leading to the breakdown of marriages among concordant and discordant couples.

The quantitative research examined the most dominant forms of violation faced by women living with HIV in Georgia. For analysis, questions about violence were grouped in four major blocks.

Verbal psychological violence

- 1 Assaulted verbally
- 2 Intimidated me in front of other people
- 3 Threatened to hurt me, shouted, broke things
- 4 Threatened to hurt my beloved ones
- 5 Prohibited seeing/communicating with my friends
- 6 Prohibited seeing/communicating with my family members
- 7 Intimidated me in public places

Physical violence

- 1 Slapped, hit and beat me
- 2 pushed me to the floor and kicked me

Sexual assault/violence

- 1 Coerced me into sexual contact against my will
- 2 Had sexual intercourse against my will as I was afraid of the man's reaction
- 3 Forced me to do something sexual that was degrading or humiliating

Economic violence

- 1 Ceased financial support/stopped giving me money
- 2 Extorted money from me (against my will)

The tables below demonstrate percentage distribution of women living with HIV who admit that they have face different forms of violation before and/or after HIV positive status was detected.

Verbal/psychological violence

- Almost half (100/206; 49%) of women participating in the research reported they have never been verbally/psychologically at any time – before or after HIV positive status;
- Almost one-third, (58/206; 28%) admit they have faced psychological violence before they were diagnosed with HIV and the violation continued after their HIV positive status was detected;
- Interestingly, 20 (10%) women reported being violated only after their HIV positive status was revealed; however, slightly more, 28 (14%) women living with HIV stated that they were violated before their HIV status, but the abuse against them stopped after their HIV positive status became known.

Table 3: Have you face emotional violence before and after HIV positive status?

Have you ever faced verbal/psychological violence?						
	After HIV positive status					
	Yes		No		Total	
Before HIV positive status	n	%	n	%	N	%
Yes	58	28%	28	14%	86	42%
No	20	10%	100	49%	120	58%
Total	78	38%	128	62%	206	100%

The data generated through the GBV and HIV in Georgia study do not allow to draw explicit conclusions about direct association between increasing psychological violence against women and being diagnosed with HIV. It is worth mentioning that among the women who were violated before HIV status but reported not being abused after identifying their HIV positive status, almost half (12) say they got divorced/separated after their HIV positive status was revealed. All these 12 women reported that the perpetrators were their spouses and mothers-in-law. Therefore, it could be assumed that the reason for reduction in prevalence of psychological violence against HIV positive women in the study might be explained by separation of the victim and the offender.

To further examine this assumption, additional analysis was performed only for those women who reported being married or having regular sex partners at the time of interviewing (women with no sex partners, widows, as well as divorced/separated women were excluded from the analysis).

**Table 4: Have you ever faced verbal/psychological violence?
(married women/women having regular sex partners; N=125)**

Have you faced verbal/psychological violence? (married women/women having regular sex partners; N=125)				
	Before HIV + status		After HIV+ status	
	n	%	n	%
Yes	61/125	48.80%	59/125	47.20%
No	63/125	50.40%	63/125	50.40%

As the table #4 shows, the prevalence of psychological violence among married women before and after HIV positive status remains almost unchanged. Therefore, research findings do not generate sufficient evidence to conclude that after disclosing HIV positive status, women become more likely to suffer psychological violence from spouses or other family members than before they were diagnosed with HIV.

Physical violence

- When women living with HIV were asked about being victims of physical violence, majority of research respondents (164/206; 80%) reported they have never been abused physically.
- Seven women respondents (3%) living with HIV admitted they have experienced physical violence only after their HIV positive status was identified;
- While 16 women who were victims of physical violence before their HIV status, mentioned that physical abuse against them stopped after they were diagnosed with HIV.
- Almost every one woman in ten respondents (19/206; 9%) said she had encountered physical abuse before as well as after HIV diagnosis.

Table 5: Have you faced physical violence before and after HIV positive status? (N=206)

Have you faced physical violence?						
	After HIV positive status					
	No		Yes		Total	
Before HIV positive status	n	%	n	%	N	%
No	164	80%	7	3%	171	83%
Yes	16	8%	19	9%	35	17%
Total	180	87%	26	13%	206	100%

As demonstrated above, research findings do not indicate that women's vulnerability to physical violence increases due to HIV positive status.

Economic violence

Economic violence was measured by asking women two questions: (1) have you been denied financial support you used to get; and (2) have someone ever taken your earnings/savings against your will. Research findings are presented in the table.

Table 6: Economic Violence against women living with HIV

Have you ever faced economic violence (denied regular financial support/money extortion)?						
	After HIV positive status					
	No		Yes		Total	
Before HIV positive status	n	%	n	%	N	%
No	130	63%	7	3%	137	67%
Yes	28	14%	41	20%	69	33%
Total	158	77%	48	23%	206	100%

Data analyses showed that economic violence against women living with HIV is quite prevalent.

- One third (69/206; 33%) of women respondents have encountered economic violence before their HIV status was revealed.
- Slightly fewer women (48/206; 23%) admitted that they were denied financial support or their savings were taken by someone after their HIV positive status became known. In most cases of economic violence against women perpetrators were their spouses or other family members.

Sexual violence

The extent of sexual violence against women living with HIV was measured by the responses admitting certain forms of sexual assault:

1. Coerced me into sexual contact against my will;
2. Had sexual intercourse against my will as I was afraid of the man's reaction;
3. Forced me to do something sexual that was degrading or humiliating.

Women who responded "Yes" to any of the three statements above were regarded as victims of sexual violence.

Table 7: Have you ever been a victim of sexual assault/violence?

Have you ever been a victim of sexual assault/violence? (N=206)						
	After HIV positive status					
	No		Yes		Total	
Before HIV positive status	n	%	n	%	N	%
No	154	75%	1	0%	155	75%
Yes	29	14%	22	11%	51	25%
Total	183	89%	23	11%	206	100%

- Three fourths of all women living with HIV mentioned they have never been victims of sexual violence;
- Only one woman respondent told that she was sexually violated only after her HIV positive status was detected;
- One woman out of every four respondents (51/206; 25%) were victims of sexual violence before they were diagnosed with HIV, but sexual violence against them ended after their HIV positive status became known;
- Eleven per cent of women confessed they were victims of sexual violence before and HIV positive status.

To examine if the reduction in sexual violence against HIV positive women after they were diagnosed with HIV was attributed to the marriage breakdown, additional analysis was done only among those women who were married and had an intimate partner (divorced/separated women and women who were not in intimate relationship were excluded from the analysis).

Table 8: Sexual violence before and after HIV positive status among married women and women in intimate relationship

Have you faced sexual violence before and after HIV positive status? (married women/women having regular sex partners; N=125)				
	Before HIV + status		After HIV+ status	
	n	%	n	%
Yes	36	28.8%	17	13.6%
No	89	71.2%	108	86.4%

As the table #8 demonstrates, the percentage of women who reported being victim of sexual violence after their HIV positive status was detected reduced by two times, that gives no indication of positive correlation between the incidence of sexual violence and HIV positive status. However, the share of HIV positive women reporting being victims of sexual violence at some point of their lives (before or after HIV positive status) is alarmingly high. The National Research on Domestic Violence against Women in Georgia²² conducted among general population women throughout the country found that only 3.9% of women were victims of sexual violence, that is almost sevenfold lower than that among women living with HIV. Even though

²²Chitashvili, M. et al. National Research on Domestic Violence against Women in Georgia; Tbilisi 2010; p.36

that the data generated from the two studies are not completely comparable due to different research methodologies, the significant difference in the percentages of general population women and women living with HIV who reported being victims of sexual violence needs to be thoroughly studied.

In general, while the GBV & HIV in Georgia study does not indicate that HIV positive status can increase women's vulnerability to any forms of domestic violence (emotional, physical, sexual, economic), it has become obvious that the study target population is most vulnerable segment of general population women. Even though the two studies do not measure the prevalence of domestic violence against women using identical methodologies and survey questions, comparison of data still provides valuable information that confirms that women living with HIV are at much higher risk of gender based violence, and, consequently, are at higher risk of HIV than general population women.

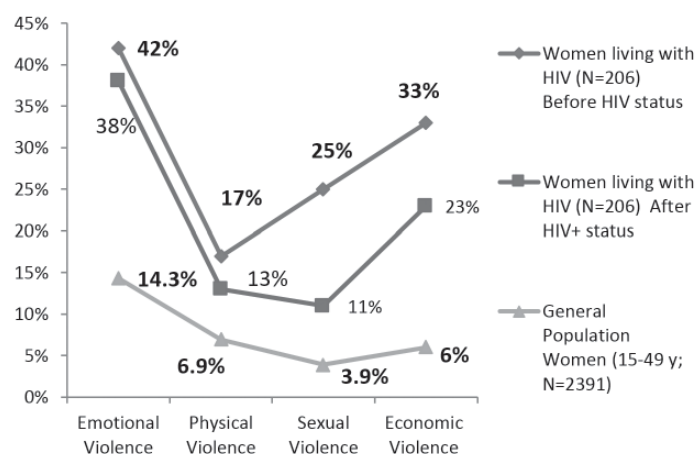
Table 9: Prevalence of domestic violence against women living with HIV and against general population women

	Women living with HIV (N=206)		General Population Women (15-49 y; N=2391) ²³
	Before HIV status (Yes)	After HIV+ status (Yes)	
Emotional/verbal violence	42%	38%	14.3% ²⁴
Physical Violence	17%	13%	6.9% ²⁵
Sexual Violence	25%	11%	3.9% ²⁶
Economic Violence	33%	23%	6% ²⁷

Percentage distribution of women being victims of different forms of domestic violence against women living with HIV and general population women indicates the following:

- The percentage of women living with HIV who encountered emotional violence before their HIV positive status was revealed is three times higher than that among general population women of reproductive age;
- The occurrence of physical violence against HIV positive women is twofold higher than that against general population women;
- The percentage of women living with HIV who admit being victims of sexual violence is almost three times higher than that among general population women;
- The percentage of women living with HIV who suffer from economic violence from spouses or other family members is seven times higher than that among general population women.

Figure 2: Percentage of women living with HIV being victims of violence before and after HIV status and percentage of general population women being victims of violence



²³Chitashvili, M. et al. National Research on Domestic Violence against Women in Georgia; Tbilisi 2010; p.32

²⁴Ibid; p.36 | ²⁵Ibid; p. 34 | ²⁶Ibid; p.36

²⁷Chitashvili, M. et al. National Research on Domestic Violence against Women in Georgia; Tbilisi 2010; p. 37

The GBV & HIV in Georgia study results found that the interviewed women have been experiencing various types of violence both before and after their HIV positive status was found. It is worth noting that occurrence of different forms of domestic violence decreases after women's HIV positive status was revealed.

