Master's thesis

NTNU
Norwegian University of Science and Technology
Faculty of Medicine and Health Sciences
Department of Public Health and Nursing

Laurita Petrulyte

Intimate partner violence and HIV: women experiences in Republic of Georgia

Master's thesis in Global Health

Supervisor: Jon Øyvind Odland Jennifer J. Infanti Izoleta Bodokia

June 2020

NTNU
Norwegian University of
Science and Technology

Table of Contents

1. ABSTRACT

Background. The human immunodeficiency virus (HIV) and intimate partner violence (IPV) continue to be two major global health concerns. The association between IPV and HIV has been the focus of a growing number of studies, however, the diverse South Caucasus region has been largely overlooked by academic scientists. There are a number of factors in Georgia, a highly religious lower-middle-income country in the South Caucasus region, that put women in an unsafe position for both HIV and IPV, such as lack of reproductive health education, gender inequality and male-favouring traditionalist attitudes.

Methodology. A qualitative study design was chosen in order to explore the IPV experiences of women living with HIV in Georgia. Focus group discussions (FGDs) were held with women facing similar experiences in safe and encouraging environments.

Findings. Four FGDs were conducted with a total of twenty HIV positive Georgian women. Almost half of participants shared being infected with HIV due to the previously unknown HIV positive status of their intimate partner or as a result of sexual violence. Twelve out of twenty participants shared experiencing domestic violence, perpetrated by their intimate partner and in some cases his family members. Most of them experienced violence for the first time after disclosing their HIV positive status. For the consequences HIV positive females who experienced different types of IPV have demonstrated repeated tendencies of past antiviral therapy disruptions, trauma and high levels of depression.

Conclusions. The findings from this study suggest an indisputable connection between HIV and IPV by them being a risk factor and a result of one another. Georgian women appear to be in a vulnerable position for both HIV and IPV because of lack of legal protection, HIV-related education and public acceptance of unequal gender power relations. However, since the study was conducted solely in the capital city of Tbilisi, further research in rural settings in Georgia is needed to gain a better understanding of the overall country situation.

2. ACKNOWLEDGEMENT

I would like to express my sincere gratitude to my supervisor, professor Jon Øyvind Odland, who provided major help while searching for local contacts in Georgia and gaining approvals from both Norwegian and Georgian ethical commissions. Also, I would like to thank my co-supervisors, Jennifer J. Infanti, who, despite time pressure, strongly supported me during my final data analysis and thesis writing, and Izoleta Bodokia, the director of the HIV/AIDS Patients Support Foundation, who provided enormous help with the participant recruitment process. Without them this study would have never be finished.

I would also like to thank the Norwegian University of Science and Technology (NTNU) for giving me the opportunity to deepen my knowledge in the public health sector and to conduct international research on IPV and HIV, which I found truly life changing, not only for my future career, but for my personal development as well.

I also thank all the participants who agreed to share their experiences on this sensitive topic and all the staff of the HIV/AIDS Patients Support Foundation for being so kind and helpful during my stay in Tbilisi.

Finally, I thank my family and friends for constant support and to my boyfriend P. for patience and the right push at the end of thesis writing which helped me to finish it in time.

3. LIST OF ABBREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome

CIA – Central Intelligence Agency

EU – European Union

FGDs – Focus Group Discussions

HIV – Human Immunodeficiency Virus

IPV – Intimate Partner Violence

NCADV - National Coalition Against Domestic Violence

STDs – Sexually Transmitted Diseases

UN – United Nations

UNAIDS - Joint United Nations Programme on HIV and AIDS

UNFPA – United Nations Populations Fund

USD – United States Dollar

WHO – World Health Organization

4. LIST OF TABLES AND FIGURES

5. BACKGROUND

5.1. Global issue of violence against women

Violence against women is one of the most common human rights violations in the modern world. Because of uneven power relations, females are the usual targets of men. It is estimated that one in three women will experience physical or sexual abuse in her lifetime (1). Although this number includes all kinds of violence, intimate partner violence (IPV) is one of the most common forms of violence against women. The World Health Organization (WHO) explains IPV as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, also including controlling behaviours such as financial and social isolation (2). Despite its wide range, IPV is also one of the most invisible types of aggression since it typically happens in family environments and, globally, women rarely reporting the crime due to cultural stigma or lack of support (3). IPV is a major global health problem associated with physical injuries, increased risks of chronic pain, disabilities, alcohol and drug abuse and mental health disorders (4).

5.2. HIV as a global health pandemic

According to the WHO, Human Immunodeficiency Virus (HIV) is considered to be one of the most serious global health threats, having caused 32 million deaths since the 1980s (5). With successful prevention programs, testing and medicine provision, HIV has become a manageable chronic disease, giving the possibility for people living with HIV to lead long and healthy lives (5). However, access to prevention, testing and treatment is unequally distributed. Many people are still living undiagnosed or being diagnosed too late. Due to pharmaceutical restrictions, treatment costs, and other related factors that limit the availability of and access to life-saving medication in many national health systems, a lot of countries are unable to meet patient needs. Consequently, in 2018, more than a half of one million people died from Acquired Immune Deficiency Syndrome (AIDS)-related conditions caused by HIV and nearly 2 million individuals were newly infected with HIV (6). Additionally, HIV patients globally continue to face stigma, discrimination and mistreatment from both broad and close environments which often negatively impact their mental health (7).

5.3. Connection between IPV and HIV

There is an indisputable connection between IPV and HIV/AIDS. A quantitative meta-analysis from 2014, conducted of twenty-eight studies, shows the association between IPV and HIV is statistically significant (8). The Global Coalition on Women and AIDS, together with the WHO, names IPV as both a risk factor for intersection with HIV, due to direct transmission through sexual violence or inability to negotiate for male using condom, and a consequence of being HIV positive (9). Since unprotected sexual contact remains one of the main root causes of individuals being infected by HIV worldwide there is strong evidence that women and young girls – being in unequal power relations, lower social and economic statuses than men – are at much higher risk of getting infected than men (10).

When it comes to women already living with HIV, it is a challenge to investigate the burden of violence they are experiencing. It is similarly difficult to attribute the level of IPV caused primarily by the HIV diagnosis, since both HIV and IPV are highly sensitive topics for women to talk about on their own. As a result of these methodological and practical challenges, the mechanisms behind the association between IPV and HIV are still unclear. However, research indicates that HIV diagnosis does provoke violence against women in new situations and is responsible for placing females in even lower positions when it comes to family power relations (11). Research conducted in Tanzania during the time when the country had the highest levels of the population living with HIV showed that, in comparing HIV negative and positive women, the ones with the disease were more than two times likely to suffer sexual or physical violence caused by their intimate partners (12). A more recent study in Swaziland stated that HIV positive status disclosure may provoke IPV by sudden interpersonal triggers, such as fear, anger or impulsivity. IPV may also be caused by long-term normative tensions, like continuing disagreements on condom use or tensions and anger caused by the woman's unwillingness to perform sexual intercourse (13). In addition, IPV may decrease HIV positive women's access to medication and as such increase the possibility of transmitting the virus to the women's children and an early death to themselves (14).

