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Punishment for your sins, the patient as a tourist attraction and exceptionally lower-class issue. HIV-associated stigma perceptions and experiences in Georgia.

Master's thesis in Global Health

Supervisor: Jon Øyvind Odland, Prof. (NTNU)

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Abstract

Background. Eastern Europe and Central Asia is the only region in the world where annual rate of HIV infections continues to rise rapidly. In spite of the progress made by implementing ‘treat all’ strategy, full expenses governmental coverage of HIV-related health services and national strategies for key groups, the rapid spread of HIV will continue if urgent measures are not undertaken. Stigma associated with HIV decreases adherence to treatment, testing uptake and might contribute to the expansion of HIV epidemic.

Objectives. The research objectives of the study are to investigate and describe the stigma experience and its impact on PLWHIV in the country of Georgia.

Methods. The qualitative study was conducted in collaboration with the HIV/AIDS Patients Support Foundation in Tbilisi and the national Center of Disease Control (NCDC) among 20 participants with a diagnosis of being HIV-positive. They were 18 years or older, speaking fluent Georgian or Russian language. Based on this four focus group discussions were performed. The interviews were tape recorded, transcribed and analyzed using the Health stigma and discrimination framework by Stangl et al. (2019).

Results. The results highlighted the connection of HIV-associated stigma with health facilities, the government level, workplace and community levels of stigma, self-stigma and their influence on affected populations.

Conclusions. The drivers and facilitators leading to stigma marking, stigma experiences and practices, that in their turn cause negative outcomes on the affected population and society were described. Further research is necessary to develop society level interventions in order to reduce discrimination around AIDS and HIV.

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1. Acknowledgements

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Finally, I wish to thank my family for their support throughout my study.

2. List of abbreviations

AIDS Acquired immunodeficiency syndrome

ART Antiretroviral therapy

FG Focus group

GHRN Georgian harm reduction network

HCV Hepatitis C virus

HIV Human immunodeficiency virus

MoLHSA Ministry of labor, health and social affairs

MSM Men who have sex with men

NCDC National centre for disease control

OST Opioid substitution therapy

PLWH People living with HIV

PrEP Preexposure prophylaxis

PWID People who inject drugs

STI Sexually-transmitted infections

TB Tuberculosis

WHO World Health Organization

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4. Introduction

4.1 Background

An estimated 1.4 million people were living in 2017 with HIV in Eastern Europe and Central Asia. This is the only region in the world where the annual rate of HIV infection continues to rise rapidly, with a 30% increase in annual HIV infections between 2010 and 2017. (1)

The first HIV case in Georgia dates back from 1989. By December 31st 2019, 8102 cases have been registered, from which 6047 were men; the majority was of age 29-40, 5003 patients had AIDS, 1635 have died. The main routes of transmission were heterosexual contacts (48.2%), injecting drug use (38.1%) and homo/bi-sexual contacts (11.2%). (2)

Georgia was one of the first countries in the region to implement the WHO strategy 'Treat all' from 2015. Also the Georgian antiretroviral therapy (ART) program was recognized as one of the best in means of having universal access to HIV treatment and high coverage of target populations (3). The opioid substitution therapy (OST) and pre-exposure prophylaxis (PrEP) have been available (4).

Nevertheless, laws criminalizing sex work and drugs for personal use, gaps in HIV literacy in population and cultural specifics have resulted in discrimination of HIV-positive people, especially in key affected populations (5,6). Consequences of this stigma might be poor access to health care, loss of income, feelings of worthlessness and secondary stigma for families of people living with HIV (7).

In spite of a large amount of existing studies on HIV-associated marginalization and quality of life among people living with HIV/AIDS (PLWH) in the world, there is a lack of knowledge on this topic in Georgia, as in all Eastern Europe countries and Central Asia region.

Prejudice and discrimination lead to people being reluctant to get tested, disclose their HIV status and take antiretroviral therapy, that contributes to expansion of HIV epidemic and AIDS-related deaths (8,9).

4.2 Georgia: overview



Figure 1. Map of Georgia

Georgia, or Sakartvelo in Georgian language, is a Caucasus region country in Eurasia, is bounded in the north by Russia, in the east by Azerbaijan, in the south by Armenia and Turkey, and in the west by the Black Sea. It includes 2 de facto independent regions - Abkhazia (city Sokhumi) and South Ossetia (city Tskhinvali). The capital of Georgia is Tbilisi.

The territory was inhabited by Georgians since prehistoric time, Georgian wine has existed for 8000 years. During medieval time there was a rise of a powerful Georgian kingdom between the 10th and 13th centuries. After that it was a long period of Turkish and Persian domination, and

then taken over by the Russian Empire in the 19th century. Georgia declared its independence on April 9, 1991 after the dissolution of the Soviet Union. This decade was a period of instability and civil unrest in Georgia, due to separatist movements emerging in South Ossetia and Abkhazia, as well as an economic crisis. Since 2000 the government pursue pro-western policy and territorial disagreement with Russia.

The country is mostly mountainous, with the notable exception of the fertile plain of the Kolkhida Lowland—ancient Colchis, where the legendary Argonauts sought the Golden Fleece, and more than a third is covered by forest or brushwood. (10)

In means of population, about four-fifths of the people are Georgians; the rest are Armenians, Russians, and Azerbaijanis. The primary language is Georgian (it has its own alphabet, evolved about the 5th century). The older generation also speaks Russian as it was second or primary language in the USSR era. Many Georgians are members of the Georgian Orthodox Church. The population of Georgia is aging, life expectancy is about 69 years for men and 78 years for women. (11)

According to the World Bank, Georgia is since 2019 Upper-middle income country. Agriculture accounts for about half of the GDP, labor force by share – one-fourth is agriculture; one-fifth is industry and one fifth is service sector. (12)

4.3 Georgia: health care system

Georgia holds one of the last places among the countries of the European region in terms of the share of state expenditure in total health care expenditures (36% in 2015), in GDP (2.9% in 2015) and in the state budget (8.6% in 2015). Despite this, the mortality rate of children under the age of five fell from 24.9 in 2000 to 10.7 in 2016 per one thousand live births, the maternal mortality rate fell from 49.2 in 2000 to 17.8 in 2016 per one thousand live births. (13)

The Ministry of Labour, Health and Social Affairs, the Social Service Agency and the National Centre for Disease Control and Public Health provide the control of national healthcare actors. The

most important achievement was the implementation of the universal healthcare program in 2013 with the Georgian Health System State Concept 2014–2020 on universal health coverage that significantly increased the accessibility of medical services. (13,14)

The government covers only the purchase for households living below the poverty line, but all other individuals are expected to purchase by their own. Out-of-pocket payments remain the main source of funding for the health system in Georgia, which reduce access to services for much of the population, particularly for access to medicines. (15)

Year	Policy	Description
2004-2006	First primary healthcare master plan	Framework for reform to improve access to high-quality basic health care
2008 -	Rural doctors program	Vertical programme that covers about 1.1 million people living in rural areas
2013 -	Universal health coverage	Introduction of universal health coverage
2017-2023	Primary healthcare development strategy	A strategy to strengthen the position of family medicine in the health system.