In conclusion, women living with HIV face various forms of gender-based violence, including emotional, physical, sexual and economic. In most cases, survivors of violence say the perpetrators are their husbands and/or other intimate partners followed by other family members. The prevalence of violence against women living with HIV does not increase after their HIV positive status becomes known. Furthermore, the prevalence of gender-based violence against women is higher before they were diagnosed with HIV than after their HIV positive status was discovered.

Even though the GBV and HIV in Georgia study does not prove that HIV positive status can increase women's vulnerability to violence, the study found that before they were diagnosed, women living with HIV were several times more likely to suffer various forms of violence than general population women. This observation calls for further analysis into the causes of this apparent variance. The study findings prove that women who are at elevated risk of HIV (due to their own or their partners' risk behaviours) are also at much higher risk of becoming victims of gender-based violence.

While summarizing the findings from the survey of HIV positive women, it should be taken into consideration that majority of women respondents in the quantitative study mentioned they have not disclosed their HIV positive status with others outside the family. Therefore, the data collected on the prevalence of violence against women diagnosed with HIV mostly reflect cases of domestic violence committed by spouses/sex partners who might have started showing more supportive/compassionate attitudes towards family members after their HIV positive status is discovered. Probably, this is one of most plausible explanations for observed reduction in domestic violence against women living with HIV.

As HIV positive women tend to hide their HIV status, it can be assumed that judgmental attitudes, discrimination and violence against PLHIV from a wider social circle (such as neighbours, friends, colleagues, employers, acquaintances, etc.) may not be accurately reflected in the quantitative data. Real stories told by experts and HIV positive women during the narrative and in-depth interviews indicate how brutal the society can be towards women living with HIV if their status is made public.

2.2.2. Society / Local Community

As noted by research respondents, societal stigma towards HIV positive people may cause not only psychological violence but also different types of obstacles. HIV positive women may face rejection and isolation from their community. They may be excluded from social events and communication with them may be minimal. Considering the fact that relationships within the local community and neighbourhood are quite intense in Georgian reality, especially in rural areas, the restriction to their relationships might be a serious source of discomfort and humiliation. For those women who do not have jobs, relationships within their micro-social environment might be the only type of social activity they can get involved, and rejection from the community might lead them to total isolation and emotional abandonment.

HIV positive women may be forced to change their place of residence and move to other cities with the aim to avoid discrimination from the society that is aware of their HIV positive status. There may not only be psychological violence from the community, but a direct demand that the HIV positive person leaves the community (see Annex #1- story #4). It is worth mentioning that the probability of such violent acts is higher in rural areas/regional cities compared to the capital city. In urban settings, the risk of revealing the status of an HIV positive individual is lower due to a more isolated lifestyle. City residents might not reveal their status; however, this does not mean that urban areas are more tolerant towards HIV positive people. It can only be assumed that HIV positive individuals are not willing to share information about their status because they are afraid of people's reactions.

As research results show, psychological violence against HIV positive people may be more prevalent in cases involving women. HIV positive women participating in the study mention that HIV infection is still associated with "promiscuity" or other types of "immoral" and "unacceptable" behaviour. Respectively, negative attitudes towards women are more pronounced, as deviant behaviour of men is more likely to be tolerated.

Comments of HIV positive respondents:

Mari, Imereti: *2 or 3 neighbours found out that I was HIV positive and they discussed issue of my banishment. They said that they did not need such a sick person and that this disease is transmitted by air. I locked myself at home and did not go outside at all.*

Natia, Samegrelo: *They have negative opinion of such women. Everyone thinks that you are immoral. They do not think that it may be transmitted by spouse or in hospital after surgery. They always think something indecent about us and I am surprised why. [...] They have such a negative opinion, they think that this is kind of dirty disease. [...] They think that you are either drug user or prostitute.*

Salome, Adjara: *our population is so unaware of this disease that they think you are prostitute if you are infected. I was virgin when I got married and this was my fate. I don't want people to think that I am a prostitute. But the majority has such viewpoints.*

Salome, Adjara: *We found out about our diagnosis 12 years ago and it was very rare disease by that time. People are not aware of it even now and imagine situation in the past. Neighbours and relatives formed very different opinion of us. Of course, it affected us in various ways; we were hurt when someone would pass by and looked at us in a different way. But we have overcome all these problems.*

Societal violence may extend to non-infected family members of HIV positive people as well. Participant experts emphasize the cases when children of HIV positive parents were not allowed to go to school.

A child was dismissed from kindergarten in Kutaisi because of positive HIV status. This means lack of information and education – they don't know how HIV can be transmitted. There was one research examining attitudes toward HIV and it appeared that people will not even buy fresh vegetables from HIV positive person. (Alternative Georgia).

The sad stories told by study participants indicate that women living with HIV are highly stigmatized in Georgia and may face different forms of violence, however due to low-self esteem and sometimes self-blame women passively accept their status of being obedient and submissive, that in turn can be the cause of other forms of abuse against them.

2.2.3. Workplace

Study respondents think that stigma associated with HIV lowers self-esteem and confidence of HIV positive women and discourages them to seek jobs. Therefore, HIV positive status may be viewed as a limiting factor for the realization of the right to work. In some cases, HIV diagnosis may become hidden reason for the loss of employment.

Research results suggest that HIV positive people face the danger of losing their job in case their status is revealed. As experts note, they have seen or heard about cases in which (1) an HIV positive person is forced to resign because of unbearable psychological violence in workplaces; or (2) the infected person is fired solely because of his/her HIV status, though true reason for dismissal has never been uttered.

I think that many organizations will avoid hiring HIV positive person. I have this opinion based on experience; I have been working in this direction for years. (WIC)

An HIV positive person may resign because of fear that his or her positive status will become known against his/her will and that he/she may suffer negative consequences. (see Annex #1- story #5). For the same reason, HIV positive women are reluctant to look for a job. High unemployment among women living with HIV increases their financial dependence that eventually make them subordinate to men.

I have heard about such cases. Of course, no one tells them directly that they are fired because of HIV positive status. One thing is that they are dismissed from work and another thing is that, being afraid to be rejected and fired, HIV positive women do not try to look for job and protect their rights legally. (Bemoni)

Comments of HIV positive respondents:

Lela, Adjara: *I quit my job as I did not want anyone to find out my HIV status*

Tamta, Tbilisi: *I had problems at work; they made me to quit that job.*

The quantitative research among women living with HIV examines employment opportunities and problems associated with job searching. Out of 206 women surveyed, 45% reported having job and 26% of respondent women were looking for job; 28% of them were unemployed and not looking for job.

Table 10: Employment opportunities for women living with HIV

Are you employed?	
Yes	45 %
No, but I am looking for a job	26 %
No and I am not looking for a job	28%
I was but I was dismissed because of my HIV positive status	0.5% ²⁸
Refused to Answer	0.5%
N=206 (Total Sample)	

The study found that the unemployment rate among study participant HIV positive women is much higher than that among general population in Georgia; according to the official statistics, by the end of 2012, unemployment rate among general population did not exceed 15% in Georgia²⁹ while fewer than half of women living with HIV were employed.³⁰

Table 11: Self-reported reasons for being unemployed

What is the reason that you don't have a job and are not looking for it?	
No one will hire me because of my HIV positive status	16 %
My spouse does not want me to work	32 %
I don't have a mood	4 %
Because of illness/health condition	11 %
I don't want	5 %
N=57 (HIV positive women who don't work and are not looking for a job)	

²⁸A total of 4 women reported being dismissed because of their HIV positive status; however two of them found new jobs.

²⁹National Statistics Office of Georgia: http://www.geostat.ge/index.php?action=page&p_id=146&lang=eng accessed on September 22, 2013

³⁰Due to sampling limitation, women participating in the GBV & HIV in Georgia study may not be representative sample of all HIV positive women in Georgia; thus the data should be interpreted with caution.

As demonstrated in the table #11, out of 57 women who are unemployed and not looking for job, 9 women (16%) claim their HIV positive status as a reason for not looking for a job. This may indicate that HIV-associated stigma lowers person's self-esteem and may lead to self imposed isolation and withdrawal.

One third (33%) of study respondent HIV positive women have tried to find job or change their job after finding out about their HIV positive status. Majority of them (77%) faced certain problems while searching a job, though 85% of them think that problems were related to general unemployment in the country and were not directly associated with their HIV positive status. Only small proportion (15%) of job seeking respondents thinks that employers would not hire them because of their HIV positive status.

Table 12: Problems encountered while looking to job

Have you had a problem while looking for a job?	
Yes	77 %
No	23 %
N=69	
(HIV positive women who tried to find or change a job after their HIV positive status was detected)	

Results of quantitative research on HIV positive women show that the fear of being fired because of their HIV positive status is rather strong. The majority of respondents (57%) think that they will be fired from work in case their status is disclosed.

Table 13: Risks and barriers to job opportunities for women living with HIV

In your opinion, if your employer found out about your HIV positive status, would you be fired from work?	
Yes	57 %
No	11 %
I don't know	32 %
N=53	
(HIV positive women, who tried to look for a job after finding out about their HIV positive status)	
In your opinion, should you reveal your HIV positive status to your employer?	
Yes	6 %
No	94 %
N=69	
(HIV positive women who tried to look for a job and had problems in the process)	

Vast majority of women (94%) correctly think that HIV status should not be disclosed to an employer. According to the Georgia Law on HIV/AIDS requesting an HIV certificate/testing for employment purposes is not permitted. The survey data demonstrate that in most cases employers follow the law and do not require the certificate, however 10 women living with HIV participating in the survey say that their employers demanded HIV certificate. Of them, 9 women were told that was a standard procedure for new staff recruitment process; one women was requested to submit HIV certificate by the employer while working in Turkey.

An HIV positive woman may not be fired from work, but she may become a victim of prejudice and discrimination at the work place.

I remember one real story –one person had hepatitis C or some disease. He looked very sick and information was spread that he had AIDS. My aunt told me that he was in her room and drank coffee. When he finished and left the room, my boss took the cup and trashed it [...]. This person was totally isolated, they used to clean the place where he would sit, threw every dish he used. I can't name this organization but this is a vivid example that took place in society which has ambition of high level of awareness. (WIC)

The Georgian Law on HIV/AIDS prohibits any discrimination, including restriction of job opportunities for people on a basis of HIV status; however, respondents complain that there are very few work places in Georgia where HIV positive employees would be welcome.

The only place where HIV positive people are accepted is HIV/AID programs; because all employees working there know the specifics [...] I practically exclude the possibility that anywhere else in Georgia will hire an HIV positive person if he/she discloses her status... (Alternative Georgia)

Limited job opportunities for women living with HIV increase their economic vulnerability and they may face difficulties to access to and control over vital economic resources. Economic vulnerability of women may prevent them controlling their sexual behaviours and may force women into risky transactional sex to feed themselves and family members.