5.4. Researched region

The South Caucasus region today is highly complex with many different languages and religious beliefs. However, the people of the nations in the region share a great part of common history that shaped their current social norms, including similarities that are traceable to long-

enduring highly patriarchal family models wherein males have dominant roles (15). When it comes to relationships between men and women in Georgia, it is still common that a woman is considered to 'belong' to someone, either to her family or her husband after marriage. This sense of ownership, along with responsibility for providing finances and security, grants men near absolute power over women (16). A 'good wife' in Georgian society is perceived as an obedient wife. The man, being the head of the family, may use violence, as traditionally accepted and practiced social norm, in order to ensure obedience, including enforcing on women a duty to perform sexual intercourse. Another issue that affects this research is public opinion towards divorce. Divorced women are often branded as 'returned women', meaning that usually divorced women are forced to go back to their parents' homes. This is considered a big shame and divorced women therefore face strong negative attitudes in society. Consequently, to save their reputations, families of IPV victims may not support their daughters in seeking divorce (15).

The problem of IPV in Georgia is accurate. In 2014, 17 women in the country were killed as a result of domestic violence (17) which urged public protests going against socially constructed gender inequality and demanding for women rights. Consequently, the Georgian government was urged to take action to eliminate the number of murders and other forms of domestic violence (18). Since then several initiatives for diminishing IPV in Georgia were introduced. Nevertheless, a 2017 National Study on Violence against Women showed that nearly 6% of females reported experiencing physical IPV and 2% sexual IPV, while the same study conducted in 2009 reported 6.9% of women facing physical IPV. The statistics show a slight, but not significant improvement, while at the same time there is a high possibility that numbers are underestimated because of the issue being surrounded by stigma and shame and thus IPV crimes are rarely reported (19).

When it comes to HIV in Georgia, the number of people living with the disease is growing each year. WHO estimated that over the last decade, the number of new HIV cases has continued to increase rapidly and now become one of the highest in the region (20). HIV is still highly stigmatized in Georgian society. A common belief is that individuals who are HIV positive are sex workers, drug users or those who are leading active sexual lives with a high number of different partners. Fear of possible social isolation discourages people from taking HIV tests and disclosing their HIV status to friends and family members (21). It is estimated that around 48% of HIV positive individuals in Georgia are undiagnosed, and 73% of those presenting for HIV care are diagnosed at the very late disease stage (22). Moreover above 70%

of people who are tested annually for HIV belong to low-risk groups, such as blood donors and pregnant women (22). Such high undiagnosed levels make it difficult to precisely measure the overall disease prevalence and stabilize the spread of HIV.

5.5. Rationale of study

The South Caucasus is a neglected region among academic researchers. Existing data on HIV and IPV is very scarce in the region, including in Georgia, and mainly consists of quantitative statistics provided in a form of reports by major international organizations such as United Nations (UN), Europeans Union (EU) and WHO. Despite the rising global attention on ties between HIV and IPV, there are no scientific publications to date on this association in Georgia. A literature review for this thesis, from various databases, resulted in information only on either IPV or HIV, but never on both issues investigated together. For instance, some studies attempt to explain cultural reasoning behind high levels of IPV in Georgia, and there are media articles on stigmatization of HIV patients, but no research on links between the two phenomena was found (15, 16, 21, 23). For example, no prior studies have investigated if IPV might be partly responsible for the increasing number of new HIV cases among women in Georgia, or if gained HIV status is a risk factor for IPV. As a result, notable gaps are evident in academic knowledge when it comes to the issue of IPV in the context of HIV in Georgia.

The goal of the present study is to contribute in filling these gaps by becoming a pioneer qualitative academic study on the intersection of HIV and IPV in the South Caucasus region. The results of the study may have the potential to inform Georgian public health professionals in order to improve the health and well-being of members of its society.

5.6. Study aim

The aim of the study is to explore the IPV experiences of women living with HIV in Georgia.

The main purpose of the research is to give voice to women who have thus far not been 'seen' in academic research and to help readers to gain a richer understanding of how and why the women in this study experienced HIV and IPV. As a result, the research question of this study is to illuminate women's experiences of living with IPV and HIV in Tbilisi, Georgia.

The study also seeks to provide a foundation for further investigations on quality of life of South Caucasian women living with HIV and for possible interventional initiatives in order to improve it.

5.7. Theoretical framework

The investigation and summary of concepts and theories of past research has helped the student to analyse and interpret the findings of the study.

The main theory which eventually was chosen to use in order to better understand the IPV, gender relations and to examine the findings was, Robert Connell's Theory of Gender and Power, which was firstly articulated in 1987, based on philosophical writings of gender, sexual inequality, and power imbalances (24). According to Connell, there are three main structures that explain the social structural relationship between males and females – the sexual division of labor, sexual division of power, and the structure of cathexis which explains the affective components of relationships. (see Table 2.1 below) In 2002, Wingood and DiClemente expanded on Connell's theory and renamed the last component of cathexis to 'affective and social exposure' to emphasize the influence of traditionally applied social norms that highly affect different gender relationships (25). According to the theory, all three structures exist in both societal and institutional levels and have emerged from numerous socio-political and historical events that have built the fundamentals of traditionally-accepted gender roles. Even though norms are constantly evolving in societies, the structures stated in the theory remain largely accurate (25).

The theory was particularly important to this topic, because Wingood and DiClemente has applied Connell's traditional theory for explaining women's vulnerability to HIV. It has helped to clarify the findings by providing a better explanation of how unequal gender power in different levels may increase certain risks to women's health and to put them into certain categories.

The following table illustrates the Wingood's and DiClemente's attempt to apply Connells's theory of gender and power to women's health. It shows how unequal gender power structured into three divisions – the division of labor, sexual division of power and structure of cathexis manifests in different institutional levels and results in widely applied social mechanisms and risk factors, which all form an increased risk to HIV.