Table 1. Healthcare policy milestones in Georgia

4.4 HIV

HIV (Human Immunodeficiency Virus) belong to the family of Retroviruses. It has 2 types, HIV-1 and HIV-2 (type 2 concentrated in West Africa). HIV infects cells in immune system, predominantly T-helper lymphocytes. HIV attaches to CD4 protein on the surface of T-helper, enter the cell and produce virus copies, and the infected cell is destroyed. In presence of HIV the immune system produces antibodies that could be found within 3-6 months in body fluids after infection. (16)

Three main routes of HIV transmission are unprotected sexual intercourse, exposure to infected blood (i.e. injections and blood transfusions) and vertical from a mother to child (through childbirth and breastfeeding). (17)

There are 3 main types of HIV-testing – antibody tests, rapid tests and self-testing kits. (18)

TYPE OF HIV TEST	WHAT DO THEY TEST FOR?	WHEN CAN HIV BE DETECTED?	HOW LONG DOES IT TAKE TO GET THE RESULTS?	RELIABILITY
3rd generation antibody tests	HIV antibodies	3 months after exposure	Between a few days and a few weeks	High
4th generation antibody/antigen tests	HIV antibodies and p24 viral proteins (antigens)	1 month after exposure	Between a few days and a few weeks	High
Rapid tests	HIV antibodies	3 months after exposure	Within 20 mins	Satisfactory for uncomplicated infection
Self-testing kits	HIV antibodies	3 months after exposure	Within 20 mins	Satisfactory but results must be followed up at a healthcare clinic

Figure 2. Types of HIV testing

The main principle of treatment is Highly Active Antiretroviral Therapy (HAART), that is a combination of at least 3 anti-HIV drugs. The World Health Organization now recommends that everybody living with HIV, of all ages and in all parts of the world, disregarding their CD4 count, should receive antiretroviral therapy. UNAIDS is now encouraging countries to work towards targets known as 90-90-90 by 2020. That means that 90% of all people living with HIV will know their status, 90% of those diagnosed will be on treatment, and 90% of those on treatment will be virally suppressed. (19, 20)

HIV prevention programs are now a combination of behavioral, biomedical and structural interventions. Behavioral interventions address risky behaviors, include sex education, stigma reduction and counselling. Biomedical interventions are condoms, treatment, needle programs, as well as HIV testing. Structural interventions address vulnerable groups, decriminalization, increasing access to school for girls, and interventions to address inequalities. (21)

4.5 HIV in Georgia

Currently Georgia is a HIV low prevalence country. But rapid spread of infection is possible if rapid measures will not be implemented due to the epidemic situation in the borderline countries of Russia and Ukraine. To the end of 2019, 8102 cases of HIV were registered, 6047 of whom are men, prevalent routes of transmission are heterosexual contact and drug injections. (2)

Nowadays a difficult situation exists among the key groups. The HIV prevalence among MSM is significantly on rise. It increased in Tbilisi from 6.2% in 2010 to 19.6% in 2015. Also the HIV incidence rate in Tbilisi significantly increased from 0.45 per 100 person-years in 2010 to 1.63 per 100 PY in 2015. (22)

Based on the latest population size estimation survey conducted among PWIDs in 7 cities of Georgia (2016-2017) the national prevalence estimates for problem drug use in the adult population is 2.24%. That is the third highest estimate in the world and the second in the EECA region. (23)

According to Georgian law, the principles of state policy are protection of the rights and the support of universal accessibility to services with regard to providing voluntary counselling, testing, treatment and support for people living with HIV. Responsibilities of the PLWH are not to create a threat for infecting other people. Another one is that they are obliged to inform their spouses/partners about their HIV status. (24)

The major problems within the HIV situation Georgia are high proportion of undiagnosed cases, expected as 48%, and the high rate of late presentation cases, approximately 73%. (25)

There is a significant gap in the cascade of HIV care, as only 48% of the estimated number of people living with HIV are aware of their status. Even so, remarkable progress has been achieved among diagnosed persons. The ART coverage increased from 62% in 2015 to 81% in 2017, viral suppression rates among those on treatment increased from 84% in 2015 to 89% in 2017. (23)

4.6 HIV-associated stigma

In 2015, WHO published new guidelines on HIV that reflect the need to address stigma and discrimination as a barrier to accessing HIV treatment (26). In 2016 UNAIDS published the Agenda for Zero discrimination in Healthcare (27).

There is a vicious circle between HIV and stigma. People who are discriminated because of race, gender, and sexual orientation are the most vulnerable to HIV, while people who are infected are continued facing this stigma, but in addition experience HIV-associated discrimination. (27)

Stigma can manifest in many ways. It can develop in healthcare settings, in household or at work. UNAIDS Research found that 1 in 8 PLWH was denied to have access to healthcare due to stigma (28).

Misconceptions around HIV are that people think HIV is equal to death, false beliefs on the ways of HIV transmission, as well as association of HIV with immoral behaviors. As a result, HIV-associated stigma could lead to poor quality of healthcare, violence, poverty, and feeling of worthlessness (7).

72 countries in the world have discriminating HIV-specific laws, i.e criminalizing HIV non-disclosure and transmission, key groups (MSM, injecting drugs, sex work), or restricting access to stay or travel in a country (29).

Possible ways to remove stigma could be education (to change attitudes and address fears), protection (decriminalization, anti-discrimination laws), empowering (understand rights) and inclusion (key populations).

4.7 Rationale for the study

The existing literature shows a huge gap in academic knowledge when it comes to the issue of life perceptions in the context of HIV positive people in Georgia. A lot of existing research on health associated stigma overall and HIV associated stigma in the world can be found, but when searching for research regarding quality of life among PLWH, only one quantitative research can be found. (30)

Thus, the qualitative research on a HIV stigma could be a basis for research in HIV stigma in the region of Eastern Europe and Central Asia that could facilitate a better action plan to empower PLWH.

4.8 Objectives

The objectives of the study are to investigate and describe the impact of stigma experience of PLWH in Georgia. Since there is little or no academic research made on stigmatization of people living with HIV/AIDS in Georgia, the research question of this project is to investigate experiences of PLWH and a deeper understanding of the reasons for the current HIV situation in Georgia. Further it might propose future initiatives in order to improve the life quality of HIV positive people.

The aims of the project are:

- explore types of HIV-related stigma, at internalized, governmental, and community level
- identify outcomes of discrimination, influencing on healthcare access, socioeconomic and psychological outcomes
- identify ways that PLWH could manage to reduce stigma

4.9 Theoretical framework

The main theory of stigma was described by Goffman as the model of stigmatized, the normal and the wise. He defined a distinction between discrediting, meaning others perpetrate stigma,

and discreditable, in which case a person is dishonorable or of disreputable character. Herek defined stigma as a lasting, negatively valued circumstance, status, or characteristic that discredits and disadvantages individuals. Stigma according to Herek is presented by four factors: prejudice, discounting, discrediting, and discrimination (31).