2.2.4. Medical Service

Attitudes of medical personnel present a rather significant case of discrimination and violence against HIV positive women. Experts and HIV positive respondents view the attitudes of medical personnel as a very serious problem. Research results show that widespread forms of violence against HIV positive people might include the violation of their right to health and wellbeing by limiting or prohibiting their access to healthcare services.

Experts and HIV positive respondents speak about cases in which HIV positive people are refused medical service, medicines and treatment. Medical personnel may display rude and dishonourable attitudes towards them. In addition, health care workers do not always safeguard patients' confidentiality.

The fact that medical personnel refuse to provide medical service shall be classified as serious violation of human rights. Such attitudes and unlawful conduct of medical personnel may result in deterioration of patient's psychological and health condition.

Results of quantitative research found that majority (72%) of HIV positive women participating in the study have not encountered problems while receiving medical services. Those women respondents who reported having problems clarified that problems are encountered when receiving medical service outside the AIDS Centre. In most cases when HIV positive women are refused medical service, medical personnel do not hesitate to openly declare that they "do not serve HIV positive people" (57%).

Table 14: Experiences while seeking medical services

Have you experienced the following while receiving medical service:	
I was denied medical service	11 %
They demonstrated careless attitude towards me	10 %
They tested me for HIV without my consent	12 %
They put medical instruments used by me aside	2 %
They avoided contact with me	1 %
None of above	72 %

N=206

(Total Sample)

Note: The sum exceeds 100% as multiple responses were permitted.

Table 15: Spoken reasons for denial of medical services

What was the reason for denying medical services?	
I was told that they don't serve HIV positive people	57 %
I was told that they did not have time	26 %
I was told that they did not have such service	4 %
I was told that they could not provide comprehensive treatment to me	4 %
I was told to take care of my immune system first and apply to them later	4 %

N=23

(HIV positive women who were refused the medical services)

Note: The sum exceeds 100% as multiple responses were permitted.

As results of quantitative research suggest, the majority of HIV positive women who were refused medical services (16/23; 88%) managed to get the needed service at the same (14%) or another institution (86%). However, it was noted that in most cases the problem was solved after the intervention by different authorities / organizations. Some respondents mentioned that doctors from AIDS Centre, or staff members of local NGO- HIV/AIDS Patients' Support Foundation, and Mrs. Sandra Elizabeth Roelofs, First Lady of Georgia assisted them in receiving needed medical service.

Lack of knowledge about HIV and how the virus can be transmitted contribute to negative attitudes and behaviours of medical personnel. Some experts recognize that the level of education of medical personnel is quite low. In some cases, their judgmental attitudes towards HIV positive people are also preconditioned by societal prejudice. Moreover, some medical personnel claim a moral right to treat them disrespectfully as HIV, in their perception, remains to be associated with promiscuity or other types of 'unacceptable' behaviours such as drug use or homosexuality. Expert respondents emphasized that medical personnel in Georgia are not well-aware of their legal duties as well as patients rights. Some health care workers are not aware of and do not follow standards of universal precautions for medical procedures that can explain their anxiety and panic related to serving people living with HIV. Due to all above-mentioned reasons, rights to health for women living with HIV are not always ensured, and their access to women-centred and user-friendly quality medical services is limited.

Comments of HIV positive respondents:

Salome, Adjara: *For instance, when you go to maternity house they have different attitude. I disclosed my status and I said I was keeping the baby; they looked at me as if I was a vampire or an alien. This is so wrong to make someone feel so rejected and humiliating.*

Mari, Imereti: *I am very satisfied with the doctors who treated me at the AIDS centre. But not all doctors are alike. Once I fainted and my neighbours called the ambulance. Doctor examined me, checked my heart, blood pressure and asked me what was wrong because everything was in order. I told honestly that I was HIV positive. The doctor stood up, called the nurse to take medicines and they left me without doing anything.*

Another problematic issue in health care sector identified by both experts and HIV positive respondents is the confidentiality of HIV positive patients' status. Medical personnel do not fully understand that disclosing a patient's status without his/her consent is a violation of the patient's rights guaranteed by numbers of Georgian legislation (State Law on Public Health; Law on Patients Rights; Law on HIV/AIDS, etc.).

The risk of breach of confidentiality drives many women, mostly in regions, to go to other cities for HIV test, as they fear

their HIV status can be spread in their community and can affect their lives negatively.

As a rule everyone avoids testing in their districts, they prefer to do it somewhere else because everyone knows each other and it is more preferable to do tests elsewhere. (Bemoni)

If a patient is hospitalized and is tested for HIV, attitudes toward the patient is normal before his/her positive HIV positive status is detected... and then, suddenly, other patients in the room recover and are discharged from the hospital; the nurse does not come in for procedures; everyone avoids infected patient... Then it becomes obvious that doctor did not keep the confidentiality of the patient and you know why people's attitudes changed drastically. Unfortunately, it happens frequently. (RTI International)

Comments of HIV positive respondents:

Irina, Tbilisi: *I can't go to dentist. I can't disclose my status as I have no hope of confidentiality.*

Lika, Imereti: *Confidentiality is not preserved. You are afraid because they don't accept you if you expose your status. There should be personal doctors for us in order to preserve confidentiality. It does not work otherwise.*

Many experts think that the issues of patients' anonymity and confidentiality bear secondary importance and are not treated with necessary attention within health care settings in Georgia. Experts emphasize that people living with HIV, men and women equally, never submit formal complaints against medical personnel for breach of confidentiality as they know that their status would be exposed to even more people and they might be at even more risk of further violence and discrimination from others. Therefore, harmful societal stereotypes and violence against PLHIV have never been challenged by victims, and a vicious cycle starts spinning aggravating self-stigma and self-isolation among people living with HIV.

In-depth interviews with experts and key populations as well as quantitative research among women living with HIV show that not many respondents are aware that HIV positive persons are no longer obliged to disclose their HIV status to medical personnel. Before 2009, when new State Law on HIV/AIDS was adopted in Georgia, every HIV positive patient had legal obligation to disclose HIV positive status to medical doctors prior to receiving medical services. This article created serious barriers to medical services for those who were obedient to the law and honest enough to disclose their HIV status to medical doctors. As a result, in most cases these patients were denied medical services in many settings of health care system. HIV advocates and policy makers have acknowledged unfairness of the Law restricting health rights of people living with HIV, and adopted new, more human rights based Law on HIV/AIDS according to which people living with HIV are no longer obliged to disclose their status with health care providers.

To minimize stigma and discrimination of people living with HIV in health care settings, number of effective strategies should be implemented. One of these strategies should be HIV awareness raising campaigns targeting not only people living with HIV but also general public, management of medical institutions, health care professionals, representatives of mass media, human rights advocates, etc.

2.2.5. Self stigma and self isolation

As participant experts state, fear of stigma and discrimination is so severe that it is common for people living with HIV to withdraw from society and relationships. Furthermore, some degree of isolation may be even self-imposed. Expert respondents mention that many people living with HIV express their desire to have special, designated medical institutions for PLHIV where they could get medical services

Comments of HIV positive respondents:

Tika, Tbilisi: *I want the government to appoint doctors for us; first of all gynaecologists and dentists as they are most afraid of us. I feel ashamed to go to a gynaecologist and tell that I am HIV positive.*

Lela, Adjara: *We get free medicines from state and it is very good. Our only request would be separate gynaecological department for us and dentist who will work only with us.*

Mari, Imereti: *Yes, we need our own doctors – our gynaecologist, dentist and psychologists. These services can be set up in ordinary hospital, but there should be separate department for us where we can get treatment.*

Irma, Samegrelo: *There should exist an institution where HIV positive people would receive gynaecological or dental service as some of us are afraid to reveal our status to every doctor. For instance, when I go to a doctor I say that I have C hepatitis and they provide treatment more easily. They are not as afraid of hepatitis as of AIDS.*

Due to negative attitudes of medical personnel, women living with HIV prefer to have special medical services where HIV positive people will not be refused needed services and will not suffer negative attitudes from other patients or personnel. This is seen as one realistic short-term solution by some respondents, however many agree that in long-term, staff capacity should be strengthened, medical services should be improved and the general mentality of society should be changed to ensure women living with HIV have equal access to quality health care.

As noted by experts, due to the mentality prevalent in society, HIV positive people have low self-esteem and low self-confidence and in some cases, they believe that they deserve the negative attitudes expressed by their community or the broader society. (See Annex #1- story #5)

There is such phenomenon called self-stigma when a person perceives himself as indecent, inferior. This person agrees on everything that is said about HIV positives and has similar opinion on himself. Only few people manage to overcome self-stigma. (Bemoni)

Comments of HIV positive respondents:

Irina, Tbilisi: *Of course, my life has changed since I found out my diagnosis. I feel incapable and inferior. For example, I can't even go to dentist. My life has completely changed.*

The effects of stigma and discrimination, self-deprecation and low awareness all contribute to the negative impact on women living with HIV and make them more vulnerable to different types of violence.

2.3. SOCIO-DEMOGRAPHIC PROFILE, AWARENESS AND BEHAVIOUR AMONG WOMEN LIVING WITH HIV

2.3.1. Socio-demographic Profile of the Respondents

A total of 206 women living with HIV were surveyed in Tbilisi, the capital city and in three other cities of West Georgia – Batumi, Kutaisi and Zugdidi. The majority of HIV positive women respondents fall in the 35-44 age category. The numbers of respondents in the youngest (18-24) and the oldest age groups (55-64) are very low (4 women in each of the two groups). This uneven distribution of respondents by age does not allow data disaggregation by age groups. Distribution of interviews by cities is presented below:

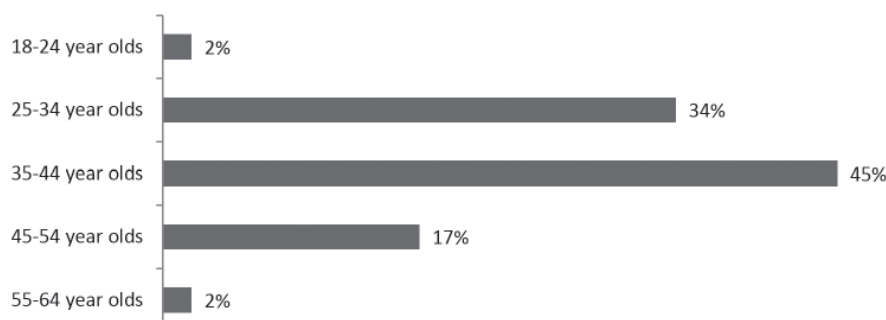
Table 16: Distribution of interviews by cities

Distribution of interviews by cities		
	N	Percent
Tbilisi	121	58.7
Batumi	30	14.6
Kutaisi	25	12.1
Zugdidi	30	14.6
Total	206	100.0

GENDER BASED VIOLENCE AND HIV/AIDS IN GEORGIA: LINKS, OPPORTUNITIES AND POTENTIAL RESPONSES

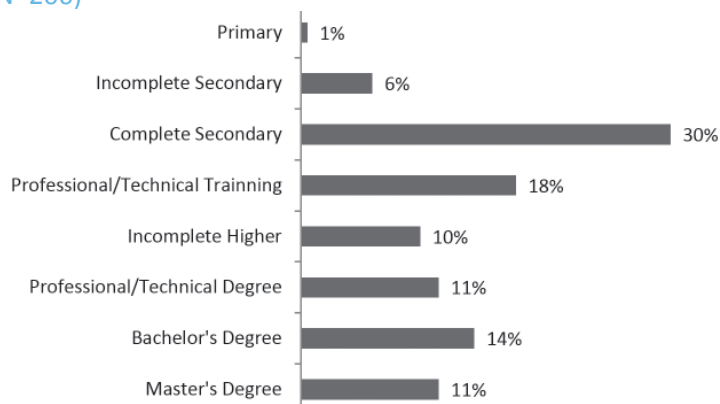
Due to high level of stigma associated with HIV status, some people living with HIV prefer to attend medical services in other cities rather than places of their permanent residency. Therefore, respondents who were surveyed in Tbilisi do not necessarily reside in Tbilisi. The question about the place of residency of respondents was not included in the survey instrument. Due to this limitation, research does not allow to present disaggregation of data by places of residency of respondents.