Societal Level of power division	**Institutional level**	**The Social Mechanisms**	**Exposures**	**Risk factors**	**Biological factors**	**Disease**
Sexual division of labor	Work site, school, family	Manifested as unequal pay, which produces economic inequalities for women	Economic exposures risk factors	Socio-economic		
Sexual division of power	Relationship, medical system, media	Manifested as imbalances in control, which produce inequalities in power of women	Physical exposures	Behavioral risk factors	Douching Pregnancy Contraception	HIV
Structure of cathexis: social norms and affective attachments	Relationship Family Church	Manifested as constrains in expectations, which produce disparities in norms of women	Social exposures	Personal risk factors		

Table 4.1 Proposed model conceptualizing the influence of the Theory of Gender and Power on women's health (Wingood and DiClemente, 2002)

For the discussion part of this research, Wingood and DiClemente's expanded version of the gender and power theory was applied in order to explain how social structures may influence women's vulnerability to various health risk factors in the context of HIV. The theory discusses factors such as lack of family support, partner abuse, inability to negotiate in intimate

relationships and social attitudes which influence women's risks of being exposed to HIV and gender-based violence while being HIV positive (25).

6. METHODOLOGY

6.1. Study design

In order to explore the IPV experiences of HIV positive women in Tbilisi, Georgia, a qualitative study design was chosen. In order to draw the attention to the interconnections and associations of two major public health issues in Georgia - HIV and IPV the possibility of using cross-sectional questionnaires was also considered. However, due to limited resources of time and finance, and access to small number of participants the qualitative design was chosen to capture HIV positive women's experiences and their perceptions of IPV.

6.2. Research setting

The research setting is Tbilisi, the largest city in the country, also the capital of Georgia. Tbilisi currently has a population of 1 108700 people of which 90% are native Georgians (26). Concerning the study topic, it is one of the two cities in Georgia with the highest HIV prevalence rates (22). It is also a place with the biggest number of IPV cases per capita (27). Consequently, these statistics made it the most suitable place in Georgia for uncovering issues related to the research topic.

Figure 6.1 The map of Georgia

6.3. Study participants

The participants in this study were Georgian females living with HIV, registered at an infectious disease and clinical research centre.[1] All participants were at least 20 years old or above. The past experiences of IPV were not inclusion criteria. Women with severe mental health disorders or emotional hypersensitivity were excluded in order to reduce the risks of negative mental health impacts from participating in the study. Mentioned exclusion criteria was decided in collaboration with infectious disease and clinical research centre. Since the centre has an access to the history of metal issues of their patients collaborating workers helped to build a list of participants who at the given moment of data gathering were not suffering from emotional hypersensitivity and were not newly infected, since during that time patients tend to find themselves in the most fragile emotional state. No other exclusion criteria such as social, academic, cultural background or work experience were present.

[1] The exact names of the organisations are not mentioned in this thesis specifically as a measure to protect the anonymity and confidentiality of research participants

6.4. Participant recruitment

The participant recruitment process took place in collaboration with the infectious disease, and clinical immunology research centre. The recruitment procedure included the staff of the centre calling to patients first and asking if they are willing to join the discussions. Later student was provided with a list of women with anonymised code names [patient's ID codes] who have agreed to participate. The researcher was assured by the centre that all of the women in the list had been verbally informed about the study and did not have a history or current mental health concerns such as clinical depression, nervous breakdowns, anxiety or others. Thereafter, the research phoned potential participants to explain more about the study, invite them to participate and schedule the time of the meetings.

Before the beginning of each discussion, participants once again received verbal and written information about research topic and goals, and also about the procedures researcher will take for maintaining the safety of their information and anonymity during data processing and thesis writing. The procedures include not knowing the names of participants, also audio records of discussions being placed to safe, password protected, laptop right after the end of discussion and being destroyed by the end of June 2020 latest. They were also assured that their personal data such as ID numbers, contact information, places where they came from, studied, worked and other would not be disclosed in any way. Also, they were informed about their right to end the discussion and ability to leave at any time. After the informing procedure women were once again asked if they agree to participate in the study. At the end of the discussions, all participants were given a small remuneration (equal to 15 USD) for their time which was suggested by the research centre as common procedure.

6.5. International collaboration

The research was conducted in collaboration between Norwegian University of Science and Technology and two HIV/AIDS related organizations in Georgia, the above mentioned infectious diseases and clinical immunology research centre which facilitated with participant recruitment and helped with ethical clearance, and HIV patient's support foundation which provided a safe space for FGDs, Georgian language interpreter and emotional support for study participants if needed. The student came in contact with infectious disease and clinical immunology centre with the help of her supervisor prof. Jon Øyvind Odland, and the research

centre had introduced the student to Izoleta Bodokia, working at the HIV patient's support foundation who gave the premises for the discussions.

6.6. Data collection

The data was collected by holding closed focus group discussions at the HIV patient's support foundation, which provided a safe physical space for the participants. The FGD method was purposely chosen over individual interviews firstly due to their ability to provide a 'safer' and more relaxed environment for study participants and encourage them to open-up among those who had the same or similar experiences. Also, because FGDs often provoke discussions among participants on a certain topic as in the case of this study the publicly accepted social norms on gender inequality. Finally, FGDs are convenient in terms of time and limited space, which was also the case, since communication with participants had to be held in close environment and the support centre has a limited space, the student was not able to use it too often without allowing the centre staff to perform their everyday work. The researcher used a semi structured topic guide (see 11.2 appendix 2.) prepared according to the WHO practical guide for researching violence against women (28) for the discussions in order to capture all meaningful experiences and views on the issues of HIV and IPV.

Throughout the FGDs the original discussion guide was modified in order to meet the needs of participants and limited physical material provided by the HIV patient's support foundation. The original scrip had an introductory causal exercise that demanded a board where participants were able to categorize which forms of IPV they would to pre-HIV status disclosure and post-HIV status disclosure in order to notice any tendencies. However, there were no possibility to use a board or any similar material in the premises of foundation since they had a very limited space and resources. As a result, the exercise was changed to a verbal discussion. Also, after the first two meetings researcher has noticed that women tend to repeatedly reflect on experiences which were not considered while forming the original discussion guide. These included male partner's hiding their HIV status, publicly accepted social norms, lack of HIV-related education among Georgian society and others, which concluded in discussion guide's modification.

All meetings were held during the period of August - September 2019. The discussions were held in three languages – Russian, Georgian and English. Since quite a large part of the

Georgian population is able to communicate fluently in Russian, as well as the researcher, most communication was performed directly between the researcher and participants. However, a Georgian interpreter – an employee at the HIV patient's support foundation – was also present and assisted as needed to ensure participants were able to express themselves freely. The interpreter also provided English-Georgian-English interpretation when it was needed. The FGDs were purposely held during weekends so that nobody else except the participants, student and female interpreter, were present at the centre. The researcher was the only one giving the questions and leading the discussion, while the interpreter only provided technical language translation. The meetings were audio recorded after gaining the permission of research participants, and some written notes were taken by the researcher as well. After each meeting, the researcher wrote a diary about participant expressions and general mood during the discussion and debriefed it verbally with the interpreter – employee of foundation. After all of the FGDs were completed, the researcher listened to the audio recordings multiple times and transcribed them in original languages and later translated to English.