The Health stigma and discrimination framework by Stangl et al. (2019) was used as a theoretical basis for this research (32). It was designed as a global framework for research in this field to standardize measures, compare outcomes and build more effective, cross-cutting interventions. The process of stigmatization is defined in the following steps – drivers and facilitators, stigma marking, manifestations and outcomes.

Drivers are negative factors, i.e. fears or lack of knowledge, and facilitators could be both negative and positive factors, i.e. legal environment. Both drivers and facilitators determine whether stigma marking occurs. When stigma takes place, it develops through the following manifestations - stigma experiences (internalized, perceived, anticipated stigma) and stigma experiences (stigmatizing behaviors and attitudes). The mentioned manifestations produce outcomes for both affected populations (treatment, diagnosing) and community or government organizations (law, media)

5. Methodology

5.1 Study design

The qualitative research design was chosen in order to examine the experiences of people living with HIV. This study design will help to draw the attention to the stigmatization of HIV positive people in Georgia. A qualitative design will enable exploring the perceptions and uncover experiences of patients that a quantitative design is unable to perform.

5.2 Study settings

The study was done in a collaboration with HIV/AIDS Patients Support Foundation (the data collection site) in Tbilisi. The research setting is Tbilisi, the capital of Georgia, also the largest city of the Republic with a population of approximately 1.5 million people. Around 89% of the population consists of ethnic Georgians and more than 95% of the residents practice forms of Christianity (33). Speaking about distribution of HIV in the country, Tbilisi is the most affected region (34), that makes it the most suitable place in Republic of Georgia to perform the proposed study.

The HIV/AIDS Patients Support Foundation is a non-governmental organization, fully sponsored by Global Fund to fight AIDS, with a main office in Tbilisi and 3 more offices in Georgian districts. The Foundation is the only organization in Georgia supporting PLWH in means of psychological help and social issues. Its main responsibilities are monitoring and evaluation, as well as support of people living with HIV, stigma reduction and education.

5.3 Participants

Participants were selected through purposive voluntary sampling selecting for interviews random sample of participants in order to increase the credibility of results, combined with snowball technique asking already recruited persons to identify potential participants. The study group included people of different age and gender as the stigma may operate differently among the genders, taking the age-specific stereotypes in mind. The subject recruitment took place in a collaboration with the Infectious Diseases, AIDS and Clinical Immunology Research Center,

Tbilisi, Georgia. All the potential participants were informed first about the possibility of taking part in this research, its aims, topic and confidentiality. Then the list of persons who agreed was provided to a researcher and the researcher contacted potential participants once more giving them information on the aim of study, its main themes and participants privacy.

Eligibility criteria included presence of diagnosis of being HIV-positive and age of 18 years or older, as well as speaking fluent Georgian or Russian language. The researcher looked on a pattern of age and gender distribution among patients of HIV/AIDS Support Foundation. The data saturation was reached while 20 patients took part in research. Four focus groups with 5 persons in each group took part in this research.

Then with the help of administrators of the foundation specific days were chosen in order to maximize the diversity of participants for their convenience. For privacy reasons all the discussions were held on weekends to ensure that no unauthorized persons will be in the Research Center. The focus group discussions were conducted during August – September 2019.

5.4 Data collection

Data collection took place using focus-groups face-to-face semi-structured interviews. Participants were informed about the purpose of research, informed consents were obtained, interviews were conducted by Russian- and English-speaking researcher. Most of the focus group interviews was direct between researcher and the participants, with a Georgian translator to support when more precise and technical understanding was needed.

All interviews were conducted in the Research Center to ensure privacy. Interviews were recorded with an electronic device, transcribed in Russian or English depending on the language of FGD, and when needed to be translated to English language. No personal data details that could violate subject anonymity were mentioned in transcriptions and the researcher is the only person that has access to original audio records.

Each focus group interview was provided based on a prepared questionnaire guide containing topics with probing questions (Appendix 3). The topics and questions were chosen based on existing research and literature and consulting with a supervisor. The focus group discussions continued until the saturation of data material was obtained. The focus groups were coded as FGI1, FGI2, FGI3, FGI4.

Each focus group interview lasted for around 90 minutes. First, participants were informed about the objectives, main topics, advantages and disadvantages for taking part in this study, then the informed consent was taken. The first part of a group interview was general questions on participants overall knowledge of HIV and HIV situation in Georgia. Next were the questions regarding participants perceptions of different types of stigma and discrimination associated with HIV in their country. The last was the part where participants discussed what should be changed and how to implement these changes.

5.5 Data analysis

The researcher must always reflect on her role as a doctor, scientist and a public health student in order to keep in mind how these aspects may influence interaction with study subjects and researcher interpretations on data analysis. Data collection and analysis are done simultaneously in order to adapt the interview guide in case of need.

The researcher read the transcribed interviews multiple times in order to find similar themes and differences. She printed out the transcripts, reviewed data writing notes on her ideas and questions, created initial codes, identified in that codes those created opinions, and combined codes into themes, and finalized themes in a cohesive manner. The analysis was done in discussion with the supervisor, and the parts of transcriptions were sorted into categories and subcategories.

5.6 Ethical considerations

Based on the special situation of the participants, i.e. mentioning of HIV status, the study was approved by AIDS Center Institutional Review Board (Georgia). The Norwegian REK approval

was given, based on the release of totally de-identified and anonymized data to be used in the assessment. The ethical principles of ethics in HIV research, autonomy of individuals, beneficence, non-maleficence and justice, were respected.

Verbal informed consent was taken from each participant. Participants were told to share only what they are comfortable to say. Participants were not asked about their names or any other identifying data. They agreed on tape-recording of the interviews and taking notes during the interviews. The tapes were deleted after the transcribing was performed.

6. Results

The results are presented based on analysis of focus groups interview data, the following categories and subcategories of participants responses were identified – health facilities, government, workplace, and community levels of stigma and self-stigma.

Table 2. Participants responses categories on stigma

Category	Subcategory
1. Health facilities level stigma	Access to healthcare Attitudes to HIV patients Disclosure of HIV status without permission Diagnosing experience
2. Government level stigma	Relevant legislations
3. Stigma at workplace	Refusal of employment
4. Community level	Public disclosure Religion
5. Household level	Family members Friends
6. Self-stigma	Mental well-being Negative self-judgements Fears
7. Ways of positive improvements	Information and education

6.1 Health facilities level stigma

Access to healthcare

Views on the accessibility of healthcare services for PLWH were consistent in the focus group discussions. All the participants mentioned that doctors could reject to provide medical care, it depends on hospital.

“Doctors will reject surgery, they’ll just pretend that there is another reason for not doing it, but it will be because of HIV [patient’s status]” (FG1)

Participants prefer to seek medical help in the capital city as the possibility of getting healthcare needed, i.e. dental care, elective surgery, obstetrics and gynecology is higher and the attitude to HIV positive patients among medical personnel is more benevolent.

“ While giving childbirth my HIV status was announced to everyone, so medical personnel visited me like I’m a tourist attraction” (FG 2)

In each discussion group were mentioned the cases where participants themselves or their family members were rejected to obtain even critical care if HIV status is announced; ambulance personnel refused to touch a patient, take blood tests or hospitalize that patient.