Figure 3: The Age of Respondents (N=206)



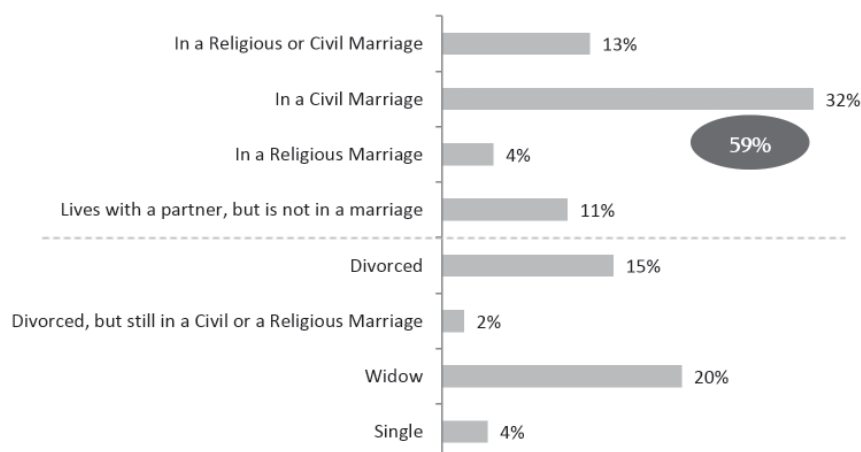
With regards of the education of the respondents, the majority reported having some level of formal education. Seven per cent of all respondents have primary or incomplete secondary education; 25% have completed higher education (Bachelor's degree – 14%; Master's degree – 11%).

Figure 4: Level of Education (N=206)



The Majority of the respondents (59%) are currently in a continual relationship with their partners – including civil, religious or unregistered marriages. Every fifth respondent (20%) is a widow and only 4% have not been married.

Figure 5: Marital Status of Respondents (N=206)



Every fifth respondent (22%) reports that the financial conditions in her family is extremely poor – “There’s barely some money for food”. In general, those who have access to primary products and necessities of everyday consumption make up a small part of the respondents. Only 2% report that their families can afford everything they need.

Table 17: Financial Status of Respondents

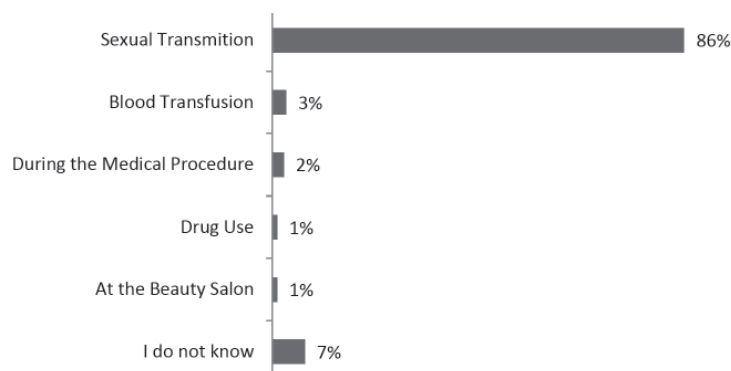
Financial Status of Respondents’ Families	
The money is barely enough for food	22%
We have enough money for food, but in order to afford clothes and shoes we need to save, or borrow some money	34%
We have enough money for food, everyday clothes and shoes. However, in order to afford good clothes, cell phones, vacuum cleaners and other domestic technology, we need to save, or borrow some money	34%
We have enough money for food, everyday clothes and shoes. However, in order to afford a car or an apartment, we need to save, or borrow some money	9%
We can afford anything we wish, at any time.	2%

N=206
(Full Sample)

2.3.2. HIV Related Awareness and Behaviour

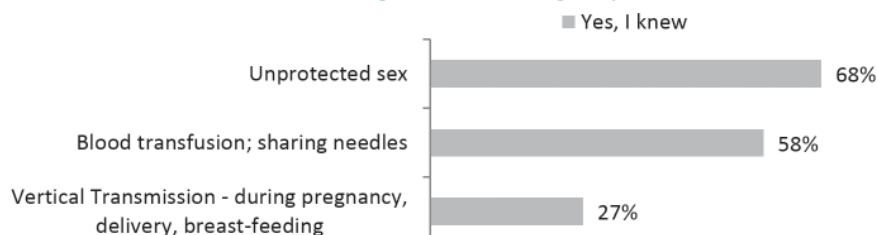
The vast majority of interviewed women living with HIV think that the virus was transmitted to them through sexual contact – 86%. Only few women indicated they were infected through blood transfusion, drug use or during medical procedures; seven per cent of respondents do not know how they were infected.

Figure 6: Potential routes of HIV transmission (N=206)



Prior to being diagnosed, HIV awareness was low among HIV positive women participating in the quantitative research. Slightly more than half was aware the virus could be transmitted through blood transfusion or contaminated medical instruments. Fewer than one-third of women respondents knew about vertical transmission of HIV. As mentioned above the majority of women (177 out of 206 surveyed) living with HIV think the virus was transmitted to them through sexual contact, however only 140 women say they were aware of sexual transmission of HIV before their status was detected. The current level of HIV awareness among women living with HIV was not studied.

Figure 7: Did you know HIV could be transmitted through the following ways? (N=206)



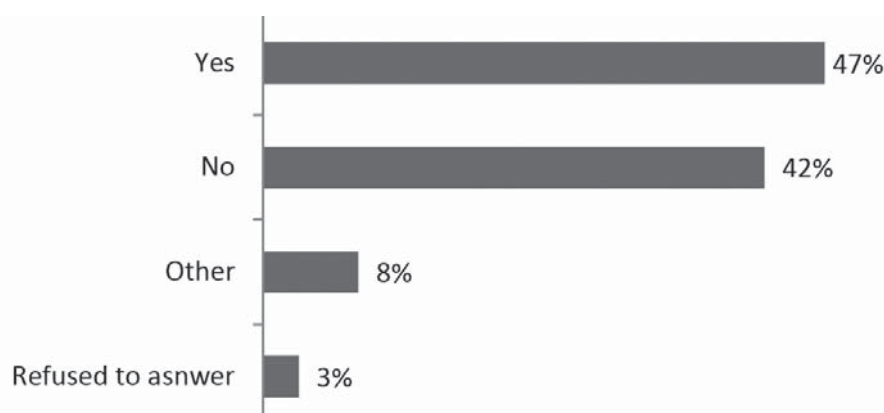
HIV positive women participating in the survey were asked about the reasons for getting HIV tests. The highest share of women (30%) got tested only after they have learned their husband was diagnosed with HIV; slightly less (26%) sought test-

ing after HIV/AIDS associated symptoms were manifested. One fifth of women living with HIV found out about their status through HIV screening during pregnancy; only fourteen women checked their status because of practicing unsafe behaviors.

Table 18: Major reasons for testing on HIV

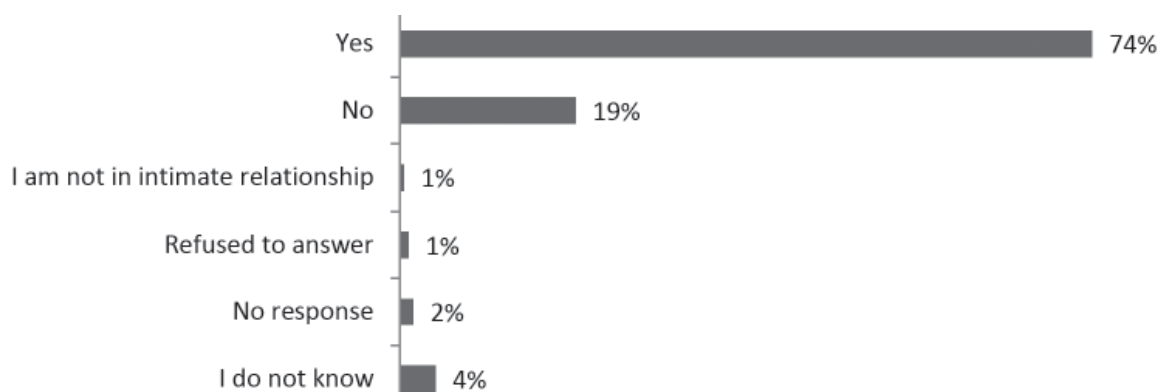
Major reasons for testing on HIV	(N=206)	%
Learned my spouse was infected	61	29.6
Noticed HIV/AIDS related symptoms	53	25.7
Screening test during pregnancy	50	24.3
Had risky behavior	14	6.8
After my child was tested and diagnosed with HIV	7	3.4
During other medical procedures/surgery	7	3.4
I doubted after my spouse died	4	1.9
Blood donor	3	1.5
Other reasons (not listed above)	9	4.4

Figure 8: Since you found out your sexual partner was HIV positive, have you asked him to use condoms? (N=155)



Almost half of women respondents (42%) have never asked their husband to use condoms since they found out about partner's HIV positive status. This indicates that women may be negligent, or not aware of the possibility of HIV re-infection in HIV sero-concordant couples. About half of respondents mentioned that after they found out their sex partner was diagnosed HIV, they attempted to use condoms; however, the study did not ask follow-up questions to find out whether their husband/intimate partners agreed to use condoms or not.

Figure 9: You are not obliged to answer, but we would still like to ask you if your sexual partner is HIV positive? (N=206)



Majority (74%) of HIV positive women participating in the quantitative research are in concordant HIV-positive relationships. Out of 153 women in marital/intimate relationship, 140 (93%) say their male partners are aware of their HIV positive status. Only 12 women report not sharing their HIV status with their spouses. According to the Georgian Law on HIV/AIDS, every person living with HIV is legally obliged to notify his/her regular sex partner about his/her HIV positive status; however after double-checking other responses, it became clear that spouses/regular sex partners of these 12 women were HIV positive.