6.7. Data analysis

Data analysis was performed by following the guidelines of Graneheim and Lundman (29). After all the FGDs were performed the audio records were transcribed and Russian parts were translated into English. Later the data was read multiple times for a researcher to become well familiarized and obtain the meanings out of it. The meaningful units were coded to create sub-categories and later categories according to the coherence of their meanings. Researcher has also counted how many times the meaningful units were repeating and highlighted the strongest participant's quotations that later were used in order to illustrate the finding section. The codes were organized by using the Mindjet Mindmanager software to make it easier to group and categorize them. The analysis was done together with co-supervisor while sharing the strategies and constantly discussing on meanings and categories till the common agreements were reached.

7. FINDINGS

A total of twenty HIV positive women participated in the research. There were four FGDs, each including five participants, which ensured the venue was not over-crowded and each individual was able to speak about her experiences. The participants ranged in age from 24 to 51 years old, with an average age of 37 years. The women were ranging in educational and social backgrounds, as marital statuses, occupation and others, so the study would capture the greatest variety of experiences as possible.

Four main categories arose from the processes of data analysis, which was described in the 5.7 section above, each comprising several subcategories, as presented in table 6.1

Categories	Subcategories
Risk factors of HIV transmission	• Inability to negotiate condom use • Male partners consciously hiding their HIV status • Transmissions caused by sexual violence
Emerging forms of IPV after HIV positive status disclosure	• Psychological and physical abuse • Pressure against antiretroviral medicine taking • Conflicts with partner's family members
Health results of IPV on HIV positive females	• Severe depression • Trauma • Treatment disruptions
Explaining IPV and risk factors for HIV among Georgian society	• Lack of education • Deeply rooted double standard traditionalism in gender roles • Societal pressure

Table 6.1. Categories and sub-categories formed from data analysis

7.1. Risk factors of HIV transmission

Fifteen participants out of twenty disclosed being infected by their current or ex-husbands or intimate partners. This indicates that Georgian women who have experience of IPV may be at particularly high risk for acquiring HIV without having multiple sexual partners. Data collected during the group meetings suggested three main subcategories of risk factors for acquiring HIV for Georgian females.

7.1.1. Inability to negotiate condom use

The usage of condoms in general in Georgian society, and especially in a marital setting, is very stigmatized as are pre-marital intimate relationships. As a result, Georgian women often engage in first sexual intercourse with their husbands, a context wherein they are less likely to use protection as condoms (30).

The data collected during the FGDs of this study suggested similar findings, with participants mentioning struggling to negotiate with husbands on condom use. Seven out of twenty participants expressed being unable to use condoms with their partners, explaining that their partners held negative opinions on protection, as illustrated by one participant below:

"When I told my boyfriend that I wanted him to wear a condom he said that he would break up with me, because he cannot always have sex with me while wearing condom, it does not give him enough pleasure." (Part. 3.2, 26 years old)

A few participants disclosed experiences when partners used psychological pressure in response to their efforts to negotiate condom use. Very often the partners seemed to argue that they would not use condoms because it would prevent them from potentially having a child with the women:

"He told me if we have to use protection while having sex he cannot have children with me, so he must have a child with another woman, make her pregnant and then come back to me." (Part. 2.1, 34 years old)

7.1.2. Male partners consciously hiding their HIV status

In order to prevent the spread of HIV it is important that intimate partners communicate about one of them being HIV positive. By doing so, the HIV positive partner might prevent the infection spread to the healthy partner by taking extra cautions in the intimate relationship.

During the FGDs seven females out of twenty shared that their husbands were hiding their HIV positive statuses from them. Some of women said that not only their husband, but also his family hid the information from them:

"My husband hid the fact that he had HIV, so I did not know. However, I do suspect that his family knew his status, because our first child died soon after birth. At that moment, I still did not know about myself being infected. Then I got pregnant for the second time and his parents demanded us to leave the child. Of course, I have refused and took the baby home…" (Part. 1.2, 27 years old)

In most of these cases, the women in the FGDs described struggling with their health for a long time after unknowingly acquiring HIV before eventual diagnosis and starting treatment. The women also mentioned that this put then in dangerous positions for more serious long-term health effects or transmitting the infection to other people, including in utero to their unborn infants. One of the research participants illustrates this, as follows:

"I was hospitalized three times and doctors did not know what was wrong with me. I was losing weight fast, feeling very bad. After the third time, they sent me to the Infectious Disease Centre for the HIV test and it came out positive. After seven years I saw his name [her husband] at the Infectious Disease register and I understood than that he had passed the disease to me. During all that time, he never called me or told me that he was infected…I am still very angry because of it. If he had told me I could have been more careful and maybe not have the HIV today. I am also angry because without knowing I could have transmitted the disease to others as well." (Part. 3.2, 26 years old)

Some participants admitted that they had learned that they were not the only ones who were infected by the same man while not knowing about his HIV status:

"My husband had a first wife before he remarried me. I have never known why they got divorced, but now I believe it was because of HIV, since the same think happened to me... When we got married I did not know about his status. I have a very strong feeling that he already

knew he was sick for a long time, and transmitted the disease both to his ex and to me since, as fas as I know, his ex-wife has serious health issues. When I confronted him with this, he said that I am imagining things. If I had not found out about my disease he probably would have never told me. " (Part. 1.1, 32 years old)

7.1.3. Transmissions caused by sexual violence

Sexual violence occurs in every country and culture worldwide. Rape relates to higher rates of HIV transmission not only because this type of intercource is usually unprotected, but also because during the forced penatration cuts and abrasions usually occur, thus leaving an entry for the HIV virus to get into the victim‘s bloodstream (31).

In Georgia, as well as the wider Caucasian region, an archaic tradition of bride kidnapping and forced marriage is still prevalent in some regions. The kidnapped woman is usually abducted and kept in captivity for a few days while the kidnapper, together with his family members, tries to win her over for marriage. Kidnappings as such are often associated with forced sex, after which women cannot rely on even her own families for support since they are automatically subjected to stigma and disgrace, so intense that families prefer for them to get married to a kidnapper to protect the family honour. (Sisvadze N., 2020) One of the women participating in this study shared her friend’s story of being infected with HIV during bride kidnapping:

“My close friend was kidnapped by a boy who wanted to marry her and had HIV infection. He raped her and transmitted the disease. She was kept locked for nine days and nobody knew where she was. After nine days she was found and released. The boy was caught by police and sentence to go to the jail. She later told me later that the rape he told her that now she will have such disease that nobody will marry her. Later she went to the doctor, did the analysis and it had revealed the HIV and hepatitis C.” (Part. 2.4, 22 years old)

It is always hard to estimate the number of HIV transmissions caused by rape, since it is highly stigmatized and sensitive topic, especially in conservative countries like Georgia. At the same time rape occurs not only among strangers, but in marital settings as well, which victims are even more reluctant to disclose. Another participant shared a personal and sensitive story of being infected herself after her husband forced her into unprotected sexual intercourse:

"I knew my husband had HIV before we got married. We tried to use protection while having an intimate relationship, however it happened a couple of times that he forced himself on me while I was sleeping. He basically raped me in my sleep and since he was physically much stronger than me, I could not resist. Later I was crying and asking why he's doing that to me and he told that he wants a child. I didn't get pregnant from those couple of times, but of course I got infected [with HIV]. He died three months after our wedding." (Part. 3.4, 37 years old)

7.2. Emerging forms of IPV after disclosing HIV positive status

Research conducted in other contexts has shown that women can experience increased risks of threats or actual violence after disclosing their HIV positive status to an intimate partner (32).