“My friend, while giving childbirth medical personnel reject to help her, so she needed to search for another clinic [while being] in labor” (FG 4)

Attitudes to HIV patients

Stigma and prejudice against PLWH perceived is still existing among doctors. Regardless the ongoing education trainings and seminars about infectious diseases for doctors and general practitioners, misconceptions and negative statements continue to prevail.

Discrimination by some healthcare workers was mostly associated from the participants views to the age of medical personnel. Questions regarding the ethical responsibility of doctors and nurses has arisen during focus group discussions.

“Being [hospitalized] in inpatient clinic, I had a hemorrhage from catheter, and a nurse didn’t help me, and I needed to wait for next shift nurse to change catheter” (FG 1)

Disclosure of HIV status without permission

“No one saying to GP about having HIV because of information spreading” (FG 1)

Issue of non-compliance to the doctor/patient confidentiality considered by participants as one of the most significant and generated highly emotional debates in the discussion groups.

The fears of unintended disclosure of patients’ HIV status by healthcare workers was perceived as one of the key reasons of patients’ hesitation to seek medical help, begin antiretroviral therapy and adherence to treatment, as well the influence on life expectancy among PLWH in the country.

“Previous year at dentist’s I told a dentist that I have HIV, and he told it to others, when I returned I’ve heard that doctor told about my diagnosis by phone. I wrote complaint in police, in court they reject that it happened and on audio my name wasn’t mentioned, so there were no consequences for a doctor” (FG 2)

Diagnosing experience

Characteristics of being a turning point of their lives were predominant among participants when speaking about the HIV diagnosing experience. The most important attitude the participants expressed was that during the first medical counselling where they found out their diagnosis of being HIV positive they were provided with educational and emotional support, and the respecting of the confidentiality and voluntary choice of HIV testing was highlighted.

An opposite view mentioned was the situation where respect to patients’ personal history was negligently provided and involuntary disclosure of diagnosis happened.

“I was in cardiology department, and doctors first told [my HIV status] my parents instead of me, so I went to court, doctor told my parents that it’s my last days” (FG 3)

Participants would prefer to be supported with more psycho-social attention in more individual manner without neglecting the educational explanation of the disease.

“I did screening, a month before diagnosis, doctor very friendly, they told that people live with it, but I would like longer first consultation” (FG 4)

6.2 Government level stigma

Relevant legislations

According to the legislations of the country of Georgia, PLWH have a right to not disclose their HIV status, both in public and during the medical procedures. At the same time, criminal penalties will be imposed for infecting another person.

Lack of knowledge regarding the rights and responsibilities was found among the discussion, in each group there was at least one person who considered disclosure of his HIV status as compulsory by law.

“In a medical reference that I needed to show at work doctor tried to insist to mention HIV” (FG 2)

The attitudes to disclosure of diagnosis to healthcare workers were divided. While some insisted on revealing HIV diagnosis to all the medical personnel that perform procedures with blood to protect them from being infected, others considered these measures as non-mandatory as a HIV test will be performed in any case before surgery or other invasive procedures. Some preferred not to announce their diagnosis in any case due to the fear of information spread.

Crime against the human rights was considered as highly unlikely in Georgia. At the same time, occasions of physical or verbal abuse perceived as possible inside the family in remote places of the country.

“I know 2-3 cases, but couldn't tell” (FG 1)

Participants expressed their views on what measures have to be implemented by government for these cases of crime against PLWH.

“We don’t need punishment, we need education at schools, what’s this disease, how to get infected, in universities, at work” (FG 1)

Another legal issue pointed out was the ban on travelling to several countries while having HIV, among those mentioned were Russia, Egypt and the United Arab Emirates.

Some participants highlighted that previously they needed to illegally buy antiretroviral medicines abroad due to the low quality of therapy in Georgia or absence of medicines in the region at all.

6.3 Stigma at workplace

Refusal of employment and termination of working contract were issues discussed by focus groups. Prejudice or undesirable behavior from coworkers were experienced, possibly due to the fact of rare disclosure of the HIV status in public.

According to the Georgian legislations, PLWH have a right to work in any services or production, with the only few exceptions for some professions, i.e. military forces. In spite of that, every participant knew someone or had his/her own experience of being fired after their HIV diagnosis was revealed by their job manager.

“At my workplace they found out that someone had HIV but didn’t know who, so they forced everyone to take tests, blood glucose and, in fine print, HIV” (FG 1)

6.4 Community level stigma

Public disclosure

“Sometimes I’m so angry at our society that I want to say [that I have HIV] to everyone” (FG 1)

Public disclosure of HIV status continues to be something unique, participants considered that two persons, a man and a woman, disclosed their status in media. Fears of staying alone for the rest of

their lives and losing the job were predominant views. Another reason participants were worried about is the lack of awareness among the society that could potentially cause negative effects, on not only PLWH, but further on their families. *“I’m afraid if at school they find out that my child infected, everyone would know it and people wouldn’t understand that they can eat and talk with my child” (FG 3)*

As being HIV infected in common perception of people linked to being engaged in “bad” actions, PLWH prefer not to disclose their status.

“My friend was so afraid that someone would know that he didn’t go to hospital, didn’t take drugs and died” (FG 2)

A common opinion was the importance of public disclosure to break the vicious circle of shame stigma, assuming that the society of Georgia is not ready for that actions now, based on the stigmatization of PLWH even by medical personnel.

“We have stigma in society until we keep in secret, we need to show that we’re healthy and alive” (FG 2)

Different views were expressed that if people with other chronic conditions are not going to disclose, PLWH should pretend that it’s an ordinary disease and disclose their diagnosis.

Religion

Georgia is a country where religion plays a highly important role in life. Issues regarding the experience of disclosing the HIV status to a preacher, question of necessity of it and following changes in preacher’s behavior after that were discussed.

“I told him I have HIV, and he told me, well, I have hepatitis C” (FG 2)

On the other hand, significance of religion depends a lot on the age group of PLWH. Younger participants disagreed with the support provided by the attendance of church or at least found the HIV disclosure to a preacher as not necessary.

“My preacher said it’s the punishment because of my sins” (FG 3)

Participants assumed that the attitude of preachers towards PLWHIV depends highly on generation issues – older preachers are more difficult to talk to. *“I told [my HIV diagnosis] and he said me to never touch anything in church” (FG 1)*

6.5 Household level stigma

Despite the beliefs that physical harm to PLWH is rare, verbal negative expressions from family members or friends may be common. Different points of view were identified speaking about the subject of HIV disclosure. While some participants agree that family support is the most relying, others pretend that friends are more understandable than family members. Attitudes those are not disclosing to anyone is the safest option were discussed.

Family members

Participants’ experiences on informing family members were highly diverse. Some participants found that the family members were highly unsupportive in acceptance of HIV diagnosis and that after disclosure only a few people stayed around with them.

“My father blamed me and said that I’ll not live for a long time, only I my friend and my mom still with me” (FG 3)

Keeping something such important and frightening in secret is highly complicated, hence the disclosure to a family assumed to be relieving.