Interestingly, half of all respondent women (103/206; 50%) report that their spouse/sex partners are injecting drug users. Only five women admitted injecting drugs themselves; of them 4 women say that this was their decision and only one woman states that her IDU husband forced her to inject drugs. All of them mention that they have used syringes previously used by their husband. Women who are partners of male IDUs and report injecting drugs with shared syringes may have been infected either through unprotected sex with the IDU husbands, or through sharing contaminated injection equipment.

CHAPTER III. COMBATING GENDER BASED VIOLENCE AND PREVENTING HIV – EXISTING SERVICES AND MECHANISMS

3.1 Fight Against GBV and its Prevention - Existing Mechanisms and Services

In Georgian reality, prevention of violence against women is carried out (1) at the Government level by different Governmental institutions and (2) by the non-governmental sector. The non-governmental sector is largely dependent on the funding of international organizations, while the relevant Governmental institutions receive funding from the state budget. Study respondents were asked to list available prevention and support services targeting female victims of violence in Georgia. Study results show that there are different types of support services that can be offered to female survivors of domestic violence at both Governmental institutions and Non-Governmental organizations. These services include:

- Psychological counselling / rehabilitation;
- Legal advice/counselling;
- Shelter;
- Medical assistance / Emergency medical service;
- Voluntary testing for STIs, including HIV;
- Professional courses and trainings (within the scope of the rehabilitation program);
- Hotline service.

All research participants admit that resources for protection and rehabilitation of the female victims of violence are insufficient. Mobilization of resources is necessary in order to diversify the scope and increase the scale of existing services. Experts participating in the research talked about the various mechanisms that are in place to prevent the violence against women and meet multiple needs of survivors:

1. A woman who is a victim of violence can call the police that registers the case and determines who is a victim and who is an abuser. Victims will then be transferred to a shelter. If a shelter is not needed, the woman is given the opportunity to use other support services, including psychological counselling, medical services and/or vocational training programs. Within the framework of preventive measures, the police officer is entitled to issue a restraining order, restricting the activity of the abuser. The court can warrant the restraining order issued by the police, which is submitted to the court within 24 hours from the issuance.
2. A victim of violence may address the court, which determines her status as a victim and refers her to legal and/or medical and psychological services as appropriate. The court may issue a protective order, implying temporary measures for protecting the victim of violence. As research participants note, a protective order may be issued in case the abuser violates the terms of the restraining order.
3. A victim of violence can address the victim identification group, which is composed of professionals from various fields (representatives of non-governmental organizations, psychologists, lawyers and social workers). Within three days after the case is registered, the victim identification group is convened by the ATIPFUND to thoroughly study the violent case. If the status of a victim is confirmed, the survivor gets access to available support services. This group may be called in case a victim asks for help through the hotline. The victim identification group does not identify an abuser; its authority is limited to only determining the victims in order to make them eligible for state sponsored services that are offered by the ATIPFUND. The police and court, however, can identify both, the victim as well as the abuser.

4. An act of violence can also be identified if the victim calls for emergency medical service (ER). If physical violence is suspected, ER staff members are required to fill out the appropriate form, that can be used by relevant services to identify whether the injuries are results of physical violence.

While the mechanisms listed above demonstrate that, there are functional procedures at the action plan level to identify cases of violence and support its elimination and prevention, research participants note that the enforcement and carrying out of these written procedures is problematic.

Cultural opinions and stereotypes prevailed in the Georgian society create barriers to enforcement and successful implementation of described mechanisms. In some cases, a police officer may underestimate the severity of cases and perceive them as mild forms of violence that do not require police action. In addition, like many other members of society, a police officer may be reluctant to intervene into family life and think that any conflicts within the family must be solved within it. Ultimately, police takes action only in obviously extreme cases of violence. In a number of cases, inadequate response from the police officers may contribute to recurrence of violence (see, story #2).

The police themselves are unprepared for such situation. Often times the police doesn't issue a restraining order when called, because they consider that this is a typical family conflict. It is a bad, Soviet vestige to believe that family topics are tabooed and nobody should interfere. (Women's Fund)

CASES OF GBV REPORTED BY EXPERTS

Gender Violence - Case #2: Problem of Social Perceptions and Police Mentality

Women's Fund: There was a case in Kobuleti, when a young girl who got married, was accused by her husband of not being virgin on the wedding night. So, he took her to the police where she was pressured to confess her premarital sex. This girl was a minor and she was treated as criminal and whore. Later, the expertise concluded that she was a virgin on her wedding night.

Standard procedures are often not enforced by the Emergency Service staff as well. In most cases, major reasons of misconduct of medical staff remain similar: stereotypes and erroneous family values, low awareness and/or negligence.

Government doesn't request strictly from medical personnel the special form on violence be filled for every reported case. The victim needs this form as legal evidence of violence. [...] So, these forms do exist but they don't work. Adequate attention is not paid to this problem (Women's Fund)

Study respondents complained that established procedures are very strict and less flexible. Any victim should go through certain verification procedures to become entitled to available services supported by the Government. Such complicated procedures when combined with other barriers (due to cultural, social, etc.) minimize the chance of service utilization by those in needs. Respondents acknowledge that the government fears that due to harsh socio-economic situation in the country and high level of unemployment and poverty some people may try to manipulate to get free shelter and meal. Therefore, Government explains that existing verification procedures are necessary to ensure that state or donor funded services can benefit those who are eligible.

Women oftentimes address the police later... when everything quiets down, when it is not easy to prove she was violated. So, if a survivor does not react immediately and does not call the police, we cannot assist them [...] We can't address the Court based solely on her story. (GYLA)

If an individual does not have a status of a victim determined, she cannot benefit from the service of a shelter (ATIP) America has a huge experience in this direction. [...] In the US, as far as I know, only the words of a victim are enough for the abuser to be removed [...] If a person says she/he is a victim of violence, she/he is taken care of and is instantly removed/guarded from the abuser. (GYLA)

Some solutions to this problem are services offered at the NGO sector within the frames of donor funded programs, where such procedures of presenting proof are not required. Some research participants note that the collaboration between the Government and Non-Governmental structures has been very beneficial as a female victim of violence may first be placed at the shelter run by NGO and then be transferred to the Government shelter.

Study experts think that relevant legislations are being harmonized in Georgia but, law enforcement is becoming crucial vulnerable point that has negative impact on prevention of GBV and provision of necessary, sometimes, lifesavings services to female survivors of violence. Lack of financial resources also is one of the most problematic issues and experts highlight that prevention of the VAW and provision of medical, social and legal services to victims of violence should be covered by the state funds and should not be heavily relied on donor funds.

Orientation on Short-Term Result - Providing Services

According to experts, it is necessary to increase the number of existing shelters and crises centres in order to provide first-line support and protect female victims in an effective and timely manner. Respondents stressed that rehabilitation centres for abusers, which do not currently exist in Georgia should become available. The existence of rehabilitation centres will allow for the abusive male to be removed from the house, in case separation of the couple is needed.

It is often criticized that a shelter is not a solution and I agree that it is not a long-term solution. But we all know that changing mentality is lengthy process and what else could be done? Of course, we should have shelters and we should have rehabilitation centres. [...] There are 6 or 7 shelters throughout Georgia and services are not enough considering what the statistics regarding the violence say. (Women's fund)

Ambivalent opinions were expressed regarding working with abusers to prevent violence. Some research participants consider it more optimal to mobilize Government and NGO resources in support of victims. Other research participants note that in terms of preventing violence, interventions should also target abusers as well to reduce the likelihood of reoccurrence of violence. This is important to make sure that female survivors who return home from the shelter do not suffer repeated abuse. Rehabilitation/correctional centres for offenders should provide various services, including psychotherapeutic counselling as well as various social and educational activities. It should be noted that some respondents believe that attendance in educational activities should be mandatory for offenders.

We only work with the victim and nobody works with the abusers [...] So, when these women return home, [...] they are met by the same person, and the same person does the same. [...] We may not put an abuser in the shelter, but just like the probationers go and sign in every day, the abuser could come, officially check-in, and go through the program. (Samtskhe-Javakheti Democrat Women's Association)

It was also noted that imprisoning abusers without providing psychological services and involving them in cognitive-behavioural treatment programs would not be effective for changing the mentality and violent behaviours of offenders. (See gender violence case #3)

Cases of Violence Told by the Experts

Gender Violence- Case #3: Domestic violence from the side of a partner

Sakhli: There was a very lovely young woman, who studied and lived in Germany, she fell in love with a guy in Tbilisi. This guy went to Germany and they started living together. They managed to save some money and bought a small apartment in Tbilisi. After this, the guy started abusing drugs and gambling. After certain period, their life turned into hell. The man had an affair on the side and was kicking his wife out of the house together with their two children from the house that they had bought together. He was trying to get rid of this woman ... what could she do. Where could she go with two children when she had no other place to live?! This man was constantly beating her. One day, while fighting, the fish-tank broke and the woman got severely injured. The police was called, the case was opened. The young woman was placed in the shelter. The guy was imprisoned but he was threatening that one day he would be released and would 'take care of them'. He accuses his wife that she intentionally sent him to prison. So, who knows what this man is capable of when he is released?

Orientation on long-term results - Increasing the Awareness

Study respondents state the awareness of available services is very low among the population and information about these services should be disseminated through various channels of communications (TV, radio, print media, billboards, leaflets). Experts emphasized that education should be provided to various target groups: general population, women at risk of GBV, police, health care professionals, media representatives.

Education of population is vitally important. We absolutely must educate women so that their self-esteem increases and so that the social attitudes towards domestic violence change. Through education, we need to convince women that it is more of a shame when you are like slave and it's never a shame when you defend your rights. Educated and self-empowered women are more likely to oppose domestic violence and protect their rights. Simultaneously, availability of services should increase; services should be geographically convenient and they should probably be free for such women. (RTI International)

While talking about international experience in fighting GBV, research participants mentioned about the positive impact of public awareness raising campaigns. There are some efforts to observe international days in Georgia, like: UN general secretary campaign, orange day against GBV, awareness raising campaign against GBV where Rugby players are involved as opinion formers; 16-days campaign against GBV, which starts at the International day of fight against GBV and ends at the Human Rights day. However, experts mention that these campaigns have more sporadic characters, and they stressed that educational interventions should be carried out on a more regular basis to break societal stereotypes and change population's mentality.