In this study, 10 women out of 20 described experiences of some type of domestic violence, physical or psychological or both, perpetrated by an intimate partner or occasionally by another member of his family, and experiences which they felt were related to revealing their HIV positive statuses.

7.2.1. Psychological and physical abuse

Psychological violence refers to trauma caused by verbal abuse, threats of abuse, or coercive tactics (33). Four participants in this study opened-up about their past experiences of psychological trauma caused by insults and scolding from their partners. One of them expressed her experience as such:

"After disclosing my HIV positive status, he [participant's ex-husband] started to treat me differently. It started with constant complaints, that I do everything wrong, that now I've become useless. Later he started spreading the information about my HIV status without my consent. He told everyone that I am scary, disgusting and that people should not get in touch with me. I felt ruined." (Part. 1.3, 28 years old)

Two women shared their experiences of being blackmailed or isolated by their husbands or his family members right after the disclosure of HIV positive statuses. Notably these women were the least educated among the other participants in the discussion. The following quote indicates the experience of one of those women:

"Ten years ago, I was infected with HIV by my husband. After I got diagnosed, he and his sisters suddenly started act violently. They were blackmailing me to not to tell anyone about my HIV status. I remember we came back from Moscow, since at that time we were living there, and they locked me down in the apartment, did not let me meet my family and friends. I did not have any money … He never hurt me physically, but the situation was still unbearable. I had to run." (Part. 3.1, 37 years old)

In addition to describing psychological violence, the women in the FGDs reflected on how living with HIV put them in perceived higher risk for suffering from physical violence. Three participants described their experiences of being beaten by their intimate partners after disclosing to them their HIV positive status:

"At the very first beginning when I have disclosed my HIV positive status it was pretty much fine, but after a short while he started physically abuse me. Once there was a fight between us, which began with bad words and sayings that I am disgusting because of my disease [HIV]and so on, he became so mad that he started beating me. The result was my broken nose… I had bruises on almost all parts of my body… And similar things happened more than just once. I understood that he was apparently torturing me." (Part. 3.3, 41 years old)

A similar experience was shared by another participant during the next FGD:

"My husband became violent [after the disclosure of HIV positive status]. After one of his violent episodes I ended up sitting in a wheelchair. The injuries were so severe that I could not walk for a month or more. Good thing that my family helped me at that time in regards to medication, since I was not able to walk to the centre … and they took care of my child." (Part. 4.3, 35 years old)

7.2.2. Pressure against antiretroviral medicine taking

As the discussions progressed, the researcher noticed a phenomenon emerging in the participants' descriptions of their experiences: HIV positive male partners were controlling or trying to control their female partners' HIV medications. Eight out of twenty participants shared similar experiences of their partner voluntarily declining antiretroviral therapy and forcing them to do the same. There were no specific questions regarding this phenomenon in the original discussion guide for the study, however, the researcher soon noticed many women

describing similar situations in the past. The following participant expressed that this type of partner behaviour is a result of ignorance:

"My husband was very ignorant. He did not care what would happen with my health or our child's health. He was not taking his medication and forced me to do the same. I was not taking my pills for a long time and eventually my condition got worse and worse. Finally, he himself became very sick. He got meningitis. His condition got worse and he died. After his death I renewed my medication taking. Probably if he had lived longer, I would be dead by now." (Part. 4.3, 31 years old)

Two other participants similarly explained controlling behaviours being a result of their partner's depression and substance abuse, such as alcohol use:

"My husband used to drink when he got upset about something and when drunk he was aggressive towards me. Well, not physically, but more like harassing or threatening to me… And the more time went by he got more and more selfish. He refused to be treated even though he understood that he will die and he forced me not to take treatment too so I could die with him. He even once told me that. At the end he felt bad, constantly. I tried to change his mind about the medication, but then he would just shout at me saying that medicine would not help him and only alcohol makes him feel better so I should just shut up." (Part. 1.5, 33 years old)

"When my husband learned about my HIV status became very aggressive, even though he was the one who transmitted the disease to me. He was not taking his medicine and forced me to do the same. He also started to drink alcohol, heavily… Maybe he was blaming himself and angry at me at the same time, I honestly do not know. But one day I told him, that it is up to him if he does not want to be treated. I want to live and to get help. So, I just left and got divorced from him." (Part. 3.4, 26 years old)

7.2.3. Conflicts with partner's family members

While discussing the various types of intimate partner violence that HIV positive women in Georgia are experiencing, four, and notably younger, participants in this study shared experiences of psychological violence and humiliation coming from their husband's family members. Most of these cases involved passive aggression which afterwards resulted in humiliation and depression. An example of such was shared by one of the participants:

"There was a situation, when me and my husband were having a first sleepover at his mother's house. My in-laws knew about my HIV positive status. After that night my husband's mother was looking in the trash and later asking if he was wearing a condom while having sexual contact with me… Also, I found that all of my dishes were placed separately and she was getting ready to boil them… I felt so humiliated… Afterwards I shut down and did not visit his family for a few years." (Part. 1.3, 24 years old)

One participant revealed discrimination being directed to both her and her child. She described it as such:

"My mother-in-law came to visit me while I was still in the hospital after the childbirth. She took the child into her arms and I saw how she was not holding him close, since the child had HIV. She was looking at the child with some kind of disgust. Still, I was hoping this would pass. However, when we were let out from the hospital and came back home, my husband's family locked me in one room with the child and simply left us isolated. I was not supposed to go out if it was not necessary. They would bring me some food so that I would eat alone… In the end I managed to save some money and ran away. I could not take the situation anymore. That happened about six years ago" (Part. 2.5, 31 years old)

7.3. Health effects of IPV on HIV positive females

IPV is associated with numerous adverse physical and mental health effects and outcomes, such as depression, post-traumatic stress, injuries, unintended pregnancy and others. HIV positive women suffering from IPV face higher health risks due to their vulnerabilities such as the necessity of regular medicine taking, coming to terms with managing a chronic lifetime condition and often financial dependency, since in many countries HIV positive individuals are excluded from their workplaces because of stigma. The women in this research described four main groups of health concerns caused by IPV.