“I keep in secret from my mother-in-law, taking drugs in secret, control my husband not to say to her anything about HIV. When you live separately you could keep in secret, but how to do it when you live with family. I need to take a glass of water every night for taking medicines, and my mother-in-law often ask why, so I’m feeling very nervous every time” (FG 1)

Friends

Importance of friends' acceptance of HIV diagnosis found by participants sometimes more essential than family acceptance.

"My friend told that if one of his children would have HIV, he'd never touch him again" (FG 2)

Fears of rejection or indifference from friends causing regrets and aggravating the situation lead to PLWH hesitancy to disclose diagnosis.

"When I need to take my medicines, I say everyone that it's vitamins" (FG 2)

6.6 Self-stigma

Being diagnosed as HIV positive was associated not only with issues in physical health but also with psychosocial, difficulties to adjust to life in society, dealing with uncertainty and moral judgments, and concern to hide the condition to remain socially acceptable.

Mental well-being

Being depressed, feeling of loneliness, suicidal thoughts, social deprivation are among the issues expressed. *"When I found out [my diagnosis], it was the end of the world for me" (FG 3)*

Causes of these conditions could be both absence of family to support or difficulties being stressed for children and other family members.

"When I found out my diagnosis, I couldn't stop thinking - why us? We are normal family!" (FG 4)

Negative self-judgements

Participants mentioned blaming themselves especially during the first years after being diagnosed for the practices that led them to being infected.

"I had depression for 5 years, my husband died of HIV, I found out that both me and my child are infected, I cried and thought that my child is going to die and it's all because of me". First months you don't want to take drugs, don't listen to doctors, blame doctors and yourself" (FG 3)

Fears

Fears of physical disability, exacerbating of the symptoms, being scared of death as well the fear being alone, problems in relations and question of having children arose in discussions.

“I had a girlfriend when I found out my diagnosis, I told her and she broke up with me, in next relations girl broke up with me too, so I don’t think I’ll have relations anymore” (FG 2)

6.7. Ways of positive improvements

Measures to perform to improve lives of PLWH and lower stigmatization in country were among the most discussed topics on focus groups. The interventions suggested were more information in Georgian language in media in available form, education at society level that HIV is not a lower class problem, solving the fear of public disclosure. Education for medical personnel on reducing their level of prejudice against PLWH was found by the participants as compulsory measures.

“Information that it’s possible to live with it if on drugs, that everyone can be infected, information in less negative way for disease prognosis” (FG 1)

According to the focus groups, the situation is already getting better due to a large amount of information in Internet on HIV topics. At the same time, attitudes of hopelessness to improve the stigma situation in Georgia were recognized.

“I don’t think that it’s possible to change something here while older generations are still alive” (FG 2)

7. Discussion

The study showed that PLWH experience negative attitudes and behaviors towards them on everyday basis from society, family members and healthcare workers in Georgia. Some mentioned specific characteristics of HIV related stigma in society were moral assessment of ways of HIV transmission, population affected and disease itself.

Important effects of stigma in healthcare facilities manifested in healthcare denial, confidentiality issues, marginalization attitudes and inadequate and insufficient diagnosing experiences lead to lower medication adherence, linkage to healthcare, and potentially to higher morbidity.

According to Georgian legislations PLWH has a right of non-disclosure and discrimination is prohibited by law. Even so, discrimination in community can cause social rejection, on a household level leading to fears of being rejected by their families, and at workplace threatening their jobs, stigmatization prosper and contribute to unemployment, undesirable HIV status disclosure and domestic violence.

Having physical disease, PLWH face constant psychological difficulties, suicidal thoughts, and depression. A feeling of loneliness and hopelessness results in lower quality of life and lower adherence to treatment.

Participants identified measures and actions that they suggest as potentially beneficial to reduce HIV stigma. Among the policies and activities proposed the participants suggest trustworthy information in media, and health education has a fundamental role. At the same time, policymakers should consider cultural background, local socially accepted norms and religious values while developing targeted plans.

The Health stigma and discrimination framework by Stangl et al. (2019) was used as a theoretical basis for this research. In it the process of stigmatization is defined in the following steps – drivers and facilitators, stigma marking, manifestations and outcomes.