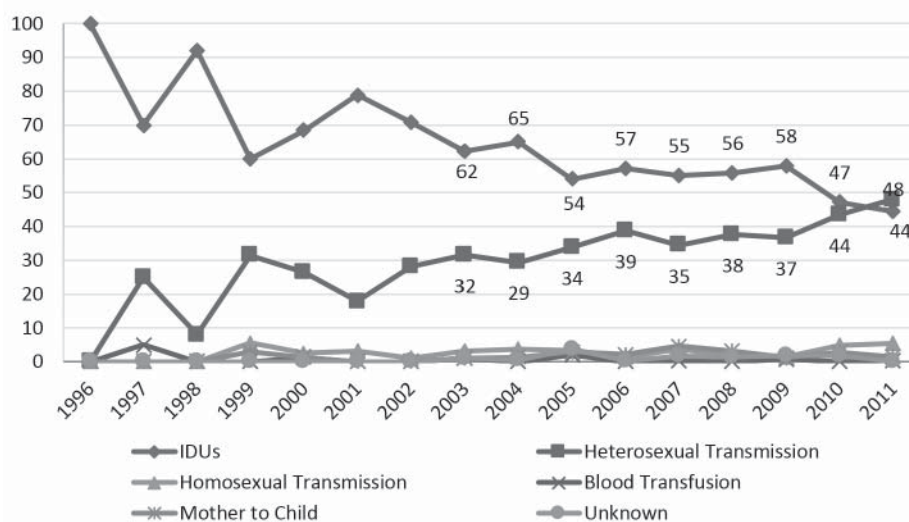
3.2. HIV PREVENTION - EXISTING MECHANISMS AND SERVICES

HIV epidemiologic profile

Georgia is among countries with low HIV/AIDS prevalence within general population (0.05%) and with a concentrated HIV epidemic demonstrated by over 10% HIV prevalence among MSM; prevalence among PWID is over 5% in Batumi and Zugdidi.^{31 32}

By May 2013, a total of 3,821 HIV/AIDS cases have been registered in the Infectious Diseases, AIDS & Clinical Immunology Research Center, including 2,804 men and 1,017 women. The majority of patients belong to the age group of 29-40; 2,422 patients developed AIDS; and 833 patients have died.³³ There is significant risk of spreading HIV infection from key populations to general public predominantly through heterosexual route. Notably, in 2011 a shift was observed in the main route of HIV transmission from IDU to heterosexual transmission, especially among females.

Figure 10: Distribution of newly registered HIV cases by transmission ways (%), 1996-2011³⁴



³¹HIV risk and prevention behaviors among People Who Inject Drugs in six cities of Georgia. Bio-behavioral surveillance survey in Tbilisi, Batumi, Zugdidi, Telavi, Gori, Kutaisi in 2012. Study report. Prepared by: Curatio International Foundation. Public Union Bemoni. February 2013

³²HIV risk and prevention behavior among Men who have Sex with Men in Tbilisi, Georgia. Bio-behavioral surveillance survey 2012. Study report. Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma. February 2013

³³[2] Infectious Diseases, AIDS and Clinical Immunology Research Center, Retrieved May 26, 2013, from http://www.aidscenter.ge/index_eng.html accessed May, 2013

³⁴Modes of HIV Transmission in Georgia; 2012; UNAIDS; page 19

HIV Prevention Services: availability and affordability

HIV prevention is acknowledged by the government of Georgia as one of the top priorities of health care system in the country. Study participants are aware that there is a broad range of HIV prevention and AIDS treatment programs that are implemented in Georgia by various governmental and non-governmental institutions. Available HIV/AIDS services include but are not limited to the following:

- ARV Therapy for all AIDS patients and treatment of opportunistic infections (free for patients)
- HIV counseling and testing and testing on Hepatitis C and B (free for key populations – IDUs and their female sex partners; MSM and their partners; female sex workers; prisoners)
- STI testing and treatment services (free for key populations)
- Prevention of Mother to Child Transmission of HIV (state supported universal testing of all pregnant women attending Perinatal clinics; free ARV treatment for all pregnant living with HIV under the Global Fund project)
- Drug addiction treatment (due to limited resources covers only limited number of drug addicts)
- Harm reduction services including Methadone Substitution Therapy for drug users/addicted persons (free for patients under the Global fund; co-payment is involved for the State supported program) and dissemination of sterile injection instruments and condoms
- Behavior change communication interventions targeting key populations and general public (donor funded programs)

While discussing available HIV prevention and AIDS treatment services among study participants, respondents mention that all services are equally accessible to every person regardless their race, age, gender, ethnicity, social status, religions or sexual orientation. These equal rights for all are guaranteed by the Georgian legislation. Women do not face any legal problems in accessing any types of prevention or treatment services. Furthermore, some programs provide additional incentives to recruit women injecting drugs in the programs (Methadone Substitution Therapy; harm reduction services). Respondents state that strict anti-drug legislation as well as strong stigma attached to HIV, drug use, commercial sex and homosexuality – all create barriers to HIV prevention and treatment services for both, women and men and prevent them from seeking the services they are entitled to receive for free of charge.

Stigma and social stereotypes that disproportionately affect women more than men are the major problems in accessing needed services. Stigma is fueled by low level of HIV awareness among general public:

When the first cases of AIDS were registered, people were saying that this is a disease of homosexuals, afterwards they were saying that this is a disease of drug-addicts, etc.; or, it's an incurable disease killing people in few years. Even though more than three decades have passed since then, stereotypes and misbeliefs around AIDS still exist in Georgia. In some regions where HIV is less common, the way people talk about an infected individual gives me an impression that they think him/her to be some kind of a monster and most dangerous person. Some people may still think that infected people are chasing others to forcibly infect them. This is so sad. In places where there are more infected individuals and people observe them to be normal humans, stigma associated with HIV decreases gradually. However, we do not want the HIV epidemic to explode in order to change people's attitude (Bemoni)

All respondents admit that HIV associated stigma is the major reason for people not to seek testing and other medical or social services. Some experts also highlighted that the information about available services is not accessible to general public. Not everyone is aware that most HIV prevention services for vulnerable populations are free in Georgia, and some of them still think that they cannot afford HIV prevention services.

Even though that HIV/AIDS services are both, available and affordable to all people regardless gender, women practicing risk behaviours (female sex works, women injecting drugs), or women living with HIV report that fear of confidentiality breach and discrimination in health care settings may deter them from seeking medical services, unless it is absolutely necessary. Some experts stressed about increased HIV vulnerability of women and they believe that women-centred, user-friendly services should be established in Georgia that will be oriented to meet specific needs of women. Few experts also noted that GBV and HIV prevention services should strengthen coordination and integrated services should become available to women who are at risk of both, gender based violence and HIV.

While talking about international experience in fighting GBV, research participants mentioned about the positive impact of public awareness raising campaigns. There are some efforts to observe international days in Georgia, like: UN general secretary campaign, orange day against GBV, awareness raising campaign against GBV where Rugby players are involved as opinion formers; 16-days campaign against GBV, which starts at the International day of fight against GBV and ends at the Human Rights day. However, experts mention that these campaigns have more sporadic characters, and they stressed that educational interventions should be carried out on a more regular basis to break societal stereotypes and change population's mentality.

CHAPTER IV: MAJOR FINDINGS AND RECOMMENDATION

Major Findings: GBV and HIV

A set of unwritten moral, ethical and social norms prevalent in Georgia permits men greater freedom than women in terms of sexuality as well as alcohol or drug abuse behaviour. Even though legally women are not discriminated and they are entitled to the same rights and the same opportunities as men, part of the Georgian society still believes that women belong to an inferior class and they are expected to marry, rear children, and be modest and obedient to their own husbands, and be fully dedicated to their families. Such societal attitudes reduce women's self-esteem and increases their vulnerability. Due to low self-esteem some women may feel worthless and secretly believe that they do not deserve happiness and should endure violence from their "masters." Awareness of gender based domestic violence is low and some women, even if they become subjects to violence, may not always qualify violent acts as a domestic violence. Most women, even if they are more knowledgeable of the phenomenon of domestic violence and can recognize its forms, are unlikely to report the violence to the police or refer to support services due to stigma.

In addition, general public attitudes of negligence or passivity create fertile ground to maintain a climate of social acceptability and tolerance towards violence. Silence from both, survivors and witnesses remains a common reaction to VAW in Georgia. Furthermore, the GBV & HIV in Georgia study demonstrates that even police and medical personnel who have mandate to report domestic violence, in most cases are reluctant to do so saying that they do not want to "intrude" into family business.

Respondents also highlight that survivor women may keep the silence and tolerate violent acts due to several personal factors: embarrassment, fear of recurrent violence, family reputation, economic dependency on sex partners. In addition, women may not expect that they can get help as they are not aware of available support services, or do not believe they can access and afford these services after the reporting. Fear of retaliation from abusers is the most frequently cited reason that inhibits witnesses (family members, neighbours, or others) to report the violence against women.

Victims of gender-based violence are at elevated risk of contracting HIV as they lack the ability to refuse sexual contacts against their will and negotiate condom use with sex partners. Many respondents highlighted that there is a widespread social norm according to which using condom in a married life is not "necessary"; moreover, to request husband/regular sex partner to use condom in marital/romantic relationship is perceived as insulting, lack of love, distrust, disrespect, or accusing in infidelity.

Beyond personal and societal factors, inadequate policy environment may contribute to low level of violence reporting and poor data collection. Due to lack of available reliable data, statistics on violence against women are very limited. Based on expert's opinion and the most common form of violence is psychological violence; sexual assault and or coercion in sexual relationship without women's will occur relatively seldom. However, the quantitative study among women living with HIV demonstrated that one woman in very four HIV positive females faces sexual violence from their own spouses or intimate partners. In vast majority of violence against women, sex-partners are the perpetrators followed by other family members (mother in-laws, other relative in-law). The society in Georgia believes that a wife has to always fulfil her husband's sexual desire, and therefore, forcing wives into coerced sex oftentimes is not perceived as a marital rape until it involves serious physical injuries.

Comparison of the extent of domestic violence against general population women of reproductive age with the prevalence of violent acts against women living with HIV unambiguously indicates that HIV positive women are at much higher risk of GBV than general population women. Further researches are needed to generate evidences for links and casual pathways between the GBV and HIV among women in Georgia.