7.3.1. Severe depression

Almost all the women in this study who shared experiences of IPV also described suffering from different forms of depression as a result of the IPV. Some of them expressed suffering

from difficult and serious depressive symptoms; for instance, as captured in the following quote:

"Sometimes after the conflicts with my husband I used to not be able to get out from bed for days. In my head was only one idea - if I am so useless and so bad, why I should I even get up? I did not care about how I looked, I did not want to eat, just to sleep all day. My husband was even angrier at me during those episodes since I was not taking care of our home at all. But I did not care that he was angry anymore, I did not care about anything at all." (Part. 1.1, 32 years old)

Others mentioned re-experiencing traumatic situations even after they broke-up with their husbands, and they were not able to move on without seeking professional help to fight against depression. One participant spoke about it as such:

"Even after I managed to get away from him [husband] I still felt miserable. I thought soon everything will go back to how it was before, but it did not. The spread of gossip about our break-up did not help ether. Little by little, I found myself being afraid to go out, speaking with people and, finally, thinking that there was no purpose in life anymore. It was like I was still hearing my husband's voice inside my head saying that I am nothing and do not deserve to live anymore. My family noticed that and started to push me to go see the specialist, if not for me, for the children at least. So, I did that, for them. I started to see a psychologist, talked with some people here in the centre, and somehow gained my motivation back to move on and take care of myself and my babies once more." (Part. 3.4, 26 years old)

Finally, the women in this study living with both HIV and IPV spoke about a vulnerability to depression that they felt many of them faced. For the women who had been infected with HIV by their husbands, the infection is also a constant reminder of the violence she had suffered. The women described how living with an uncurable viral infection as an inheritance of the past makes it difficult to find a peace with it and move on. Such thoughts were expressed by some of the females participating in the study as illustrated in the quote below:

"I believe for a woman who has HIV, the negative results of violence at home are even more severe. She is already very depressed about her disease and often blaming herself about it, so additional violence makes her even more vulnerable. The feeling of uselessness and guilt may lead to isolation, depression, or she even may become suicidal, as, at the beginning, this was how I felt." (Part. 4.3, 31 years old)

7.3.2. Trauma

Trauma may develop after long lasting disturbing events, such as physical, psychological or sexual abuse caused by a previously trusted person such as an intimate partner. Trauma is often a consequence of IPV or violence in general. Each persons' reaction to trauma is different, but some typical symptoms are isolation, shame and blaming oneself, panic attacks, fear and feelings of helplessness (34). Some of the FGD participants shared experiences of suffering from such symptoms of post-traumatic stress caused by the violence they had previously suffered at home. One participant expressed her mental state after abuse caused by her husband's family members:

"*The way my husband's family was treating me was so upsetting and has caused me some seriously bad effects for a much longer time after all of it was over. I was not able to speak with anyone for about 5 years, only just answering questions like a robot. Yes or no, that was all. It was a very hard time. I thought I could not trust anyone, also that no one would help me if I would tell them my story that I was kept locked in a room … I thought that everyone would just laugh at me and tell me that since I have HIV what should I expect, it is my own fault. There was no emotional or financial support from my husband either. I even tried to take my own life two times." (Part. 1.5, 33 years old)*

Other participants shared having long-time trust issues in their current relationships after suffering from traumatic events in the past. There is a deep-rooted stigma concerning HIV infected people in Georgia, which causes social isolation, unemployment, gossip and other negative consequences for HIV positive people. As a result, disclosing one's HIV status is a highly sensitive matter. During the FGDs a few participants shared their difficulties in trusting people after their ex-partners had spread information about their HIV statuses to others without their consent. One of the participants named it as such:

"He [partner] then started to tell everyone that I have HIV. In our school, at his work, soon his whole family and friends knew … The information was spreading so fast that at one point I thought that half the town knows. Gossip arose about how I got infected, if I was doing drugs, or slept with an infected person … The saddest thing is that, at that point, I was not ready to disclose my status to my family. I was planning to prepare them, educate them a bit and then tell, but they got to know it in the most disgusting way. Eventually, I was forced to leave my

hometown and come here, to Tbilisi, because it was unbearable … Now, it seems that all went back to normal with my family and friends, but even after four years I feel I cannot trust other people. I think the past has traumatized me and I cannot build up an honest relationship anymore. Every time, I fear the story will repeat itself and there will no longer be a place to run." (Part. 4.3, 23 years old)

7.3.3. Treatment disruptions

Treatment disruption is a very serious and common result of IPV among HIV infected people. Treatment disruptions emerge not only when a violent partner forbids taking medication, but also due to other IPV-related reasons such us woman suffering from violence-caused depression or not having the autonomy or means to attend regular medical check-ups due to physical injuries or the partner's controlling behaviour.

Depression-driven treatment disruptions were the most often described negative consequence of IPV shared by women at FGDs. Six females spoke about purposely not taking medicine after conflicts with a husband or partner at home. Some of them, such as the participant quoted below, were still working with staff at the HIV and AIDS Patient Support Centre to cope with this issue at the time of the FGDs:

"Sometimes I have depressive moods where I do not want to take medicine … I realize that I do harm to myself, but I just cannot help it." (Part. 1.3, 24 years old)

Apart from psychologically driven treatment disruptions like the above, two participants opened up about inability to receive medicine due to severe physical injuries. One of them shared this memory:

"There were periods when I was not able to take medicine. Usually after he was beating me very badly. Once I remember that my pills were finished and I was not able to go to take some more since my condition was tragic. My whole body was hurting, I had a black eye, and in that time the shame of going outside like that was bigger than the need to take medicine. I was crying, because it made me feel so powerless, but he did not care about my tears at all. Another time, a similar situation happened and I was almost begging him to go to the infectious disease centre and get the pills for me, but that made him even angrier ... After that time I believe I did not take medicine for a couple of months." (Part. 4.3, 35 years old)

7.4. Explaining IPV and risk factors for HIV among Georgian society

At the end of the FGDs, the participants were asked to consider their own experiences and share their insights on the main reasons for IPV in intimate relationships where both or at least one of the partners has HIV in Georgia. Participants' explanations for the existence of and risk factors for IPV in Georgia fell broadly into three topics: lack of education on HIV and general reproductive health in Georgian society, deeply rooted patriarchal traditions and unequal gender norms, and societal pressure of not disclosing family matters and violence in public. The findings help to clarify why many HIV positive Georgian women seem unwilling or unable to seek help after suffering from violence at home.