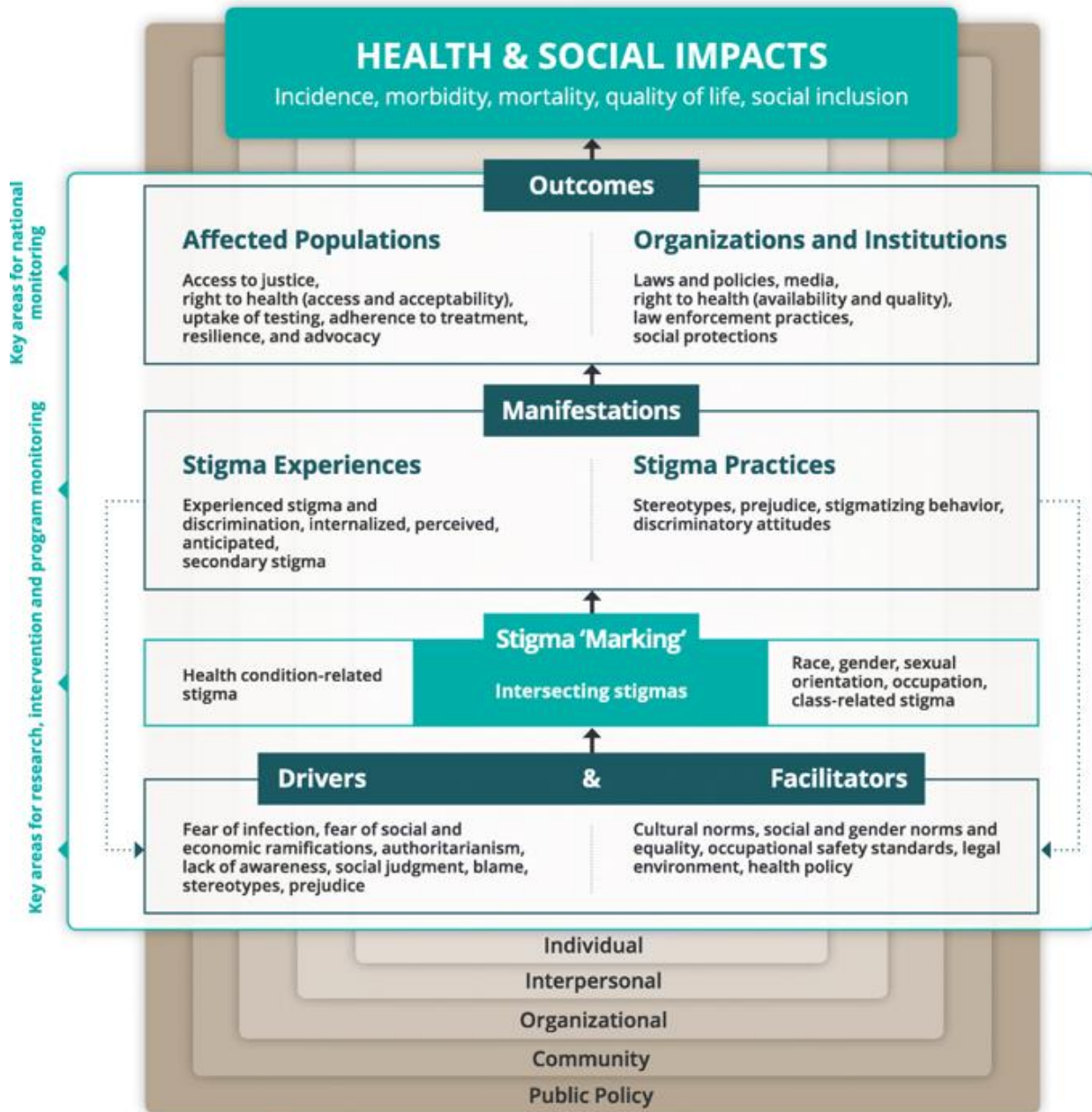


Figure 3. The Health stigma and discrimination framework

7.1. Drivers and facilitators

In this study, PLWH perceived fear of being infected and lack of awareness on HIV transmission and prevention in society, especially in older people or people living in remote areas, as drivers of HIV-related stigma. Educational programs giving adequate knowledge on the modes of HIV transmission and raising awareness on living with HIV was proposed as effective to reduce stigmatization. In consistence with these findings a study performed in China estimating effects of HIV health education program showed that living in the rural areas and age 60 years and above were factors linked to having lower knowledge about HIV, and that supplementary HIV education by healthcare workers or mass media was effective to raise awareness (35).

Concerns of social judgments and other negative attitudes, as well as fear of social and economic consequences if disclosing HIV status, were explained by PLWH as internal drivers of stigma among participants themselves. Risk of unemployment and income loss, and challenge of getting hired if the HIV status were stated as potential contributors to depression and fears. Another study conducted in France showed significantly lower employment rate in PLWHIV than in the general population as well as lower probability to reenter the labor market (36).

Stigma attitudes and behaviors in traditionally supporting circumstances, i.e. healthcare settings and in their own households, were perceived by the participants as affecting their psychological well-being, resulting in negative self-judgements. In a cohort study in Canada the significant interaction between HIV stigma and recent household violence and depression was identified (37).

Study participants considered cultural and social norms in Georgia as the main factors facilitating discrimination. Equating HIV to a sinful life by certain religious leaders, conservative mindset in community foster moral judgements and stigma manifestations. In Puerto Rico a study was performed investigating the role of religion on HIV stigma among nurses. It revealed that in some narratives religious beliefs have positive influence raising commitment to patient's health, but in others it evokes negative practices blaming PLWHIV for their condition (38).

7.2 Stigma marking

Participants perceived HIV health condition related stigma as a ‘marking’ reducing the status of the individual in the society. They focused on incorrect understanding of HIV prevention and a life with HIV on all levels, including domestic, community, healthcare facilities and government levels.

Participants mentioned the common belief existing in society stating that HIV is exclusively a disease of groups at risk associated with sexual orientation, professional occupations and drug addiction, pointed out that this prejudice results in intersecting double stigma of immoral and socially unacceptable behaviors. A study from New England suggested a straightforward relation between prejudice to psychological distress and PLWH, pointing out sexual orientation prejudice and low community motivation to control social prejudice (39).

7.3 Manifestations

Participants perceived that living with HIV, particularly during the first years after diagnosis confirmation, as extremely influenced by internalized stigma, individual acceptance and application of stigma to themselves. Self-blaming for life choices, as well as feeling miserable and hopeless were among predominant perceptions. In consistence with these findings is a study from UK on philosophical reflections on HIV stigma where the ways self-stigma and shame impact on PLWH were identified, i.e. preventing individuals from disclosing their HIV status and from engaging with healthcare and adherence to the antiretroviral therapy (40).

Perceived stigma, referring to a person’s understanding of how others may think or feel about the individual, is characterized by participants as causing serious limitations, depending on family support, healthcare workers attitudes and life conditions, resulting in low self-confidence and hopelessness as well as low adherence to healthcare recommendations. Consistent to these findings, a study from China on HIV-positive MSM pointed out perceived stigma affecting depressive symptoms through social support and self-esteem (41). A systematic review on perceived HIV-related stigma in low and middle-income countries depicted that low presentation

to healthcare (both HIV diagnosing and beginning antiretroviral treatment) was 2-5 time higher in those experiencing high levels of perceived stigma, that potentially will lead to continuous transmission and increased morbidity (42).

Regarding anticipated stigma, described as expectations of stigma experiences happening if being HIV infected, participants considered that they avoided HIV testing and diagnosis confirmation due to the knowledge of social, psychological and health consequences of positive HIV status. A study conducted in New York City on MSM and transgender women showed consistent findings, examining the effect of anticipated stigma on delay in HIV testing, where participants willing to differentiate themselves from the groups of high risk underestimated their risk of contracting HIV(43). However, in contrast to this research, in our study there was no correlation between age and HIV testing delay.

In the case of secondary stigma, i.e. stigma directed to the family of PLWH, was considered as highly stressful by the participants, therefore providing concerns that family members, especially children, would experience discrimination and isolation from society due to existing negative social attitudes. In a qualitative study on HIV-positive injection drug users in Vietnam, another country where the family side has a serious value, concerns on the consequences of HIV stigma on social and economic well-being that extended to family, as well as emotional burden of disclosure of HIV status for family members are illustrated (44). In contrast to this study our results showed a good association between testing positive and seeking support in a family or friends.

Participants perceptions of enacted stigma, discriminatory acts or behaviors, was focused on experiencing low quality and negligent healthcare from providers, social rejection from the family and friends, job loss or issues returning to labor market, or physical violence from community members. Particularly emphasized by the participants was the concept of interrelationship and exacerbation if several types of coexisting stigma. In accordance with this, a study on HIV positive children in rural China recognized the vicious circle when enacted stigma lead to depressive symptoms, resulting in perceived stigma that in turn increase enacted stigma (45).

7.4 Outcomes

In the participants views, HIV-related stigma in healthcare settings was an unexpected issue as medical professionals seemed to be unjudgmental, respecting patient's private life and having enough knowledge to be familiar with transmission modes of HIV. Alternatively, they found themselves struggling with issues with access to healthcare – rejection of healthcare services, or limited access to it, including emergency healthcare. As showed in systematic reviews on stigma among healthcare providers in US, lack of knowledge on HIV prevention and fear of occupational disposure result in reduced quality of healthcare (46, 47).

Adherence to treatment, as participants consider it, is influenced by not simply attitudes and believes of PLWH, but almost exclusively by discriminating behaviors of health personnel, their attitudes to HIV patients, and doctor\patient confidentiality. Consistent findings were presented in a study on HIV patients' discrimination in New Zealand healthcare settings, where half of PLWH experienced stigma by a healthcare worker including confidentiality issues, unnecessary infection control measures and impoliteness (48).

The participants perceived government level laws and policies as being sufficient in means of social and criminal protections, at the same time mentioning high possibility of cases of domestic or neighborhood violence in rural and remote areas. In comparison, a study among Western Indian HIV positive women pointed out that 50% of respondents experienced domestic violence, of them 75 % physical and 25 % sexual violence (49).