Recommendations:

To prevent GBV and HIV infection among women, to reduce women's vulnerability to GBV and HIV, and to mitigate harmful consequences of both, GBV and HIV for women, effective policy and interventions should be enforced at various levels of social life:

Government/policy level:

- Ensure protective laws and policies are in place and enforced to prevent GBV; establish effective mechanisms to monitor enforcement of related legislation; policies and protocols for improved identification and management of survivors should be developed and institutionalized;
- Support more active, multi-sectoral cooperation between government and non-governmental sectors and build relationship and effective referral pathways among organizations working on GBV and HIV;
- Increase the number of shelters and crises centres for female victims of violence to offer immediate, first-line support at a minimum. Immediate support should include minimum package of interventions that ensure physical and emotional safety of survivors. First-line support should be in accordance with the WHO clinical and policy guidelines released in 2013;³⁵
- Support integration of GBV and HIV prevention services to ensure that voluntary HIV counselling and testing services are offered to survivors of domestic violence;
- Recruit social workers and create a network, which will help the state identify victims of violence and prevent violent acts. It may also be effective to recruit female victims of GBV as social workers and involve them in violence prevention programmes;
- Develop and implement GBV and STI/HIV prevention protocol/standard operation procedures that will cover the topics of HIV testing, HIV post-exposure prophylactic treatment and its adherence, emergency contraception, other prophylaxis/presumptive treatment for STIs.
- Challenge harmful societal stereotypes and gender norms to reduce acceptance of GBV through education;
- Train representatives of law-enforcement agencies (police officers, personnel working in penitentiary system, etc.) regarding violence to increase their capacity to identify, prevent and manage violent acts against women;
- Increase availability and accessibility to psychological counseling and care services for survivors in women-focused care centers, including family planning and reproductive health services. Psychologists will help female victims of hidden/potential violence know more about violence prevention and achieve certain psychological rehabilitation;
- Increase accessibility to female condoms for the prevention of certain types of GBV and HIV. Inform relevant state and non-state bodies about the need of informing the general population about female condoms;
- Promote women's and girls' economic security and independence and initiate women's economic empowerment strategies;
- Identify knowledge gaps to understand intersections of GBV and HIV in Georgia and address these gaps through researches;
- Design and implement national monitoring and evaluation system and establish routine data collection of national key indicators to measure effectiveness of national response aiming at GBV and HIV prevention in Georgia. A special database should be developed to track domestic violence, referrals to the police and/or support services to assess the extent of violence against women and evaluate services offered to survivors.
- The government should ensure confidentiality of victims of domestic violence; all data should be handled in accordance with the national standards; training sessions should be organized for law enforcement agencies and medical personnel on laws and policies protecting human rights to privacy and confidentiality;
- Medical personnel should be trained on crosscutting nature of GBV and HIV; special emphasis should be placed on maintaining confidentiality of survivors as well as people living with HIV in health care settings. The state should intensify measures to ensure that medical personnel safeguard patients' rights to privacy and confidentiality.

Community-based actions:

- Include GBV topics in HIV prevention curricula and peer education interventions targeting young girls and women of reproductive age; provide information about existing GBV support and HIV prevention services. Support life-skills education for young women in formal education system as well as out-of-school programs;

³⁵Responding to intimate partner violence and sexual violence against women; WHO Clinical and Policy Guidelines; 2013

GENDER BASED VIOLENCE AND HIV/AIDS IN GEORGIA: LINKS, OPPORTUNITIES AND POTENTIAL RESPONSES

- Mobilize communities and advocate for changes of harmful gender norms, misbeliefs and practices that contribute to both, GBV and HIV spread;
- Increase GBV awareness among general population, including young girls and women to reduce acceptance of domestic violence. Provide basic education about violence, including laws and policies relevant to GBV;
- Increase women's awareness of women's rights; types and forms of domestic violence and their occurrences; help and support services available in Georgia;
- GBV prevention and victims' identification information should be integrated within HIV prevention programs in the context of the country's HIV epidemic. Specific needs of women at high risk of domestic violence and HIV should be identified and addressed;
- To reduce violence against HIV positive women, it is necessary to educate the population on gender-based violence, HIV infection and the links between them. Various channels of communication (print media, social events, talk-shows, public service announcements, billboards, print educational materials) should be utilized to disseminate information tailored to specific segments of target audiences.

Specific interventions targeting key vulnerable populations: (female partners of men who inject drugs; female commercial sex workers; women who inject drugs; women victims of domestic violence; women living with HIV):

- Educate women to understand forms of domestic violence and increase their skills to cope with it;
- Educate women about potential risks associated with sexual violence and having coerced unprotected sex; inform them about availability of HIV/STI post-exposure prophylactic treatment and/or emergency contraceptives;
- Develop a directory of available prevention, support and legal services (addresses, hot-lines) and provide advises to whom, when and how to refer in case of violent acts against them;
- Empower women through education to overcome self-stigma and increase self-esteem; strengthen their assertiveness and condom negotiation skills; during awareness raising interventions explore real and imaginary situations of GBV and help women to identify a likely outcome and safe alternatives for dealing with violence;
- Ensure that female IDUs are aware of risks associated with drug use behaviors and ensure they have access to harm reduction services, including needle exchange and Methadone Substitution Therapy programs; disseminate female condoms to women at increased risk of GBV and HIV;
- Educate female sex workers on specifics of human trafficking;
- Teach female sex workers techniques of safe contact with clients and educate them how to identify clients under the influence of alcohol/drugs and how to avoid providing sex services to them;
- Provide key vulnerable populations with print educational materials and provide them with written information on coping strategies for dealing with stress (provide appropriate warning about talking print materials if a woman thinks that an abusive partner might see them).

Community-based actions:

- Include GBV topics in HIV prevention curricula and peer education interventions targeting young girls and women of reproductive age; provide information about existing GBV support and HIV prevention services. Support life-skills education for young women in formal education system as well as out-of-school programs;
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- GBV prevention and victims' identification information should be integrated within HIV prevention programs in the context of the country's HIV epidemic. Specific needs of women at high risk of domestic violence and HIV should be identified and addressed;
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- Educate women about potential risks associated with sexual violence and having coerced unprotected sex; inform them about availability of HIV/STI post-exposure prophylactic treatment and/or emergency contraceptives;
- Develop a directory of available prevention, support and legal services (addresses, hot-lines) and provide advises to whom, when and how to refer in case of violent acts against them;
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- Provide key vulnerable populations with print educational materials and provide them with written information on coping strategies for dealing with stress (provide appropriate warning about talking print materials if a woman thinks that an abusive partner might see them).

Research Gaps:

- More researches are needed to generate statistically significant information about the intersections of GBV and HIV among women in Georgia. Study design should have more statistical power and should enable researchers to produce data disaggregated by different variables: age, place of residency: urban vs. rural; level of education; economic status; discordant vs. concordant couples. Target groups should be extended to female partners of men who inject drugs.
- The GBV and HIV in Georgia study results should be analyzed in the context of findings of other related studies available in Georgia. To maximize the synergy and complementarities of research data in the country, researchers should establish effective coordination to ensure that major national indicators related to GBV, HIV, women's reproductive health, etc. are measured in standard ways that will make data comparable across studies.
- More in-depth analysis is recommended to understand social norms and stereotypes that may contribute to acceptance of GBV by women and society in general.
- The WHO guideline released recently states that mandatory reporting is not recommended.³⁶ Further research is needed to assess effectiveness of the mandatory reporting of domestic violence to the police by the health care providers in Georgia. Experts should revise existing mandatory reporting mechanism and discuss what are the benefits and risks of the reporting mandated by law vs. professional codes of conduct in health care settings.
- Operational researches and cost-effectiveness studies of GBV and HIV integrated services should be conducted. Study findings will inform national policies aiming at reducing GBV and HIV among women, and improving health and wellbeing of women in Georgia.

³⁶Responding to intimate partner violence and sexual violence against women; WHO Clinical and Policy Guidelines; 2013

ANNEX #1 – STORIES OF FEMALE VICTIMS OF GBV AND HIV POSITIVE WOMEN

STORY #1

“I am 20 years old but I have been through so many things, I saw and learnt so much...”

Ann is 20 years old. She has a 6-month-old baby and currently lives in Tbilisi.

Ann had rather tough childhood. Her father was an alcohol addict and that is why she has witnessed many violent situations in her family.

„My father used to drink a lot, he used to beat me. Father made me work in maze fields, gardens. Sometimes I used to carry heavy sacks, baskets. I used to take them in Akhaltsikhe market, sold them, took care of cows, milked them, I used to be a boy and girl at the same time, or beast or I don't know what. It was terrible. My father used to turn me out of the house naked and I had to sleep with cows in manger or in cattle-shed. My mother did not have any reaction on this.”

Ann used to have a boyfriend and she got pregnant. Her boyfriend refused baby and declined to marry her if she kept the baby. But she did not want abortion. Ann tried to commit a suicide after a fight with her boyfriend.

„He stopped the car at the bridge and told me to jump, he did not care if I died. I was going to jump but some guys stopped me.”

Despite the fact that she broke up with her boyfriend, Ann decided to keep the baby. She used to hide that she was pregnant for 5 months. She was afraid of losing baby as she had to carry heavy things. Ann used to wake up at 7 a.m. to do all the things at home before 9 a.m. as she had to be at café for 9 o'clock where she worked as a waitress.

The only person who knew about her condition was her stepsister Irina. Irina was pregnant too and promised her that she would say she had twins and would raise Ann's baby as her own. Though Irina's baby died before delivery and on the fortieth day after baby's death, Irina had heart attack at the grave and died.

After Irina's death, Ann told about her condition her two friends. They decided to take Ann for ultrasound examination.

„My father would put me in terrible condition if I spent even a penny from my salary. I gave everything I earned to him. My friend told me that she would pay for ultrasound [...]. My friend borrowed her sister-in-law's marriage ring, so I looked like I was married.”

One doctor had ultrasound cabinet at his home. Ann's relative lived in front of this house and she saw Ann going to ultrasound. She found out about her condition. She talked with her and offered that she would tell about Ann's condition to her parents and tried to solve the problem.

Before her relative went to talk with her family, Ann stayed at her aunt's house as “my father is a terrible person, he might kill me” – says Ann. Ann's relative talked to her family. Family's reaction was very negative. As Ann says, “my father crashed everything there. I called my friend and she came with her boyfriend's car and took me. This boy took us to his grandmother in the village where I was hiding for a week. I had contact with my friend. My father went to her house and used to fight, he was furious. This girl did not reveal my location. [...] My father had been searching for me everywhere, not only father but also my uncle wanted to kill me. They are type of people who can really do it”.

Ann had been hiding from her family for a long time and finally, she managed to come to Tbilisi. Baby was delivered early though everything ended well. Ann lives in Gldani shelter nowadays. State shelter contacted Ann's parents, but they don't want to see her. As Ann says “they refused to see me. They said that they would accept me if I got married. I said thank you, but if I manage to settle my life and get married, I will not even look at you”.

Ann feels better after psychological counselling sessions.

„I attend a course of psychologist. I am very content because I am not depressed any more, I am not afraid of anything in life. I have a wonderful baby, very beautiful and cute. I trust in God and hope in future.”

When Ann recalls her past life, she tried to imagine what she could do to protect herself. However, she thinks that women should be against this violence and must not remain quiet.

„I could not do anything and remained silent. I did not have a right to say anything ... I would have faced even more severe violence from my family. I was an ordinary person and nothing more, I had no right to express my opinion. No one has a right to commit violence on another person, women should not stay silent”...