7.4.1. Lack of education

Nine out of twenty participants named lack of HIV-related education as the main reason for IPV, and social stigma towards HIV positive individuals. The participants emphasized that people are afraid of the things they do not know. They felt that a large proportion of Georgian society lacks general knowledge about HIV or are being misinformed about it. There are still deeply rooted but inaccurate beliefs circulating in Georgia regarding how HIV is being transmitted and what is the course of disease. Four participants believed that misinformation is one of the reasons why HIV positive women suffer from violence in both close relationships and general environments:

"I think the main problem here is that if one does not have HIV infection, he or she usually does not know anything about it in our country. People are aggressive towards things they do not understand and believe them to be harmful. What people mostly know in Georgia about HIV are the old stories like Freddie Mercury who was a drug addict, slept with a lot of people and died in agony. Some still do not know that HIV and AIDS are not the same thing. In the end, it is hard to convince a person not to be afraid of HIV infected people since it is hard to stop believing in mainstream misinformation. So, I think these misunderstandings are even causing violence in the family, or family breakups." (Part. 1.3, 24 years old)

A few participants shared some examples of personally facing consequences of HIV-related myths flourishing among society. One participant shared receiving misinformation from medical professionals, which shows the gravity of the given issue:

"I could not believe my own ears when I heard that a medical doctor, a highly educated person, said there is a slight chance of getting HIV after sitting on the chair where previously a HIV infected patient was sitting. I was a medical student then as well and I was in shock after this…Sure it was ten years ago, but still how was that possible? And how to not believe a doctor?!" (Part. 3.5, 39 years old)

Another participant shared a story about her attempt to discuss HIV with her colleagues without disclosing her positive status first:

"I just casually asked my colleagues what would be their reaction if one of their friends or even their significant other disclosed being infected with HIV. They told me such awful things, such as if that person was a woman she probably would be a prostitute, and they would not feel comfortable to be with a HIV infected person in the same room, or even worse to use the same dishes with them … Men were even worse. When I asked them what they would do if suddenly their wives were to get infected they started to tell how they would throw them out of the home and other terrible things would they do … What all of them did not know is that they were speaking with a HIV positive person." (Part. 4.2, 43 years old)

Finally, most of participants agreed that the situation in Georgia will probably change with upcoming and better educated generations:

"The situation concerning women and HIV is already slowly getting better in Georgia. Our children know more than we used to when we were at the same age and they are becoming more and more tolerant. I think the situation will eventually change but only with a change in generations. There are some attempts to educate the general Georgian society but people simply do not pay attention to information given to them unless they or their family members are infected." (Part. 4.3, 31 years old)

7.4.2. Deeply rooted double standard traditionalism in gender roles

In the entire Caucasus region, the characteristics of a patriarchal family model are still very present. To the present day, this model contributes to unequal gender standards and power relations between men and women. Twelve out of twenty FGD participants named the inequalities rising from traditional gender norms as their main explanation for why HIV

positive women are suffering from violence at home. Many participants felt that IPV is strongly connected with which partner, male or female, is first to disclose the HIV positive status:

"If the husband is first to know and reveals his status to his wife, in this case, the situation mostly continues as normal. There are no bad reactions from society. Like in my case everyone in both of our families know that I got infected by my husband, so everyone treats me with respect. But, on the other hand, if the wife is the first to reveal she has HIV then everything is different. Firstly, most of the men here in Georgia would think that she was unfaithful and slept with someone else. And if the wife is pregnant it is even more difficult. The average Georgian man would think that the child is not his and society would accept his thinking. "(Part. 4.2, 43 years old)

Other participant spoke about unequal gender norms that are widely accepted in Georgian society and how these create risks for women living with HIV:

"We have very strong double standards here in Georgia. Since I am infected and my husband is not, I am getting a lot of questions, such as has my husband ever thought that I have slept with someone else? Or just claims that I should feel very lucky that my husband has not left me and we continue to be a family. Here in Caucasus it is like that – a man can drink alcohol, can sleep with another woman, can beat his wife, in short he can allow himself to do whatever he wants. But women, God forbid, no. They must be shy, always faithful and obey to their husbands. If a woman here would suddenly start to act in a similar way as men, the society would eat her alive. The truth is, I was in a good position since everyone, including my husband knew that I got HIV during a blood transfusion performed in a hospital, but if that was not the reason, I am not sure how my husband would react." (Part. 2.5, 31 years old)

Finally, the following quotation summed up the discussion of gender norms and HIV in Georgian society:

"Here in Georgia a woman needs to be and act appropriate. If she has HIV this means she is not appropriate. In addition to that, of course, goes the fear. It is said that with proper medicine taking there is a very small possibility to transmit the disease, but it does not matter how small the chance is, it is still there. That is it, there is no reason to speak more on this matter. If a woman has HIV no one will bother to ask any further questions, such as how she got infected, if she is taking the medicine or if she is not… The disease is a final and absolute decision, like in court" (Part. 4.2, 43 years old)

7.4.3. Societal pressure

Based on opinions and perceptions of women participating at the FGDs, societal pressure of divorce condemnation and for keeping family matters private are two of the main reasons why Georgian women keep living in violent environment and rarely seek formal help. While public opinion towards divorce has changed drastically in Western Europe during the past couple of decades, it is only now starting to make a shift in Georgia. The participants felt that especially outside of Tbilisi, in smaller towns or regions, getting a divorce is still considered to be disgraceful and, in order to avoid this shame, a lot of women choose to continue living with an abusive partner:

"The mentality of people living in Georgian villages is still a bit old. They continue living under the norms of men controlling everything in the family and women accepting it. Otherwise, if you are a female and divorced, it is a big shame. There it is still very important what the neighbours and other people in the town say. That's why women there [in smaller towns and villages] are more scared to leave their husbands and tend to keep silent about the bad things at home." (Part. 3.4, 26 years old)

The participants in the FGDs also perceived that family members have a big influence on women's decisions to divorce an abusive partner. A few women found it hard to make such a critical decision without the support of people close to them, such as family members. The story of one participant illustrates how family members may push victims to stay with an abusive partner against the woman's own will:

"Eighteen years ago, I came to Tbilisi from one village to study in a medical university. My parents at that time still believed in gossip very much and even though I was living far away the talks of me dating a guy and not getting married had reached them. They started to push me to marry him or to come back home, since soon my reputation would be ruined. Little did they know that this man had HIV and that was the reason I was saying no to his marriage proposals. What I want to say is that even if you are away from your village that does not mean that you are free from your family and the influence of gossip. Think now if I for example got divorced while staying in Tbilisi and kept being here or, even worse, started to see someone else… All the village would call me a prostitute and it would be too much for my parents to

take. As a result, I know, that some woman chose not to speak about violence in order to keep family together." (Part. 3.5, 39 years old)