The participants expressed their views on the media impact on the issue of HIV-related stigma from two perspectives. From one side, media is an open source of knowledge, where the stigma in society could be reduced if providing correct information on HIV prevention by popular influencers. In contrast to it, research on African-American and Latino MSM found a negative association of social media usage and HIV stigma (50). At the same time, concerns regarding involuntary disclosure of HIV status in media and following information spread were raised by our research participants. That correlates with The Lancet article on sharing by Grindr the HIV statuses of their users with other companies without users' permissions (51).

8. Reliability. Strengths and limitations of study.

This study was the first of its kind in Georgia. It is also among very few in this region of Central Asia and Eastern Europe on the topic of stigma and discrimination associated with HIV, that may be connected with legal and cultural barriers and limited possibility of international collaboration.

The main strengths of this study are the methodology and theoretical framework. A systematic analysis of data was obtained through focus group discussions. Frequent reading of transcribed data was done, and several discussions with the supervisor were performed. The study setting, selection criteria, selection process and data collection process has been described clearly to gain transferability. The same researcher conducted all 4 focus group discussions within a month period to secure consistency of data.

It was considered that a qualitative methodology in the form of focus group discussions was the best option to investigate the perceptions and experiences of people living with HIV on discrimination around HIV and AIDS.

The researcher is a medical doctor with many years of experience, working in a post soviet country environment similar to the Georgian. The candidate also has experience working with HIV patients in medical settings. Living in an Eastern European country the candidate knows from her own experience all aspects of government policies, prejudice and misconceptions regarding health and well-being existing among people in this region that helped to give a better understanding of the participant views.

A possible limitation of the study is that the participants are not sharing their actual perceptions and experiences because of shame or fear. Instead of this, we found that the participants were very open in discussing the topic, and that there was no evidence that they were holding back information. Another possible limitation is that we did not include those perpetuating stigma. But the aim of study was to explore the attitudes of people living with HIV.

9. Conclusions

The study documented the types of HIV-related stigma on people living with HIV infection and made the concept of HIV-related stigma in the country of Georgia clearer. It showed the complex of experiences and perceptions of PLWH regarding their own health and well-being, misconceptions existing in society regarding HIV, and attitudes to disclosure of their experience. It highlighted the drivers and facilitators leading to stigma marking, that manifests in stigma experiences and practices, that in turn produce negative outcomes on an affected population.

The benefits of this research for the participants were the possibility to take an active role in their life situation, discuss the significant issues with others who perceived them too, to help combatting with helplessness, as well as to contribute to the advancement of public health and science in Georgia.

This study provides basis for future in-depth research and design of community stigma reduction programs on the topic of HIV-associated discrimination. Possible further research objectives are to investigate behaviors and attitudes towards HIV positive people among community representatives as well as healthcare providers to develop stigma reduction interventions.

Society awareness programs as well as educational programs for healthcare providers should be implemented to address the misconceptions around HIV in the country of Georgia.

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11. Appendices

App. 1 Informed consent for participants

Informed Consent

Study title: HIV and stigma: patients' experiences in Republic of Georgia

Date: Name of Group Interviewed (Group Code): Data collection site: Time of discussion:to..... No. of participated: Name(s) of Facilitator(s):
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Study Supervisor:

Please, take part into medical study, that is conducted by Norwegian University of Science and Technology. You will get the detailed information about the study. Don't hesitate to ask questions. Your consent will be confirmed by signing this document and one of the copies will be with you. remember that:

- Participating into the study is completely voluntary
- You can refuse to participate into the study. Despite your decision privileges will not be affected

Study goals

The goal of this research is to investigate and describe the impact of stigma experience of PLWH in Georgia. Since there is little or no academic research made on stigmatization of people living with HIV/AIDS in Georgia this project will aim to investigate their experiences and deeper understanding of reasons of current HIV situation in Georgia. Further it will possibly propose future initiatives in order to improve the life quality of HIV positive people.

Procedures

If you are agree to take part into this study, your participation will last *approx. 2 hours*

During the research following procedures will be held – you will take part in focus group discussions.

Possible risks and discomfort

We do not expect that participating in this study will cause you any harm. But asking sensitive questions information is possible.

Possible benefit

We will learn by hearing your opinions and including them in our study which will hopefully be for benefit of others in the future.

Confidentiality

The following measures will be taken to ensure confidentiality

With your permission, we will be taping this discussion to facilitate recollection. Despite being audio recorded, we would like to assure you that the discussion will be anonymous. The tapes will be kept safely in a locked facility until they are transcribed word for word, then they will be destroyed. The transcribed notes of the focus group will contain no information that would allow individual subjects to be linked to specific statements.

Financial Issues

All the participants will be given 15 usd compensation for their participation and time.

Refusing participation into the study

It is volunteer to take part into the study. You can refuse to participate or leave the study at any time. It will not influence on your rights and privileges that belongs to you legally.

Questions and problems

If any question raises through this study, please contact the study Prof. Jon Odland, or other personnel of this study. Their telephone numbers are indicated below:

contact person:	Jon Odland	phone: + 4790953887
	Olga Teterina	phone + 4746361920

If any questions raises about scientific study rights, please contact IRB of the Infectious Diseases, AIDS and Clinical Immunology Research Center e-mail: irb.idacirc@gmail.com

Researcher application

I confirm that I have provided the detailed information about the survey, and I answered all his/her questions. In my opinion, the participant understands the essence of the research and voluntarily agrees to participate in the study.

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researcher name	signature	date

Информированное согласие

Название исследования: ВИЧ и стигма: опыт пациентов в Республике Грузия

Дата:
Номер группы (Код группы):
Место сбора данных:
Длительность дискуссий:to.....
Число участников:
ФИО исследователя:

Исследователь:

Пожалуйста, примите участие в медицинском исследовании, которое проводит Норвежский научно-технический университет. Вы получите подробную информацию об исследовании. Не стесняйтесь задавать вопросы. Ваше согласие будет подтверждено подписанием этого документа, и одна из копий будет с вами. Напоминаю, что:

- Участие в исследовании полностью добровольно
- Вы можете отказаться от участия в исследовании. Несмотря на ваше решение, ваши преимущества не будут затронуты

Цели исследования:

Цель данного исследования - изучить и описать влияние стигматизации в отношении людей, живущих с ВИЧ в Грузии. Поскольку в Грузии практически не проводится научных исследований по данной тематике, этот проект будет направлен на изучение их опыта для более глубокого понимания причин текущей ситуации с ВИЧ в Грузии. В дальнейшем, возможно, будут предложены будущие инициативы для улучшения качества жизни ВИЧ-позитивных людей.

Мероприятия

Если вы согласны принять участие в этом исследовании, ваше участие продлится около двух часов. Во время исследования будут проведены следующие процедуры - вы примете участие в обсуждениях в фокус-группах.

Возможные риски

Мы не ожидаем, что участие в этом исследовании принесет вам какой-либо вред. Но исследование включает в себя вопросы на приватные темы.