STORY #2

“I often thought to call the police during that aggression, but [...] I did not want my neighbours to speak about it, ask questions, I did not want to reveal my family business, that’s why I endured everything.”

Maya is 36 years old and lives in Tbilisi state shelter together with her two children.

Maya was 16 when she got married. Her former spouse, Giorgi abducted her. She did not want to get married and imagined her life in another way, but she was forced to stay and start a life with her husband. As she says, “kidnapping was quite fashionable by then, you could not return home as your reputation would damage, so I appeared to be married”. Newly married Maya was under regular psychological violence from her mother-in-law.

„She set certain hours when I had to wake up, do the house, I had to ask her permission for everything I was doing. This was unbearable for 16-year-old kid. I was forced to live according to her rules. She told me which neighbour to visit and for how long. If I failed to obey and was a little bit late, she would scream for distance – where are you, why are you late.”

Because of threat from her mother-in-law, Maya could not tell anything to her spouse, though their relationship was not very good. Maya’s spouse and his mother had conflict which was mostly conditioned by Giorgi’s addiction to alcohol. He used to express aggressive attitude towards Maya and child.

„Every time my husband was drunk, there was a terrible fight, he used to break tables, dishes. Son and mother used to throw everything to each other. My husband spent all his anger to me and I had to hide my children. I did not know what he wanted from me. He used to fight if I was sleeping with my children when he got home at night.”

After a while, Maya moved to Tbilisi with her spouse and children but difficulties in family were not solved. Maya’s husband became addicted to gambling. He used to go to Russia and Kazakhstan and after accumulating debts here, he would return to Georgia and continued gambling. In order to avoid debtors, he used to escape to Russia and this situation lasted for several years. Maya had to pay her husband’s debts.

„He was very aggressive, he used to take things from children. My daughter had a photo camera and hid it under the pillow, he sold her cross, took a silver chain. He sold everything my children had. He even stole my gold cross which I hid in lining – that was the only thing I had from him.”

Maya’s severe psychological condition was worsened by another tragedy. One summer she sent her children to her mother-in-law. One day she was called and told to go to village immediately as her mother-in-law was in accident. However, mother-in-law appeared to be healthy when she arrived in village. It appeared that her child fell into canal and died. Her husband went to Russia after this tragedy. He returned after a while and continued to take money from her. He is in Georgia now and goes to his child to ask for money.

„He went to my child at work and asked for money. He wants to have relationship in order to get money and my child was angry – she was ashamed.”

As Maya says, several times she wanted to call the police when her husband was abusive and very violent, but every time she was giving up due to many factors. She did not want her neighbours to know about the conflict and did not think that the police would be able to solve her problem. However, finally she did decide and called the hot line as her sister advised her.

„I used to think to call the police but it would not change anything – police would make him write something and this would not change my life. I did not want my neighbours to speak about it and ask questions, I did not want to reveal family situation to others but violence became horrible. He was violent towards kids – to a girl because she did not give him something and to a boy because he did not want to come home. I was afraid that my son may appear in bad company and my sister called hot line. I was taken to shelter and it was the only way out.”

Maya lives with her two kids in shelter where their basic needs are met. However, the term of being in shelter is to be over soon and she does not know how to manage to rent a house when she has so many debts. She and her children work though have very small income. Besides, Maya has unsecured... she has a feeling that her abusive husband may appear in her and her children's life again.

„My husband demands money from my children. He must understand that that is him who needs take care of his children, but this is very difficult.”

STORY #3

“My mother forced me to leave the house. She threatened me that she would distribute the photo of me with the title “HIV positive” in the town, if I wouldn't.”

Lika is 40, divorced, with two kids and she suffers from HIV already for 10 years.

Her ex-boyfriend called her one evening from Greece to tell her to get testing for HIV. He was worried because he recently found out that he was HIV positive. Lika was very nervous. She was worried for her kids, for herself... She asked her mother to go together with her to the hospital. Next day Lika found out that she was HIV positive.

Before her status was discovered Lika was living together with her kids in a family house. She had quite a happy life, her brother supported the whole family financially and she did not have to work. She was caring for her children and this lifestyle was very much enjoyable for her.

However, everything changed when Lika's HIV positive status became known. She was afraid to go out of house, to talk to people, to have normal relationship with them as it used to be. She literally locked herself in the house with her children.

“Everyone pointed with finger at me because I was infected; everyone was speaking about this... When everyone found out I locked myself in the house and have no courage to go out.”

The reaction of her mother was the most painful thing Lika has experienced. Lika's mother forced her to leave their family house. She let neighbours and relatives know that Lika was infected with HIV. She was telling them that they should abandon her. She also threatened Lika she would spread her photos saying “HIV positive” throughout the town, if she would not leave the house together with her children. So, Lika was forced to leave the house and to move to another city.

“When my mother find out I was HIV positive I was forced to leave the house because she let all our neighbours and relatives know about my disease and that they started avoiding me. She threatened me that she would post my photos with warning “HIV positive” throughout the town, if I did not leave the house. So, I had to leave.”

When Lika started her [ARV] treatment she had experience most severe side effects. Her children were scared seeing mom in such condition and threw away her medicines. Lika did not take medicine as prescribed. However, later after she was told she would not survive without the treatment, she started taking medicines as needed. Fortunately, the side effects were more tolerable for the second time. The psychological assistance Lika received at AIDS Centre was quite helpful for her and

now she feels better, stronger and more optimistic.

"I want to tell all HIV positive women that they should not be scared. Live your normal life as you was living before and don't pay attention to things that might irritate you. [...] First reaction when you find out is extreme.. shock. You want to kill yourself, you think that no one will ever need you. But later you find out that your children need you, your husband, your mother, your friends need you. You might have to explain to them that you are a normal person, just like anybody else."

STORY #4

"My husband left me after he found out. He said he does not need such a sick wife."

Mary is a 52 year old mother of three children. Seven years ago she found out that she was infected with HIV.

Mary was happily married woman with 3 kids. Both she and her husband had a job and sufficient salary to support the family. In 2002, Mary became pregnant and due to the complicated pregnancy had to do Caesarean section. The surgery did not go really well. Mary lost lots of blood and needed blood transfusion. Fortunately, her life was saved and Mary returned home with her baby. However, during a long time after the surgery Mary was feeling very weak and tired and was practically always in bed. She did several tests in the hospital, but every time doctors kept saying she was fine.

After three years, Mary saw in the local news an interview with a lady with HIV positive status. It was weird... she recognized the lady from the hospital – they delivered babies on the same day. Mary became alerted. In October 2005 a group from HIV/AIDS Centre visited Mary and took her blood test. That is how Mary found out that she was infected with HIV.

After Mary's positive HIV status was revealed her life changed dramatically. Her husband left her and the kids. Mary recalls - "he said he does not need such a sick wife... my whole life was destroyed". Mary experienced serious problems with her neighbours. They wanted her to move out from the neighbourhood. Mary was also discriminated because of her HIV positive status by medical personnel. Once she felt very sick and called the emergency. As soon as the doctor found out she was HIV positive, he stood up from the chair, told the assistant to pack medications and instruments because they were leaving. And they left without even inspecting her.

Mary is currently unemployed. Her only moral support are her kids and the HIV/AIDS Centre that is very supportive to her. An interview with Mary ended with her wishing courage and strength to all HIV positive women:

"I wish all HIV positive women to have physical and moral strength. I would like to tell them that I have been infected already for 12 years, I tried to commit a suicide twice, however today I want to live and I have a hope that God will send a blessing to us and soon the cure to AIDS will become available and we all will recover. We, women, just need to be patient and endure."

STORY #5

"I should have used contraception as long as my husband was a drug addict... But I could not imagine something like that could have happened."

Lela is a 42 year old, a widow. She became aware of her HIV positive status 7 years ago.

When Lela was 35, her husband told her to go to the AIDS Center and test for HIV. He told his wife that he recently found out he was HIV positive. Lela's husband was drug user and was infected because he was sharing syringes with others... apparently, someone was HIV positive.

Lela's life has never been quite happy. The drug abuse of her husband was a serious problem in the family. He was always desperate to find drugs and was extremely aggressive and violent during withdrawal. Lela's brother was trying to help her

and to preserve her somehow from husband's abuse. But his attempts were not very successful. She was assaulted and beaten by her husband frequently.

"He has assaulted me publicly, he was refusing to give me money to buy something for our children, he prohibited me to go to work, he was beating me..."

After her positive HIV status was revealed, Lela's life became more tragic. She decided to quit from her job, because she did not want other people to find out about her disease. Luckily, when her family members found out, they did not reject her, which was a big relief for her, but she was afraid of the reaction of the society.

Now Lela is under treatment. As Lela says, strong women can defeat this disease. She hopes she is the one.

STORY #6

"My husband refused to get a treatment and prohibited me from taking medicines as well. I was only able to start therapy after he died."

Irma is 30, a widow with children of whom she is taking care. Her husband died from AIDS.

Irma found out that she was HIV positive after she gave birth to her second child. Her husband came to the hospital for testing and he too appeared to be infected. Irma believes that the virus was transmitted to her from her husband, as he was the only man she has ever had sex with. Irma recalled she was feeling quite sick after her marriage, she was having temperature frequently, but she could not link her illness with AIDS in any way.

Irma's husband was against treatment and did not allow her wife to take medications. Generally, his behaviour changed for worse after his HIV positive status was detected. When he was drunk he was extremely aggressive and was insulting Irma verbally and beating her as well. Irma often suffered from sexual violence as well.

"I wanted to protect myself, but he was often against it, we often had argument about this issue. I sometimes resisted and refused to have sex with him, however he always insulted me and in order to prevent these insults I had to agree..."

Irma wanted to leave her husband, but she always hesitated. She tried to justify her husband's behaviour by his illness. She did not know where to go with her 2 kids. Apart from that, she was told that she had to endure. Irma also tried to threaten her husband that she would leave him, however this strategy made situation even worse: Irma's husband became more aggressive and threatened her to harm her relatives if she did. After a while Irma's husband became extremely ill and could not get up from bed. Irma finally felt pity over him and decided to stay with him to take care of him.

Fortunately, Irma was not rejected by her family and neighbourhood. Her relatives still support her and she does not feel any negative attitudes from her neighbours. But she feels very ill and says that she would not be able to cope with the disease without the support of the family.

Now Irma regrets that she did not seek help from other people and was enduring the violence from her husband. If she could turn back time, she would have reported the very first time her husband insulted her. Irma says:

"I was hiding everything and enduring. If you don't say anything, he will do you worse. He will hope that you will never say anything to oppose. As a result of repetitive violence, women become introverted. Now I know... women do not have to behave like that. After all, he is a husband, he is not your master, he has no right to humiliate you. There should exist something to protect us. [...] You should not forgive him the very first time. You should tell someone, who might or will protect you. If he sees that you are unprotected, he would do even worse. If your parent or relative has no ability to protect you, you should ask someone else to protect your rights."