Возможная польза

Услышав ваши мнения, мы включим их в наше исследование, которое, впоследствии, в будущем приведет к эффективным мерам.

Конфиденциальность

Для обеспечения конфиденциальности будут приняты следующие меры.

С вашего разрешения мы будем записывать ваши интервью для их точного воспроизведения впоследствии. Несмотря на то, что мы записали аудио, мы хотели бы заверить вас, что интервью будут анонимными. Записи будут надежно храниться в закрытом помещении, пока они не будут расшифрованы дословно, а затем будут уничтожены. Переписанные заметки фокус-группы не содержат информации, которая позволила бы привязать отдельные темы к конкретным высказываниям.

Финансовые стимулы

Всем участникам будет предоставлена компенсация в размере 15 долларов США за их участие и время.

Отказ от участия в исследовании

Участие в исследовании добровольно. Вы можете отказаться от участия или покинуть исследование в любое время. Это не повлияет на ваши права и привилегии, которые принадлежат вам на законных основаниях.

Вопросы и проблемы

Если в ходе этого исследования возникнет какой-либо вопрос, пожалуйста, свяжитесь с профессором Джоном Одлендом или другим персоналом этого исследования. Их номера телефонов указаны ниже:

контактное лицо: Джон Одланд телефон: + 4790953887

Ольга Тетерина телефон + 4746361920

Если возникнут какие-либо вопросы о правах на научные исследования, пожалуйста, свяжитесь с

ИКС Научно-исследовательского центра инфекционных болезней, СПИДа и клинической иммунологии

электронная почта: irb.idacirc@gmail.com

Подпись исследователя

Я подтверждаю, что предоставила подробную информацию об опросе и ответила на все заданные вопросы. Участник понимает суть исследования и добровольно соглашается принять участие в исследовании.

ФИО

подпись

дата

App. 3 Topic Guide for focus group discussion

TOPIC GUIDE FOR FOCUS GROUP DISCUSSIONS ON HIV-related stigma

Introductory question

I am going to give you a couple of minutes to think about your experience about HIV in general. Would anyone like to share her experience?

Guiding questions

Could you describe what you think is known about HIV in this area?

Probe for:

Would you think it is a usual condition?

How do women get HIV in your view?

How do you think it can be prevented?

Would you think it is a dangerous condition?

What do you think about HIV screening?

Probe for:

Have you ever experienced HIV-related stigma?

Have you been treated unfairly in making or keeping friends?

Have you been treated unfairly by the people in your neighbourhood?

Have you been treated unfairly in dating or intimate relationships, marriage or divorce?

Have you been treated unfairly by your family?

Probe for:

Have you been treated unfairly in finding or keeping a job?

Have you been treated unfairly getting welfare benefits or disability pensions?

Probe for:

Have you been treated unfairly in your religious practices?

Have you been treated unfairly in your social life? (socialising, hobbies, attending events, leisure activities)

Probe for:

Have you been treated unfairly when getting help for physical health problems?

Have you been treated unfairly in your levels of privacy?

Have you been treated unfairly in your personal safety and security?

Probe for:

Any suggestions how to reduce HIV-related stigma?

Concluding question

Of all the things we have discussed today, what would you say are the most important issues you would like to express about this issue of HIV-related stigma? Do you have anything to add?

Conclusion

Thank you for participating. It has been very valuable for us to hear your thoughts.

We hope you have found the discussion interesting.

I would like to remind you that any comments featuring in this report will be anonymous and will be used only for research purpose.

Приложение. 3 Тематическое руководство для обсуждения в фокус-группах
РУКОВОДСТВО ДЛЯ ОБСУЖДЕНИЯ В ФОКУС-ГРУППАХ ПО ВИЧ-
АССОЦИИРОВАННОЙ СТИГМЕ

Вводный вопрос:

Я дам вам пару минут, чтобы вы подумали о вашем опыте в отношении ВИЧ в целом. Кто-нибудь хотел бы поделиться своим опытом?

Основные вопросы:

Не могли бы вы описать, что, по вашему мнению, известно о ВИЧ в этой области?

Пробные вопросы:

Как вы думаете, ВИЧ – это часто встречающееся заболевание?

Какие, по вашему мнению, пути заражения ВИЧ?

Какая, по вашему мнению, существует профилактика ВИЧ?

Как вы думаете, ВИЧ — это опасное состояние?

Что вы думаете о скрининге на ВИЧ?

Пробные вопросы:

Вы когда-нибудь испытывали дискриминацию в связи с ВИЧ?

К вам относились несправедливо друзья?

К вам предвзято относились ваши соседи?

К вам относились несправедливо в отношении свиданий, брака или развода?

Есть ли дискриминация по отношению к вам в вашей семье?

Пробные вопросы:

Существует ли дискриминация по отношению к вам на работе?

Были ли у вас проблемы при получении социальных пособий или выплат?

Пробные вопросы:

Существует ли дискриминация по отношению к вам в церкви которую вы посещаете?

Дискриминация в социальной жизни? (общение, хобби, посещение мероприятий, досуг)

Пробные вопросы:

К вам относились несправедливо при получении медицинской помощи?

Были ли нарушения конфиденциальности по отношению к вам?

Случались ли у вас проблемы с личной безопасностью?

Пробные вопросы:

Любые предложения, как снизить стигму ассоциированную с ВИЧ

Заключительный вопрос

Из всех тем, которые мы обсуждали сегодня, что бы вы назвали наиболее важными вопросами по вопросу стигмы связанной с ВИЧ? У вас есть что добавить?

Вывод

Спасибо за участие. Нам было очень важно узнать ваше мнение.

Мы надеемся, что вам были интересны эти интервью.

Я хотела бы напомнить вам, что любые комментарии, представленные в этом отчете, будут анонимными и будут использоваться только для исследовательских целей.

App. 5 Ethical approval from Georgia

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Institutional Review Board

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ინფექციური პათოლოგიის, შიდსის და კლინიკური იმუნოლოგიის ს/პ ცენტრი
Infectious Diseases, AIDS & Clinical Immunology Research Center

July 31, 2019

Olga Teterina, MD
Faculty of medicine
Norwegian University of Science and Technology
NO -7491 Trondheim, Norway
Tel: +4746361920
Email: olgate@stud.ntnu.no

Protocol number: 19-004

Title of the project: "HIV and stigma: patients' experiences in Republic of Georgia"

Dear Dr. Teterina,

Institutional Review Board of the Infectious Diseases, AIDS and Clinical Immunology Research Center (OHRP # IRB00006106) has reviewed your request for the review of a new study referenced above.

This is to confirm that your application is approved and you are granted permission to conduct the study as described in the application effective immediately. The protocol is approved through **July 19, 2020**.

Your study has been assigned number **19-004**. Please reference this number in any further communication. The study is not a subject of continuing review and will be closed by this date.

Researchers assume responsibility of notifying IRB promptly on any changes of this approved protocol. Please note that some changes may be approved by expedited review, while some changes require full board review. Please contact us if you have additional questions.

Good luck with your study.

Sincerely,

Ketevan Shermadini, MD
Chair of IRB