A lot of participants stated that public discouragement of disclosing family matters according to customs is now mostly accurate in smaller parts of the country, outside the capital. The participants shared what is, in their opinion, changing Tbilisian women's behaviours from being supressed in society to becoming more open and willing to take actions against domestic abuse. However, there were a couple of participants, as the one quoted below, who felt that, even in the capital, some women still live by 'old standards' which interfere with their willingness to seek help:

"Nobody should know about what is happening inside your family, no neighbours or even relatives. You know, here in Georgia, even in Tbilisi, almost everyone knows each other. The population is small, so often we have these situations when someone is another one's relative or friend, or friend of friend, and so on. That is why it is easy for gossip to spread. In addition, it brings big shame if the gossip is about violence in the family, divorce, HIV or any other unpleasant private family matter. People do like gossiping here, very much. I believe that is why we have stigma and fear to make a change." (Part. 4.2, 43 years old)

8. DISCUSSION

The given study sheds light on how IPV and HIV are interconnected and accurate health care issues in the Southern Caucasian Republic of Georgia; both appear to be risk factors and consequences of each another. From previous studies, we know that statistics shows the growing numbers of both IPV and HIV in the country (23, 15, 16, 21) This qualitative study has now provided insight into some of the ways *how* IPV and HIV are connected. The stories and thoughts expressed by study participants also suggest that IPV and its' related stigma are linked to unequal gender roles which are widely accepted by Georgian society. The experiences shared by participants in the study highly correspond with Wingood and DiClemente's expanded theory of gender and power. Participants of the study reflected on how their lower power positions in intimate relationship may result in financial dependency on husband, pressure against protected sexual intercourse and antiviral therapy, lack of family support and other elements which increases their vulnerability for IPV and HIV-related health conditions (25). Studies conducted in other contexts show that various forms of IPV, which always put

women in lower positions in family power relations, serve as risk factors for HIV and at the same time might be result of HIV disclosure (32, 35, 36). This study illustrates similar findings in Georgia, which is a modest but important first step in addressing the lack of academic attention to this topic in Georgia today.

8.1. Increased rates of HIV transmissions

According to UNAIDS, women are in general close to twice more vulnerable for HIV than men (6). These statistics account for all modes of transmission of the HIV virus, including in women's intimate relationships. Condoms are one of the most effective measures to reduce HIV transmission. However, from previous research we know that women facing IPV have less confidence and power in negotiating using them (36). This study shows that males are hiding their HIV positive status from female partners, and women feel unable to negotiate protection use during sexual intercourse. The participants in this study felt these are two acute issues concerning women's vulnerability to HIV in Georgia. In some other contexts, not disclosing one's HIV status to intimate partners before engaging in any sexual activity is considered an illegal activity (37). Nevertheless, there is no data to suggest that Georgia has similar laws. What is more, from Wingood's and DiClemente's advanced theory of gender and power we know that reluctance to use condoms among married couples corresponds to two out of the three societal levels of power division - the sexual division of power and social norms and affective attachments. It is known that in Georgia using condoms among married couples is a rare phenomenon due to customs and limited economic access (38). This research indicates that Georgian women are being infected with HIV without previously knowing that their partners were HIV positive.

8.2. Rape in the context of Georgian law and traditions

One more acute issue in Georgia are shortcomings in the current legal system and public support of archaic traditions that put women in powerless positions when it comes to marital rape and bride kidnapping. Georgia has a rape incidence of 82 per 100 000 people each year (39). It is challenging to estimate the actual numbers of HIV transmissions caused by rape due to under-reporting of cases because of shame and fear of possible discrimination and stigma (40). Still, the HIV positive women who participated in this study felt that HIV can be caused by forced sexual intercourse in marital and bride kidnapping contexts. During the study

discussions, two participants shared relevant experiences - one of being raped by her HIV positive husband and the other of a friend being bride kidnapped and as a result infected with HIV and Hepatitis C. Marital rape remains a violation of women rights worldwide, and one shrouded in stigma and tendency to be hidden as a "family matter". In Georgia rape is an illegal activity and abusers are punished by law, but there are no specific legal protections for married women who are raped by their husbands. As a result, marital rape is often not accepted as a crime in public nor even as a form of domestic violence (41).

8.3. Socially constructed gender norms and limitations

The structure of cathexis explained in the expanded version of theory of gender and power refers to the ways in which social structures dictate the appropriate behaviours of males and females regarding their sexuality. This is very relevant to the given study in Georgia. Women's risks of HIV infection appeared to be highly related to publicly accepted gender roles, norms and limitations. Though some recent studies show a slow shift of gender norm tendencies from a male dominant system to more acceptance of feminism and gender equality among younger generations (30), other studies reveal that double standards are still deeply rooted on certain behaviours, such as drinking alcohol or having premarital sexual intercourse (42, 43). The participants in this study also shared their thoughts on publicly accepted beliefs which permit men to drink alcohol or use drugs or have out-of-marriage sexual relationships, while the same behaviours for women are considered to be taboo. The women in this study also stated that because of such beliefs, society judges HIV positive men and women differently. In their own words of the society expects wives to calmly accept the fact of husband being HIV positive, while on the opposite case it is perceived to be normal for husband to divorce or abuse HIV positive wives.

Furthermore, the theory of gender and power states that unequal gender biases in intimate relationships might be responsible not only for higher HIV prevalence rates, but also further negative health results, such as medication disruptions, complications or mother-to-child HIV transmission in the female population. According to the experiences shared by the participants of this study, it seems that in Georgia one of the major issues of HIV-related violence is the male partner controlling the female's medicine intake. Higher antiretroviral therapy disruptions among HIV positive IPV victims have also been discussed in previously conducted studies in different contexts (36). In Georgia, a study on IPV conducted in 2010 showed 36% of female

participants claimed their husbands controlled their everyday lives from the clothes they should wear, where they could go and with whom they could have contact (44). This study did not stratify of identify any participants by HIV status, nor specifically mention the use of medicine, but it establishes the extent of male controlling behaviour in Georgia, which gives a better understanding of why the HIV positive women in this study were facing the issue of medication control (44).

8.4. Lack of HIV and other STD-related education

Knowledge on HIV may vary from region to region due to socioeconomic and cultural factors. However, STD-related education is crucial for illness prevention practices and stigma reduction (45). A previous study conducted on reproductive health in Georgia showed that less than six per cent of young female participants have talked about contraception, HIV/AIDS and other sexually transmitted diseases (STDs) with their parents at home (46), and a national survey conducted by UNICEF disclosed that even though the most part of youth know condoms are a contraceptive and protective against STDs, more than half of them did not know how to use a condom (46). The majority of participants in this thesis study also expressed concerns about Georgian society lacking knowledge on HIV and about the few measures taken by government and other organizations to change this situation. The phenomenon might partly be explained by the fact that Georgia remains a highly conservative and religious country, where 83.4% of the population identify themselves as Christian Orthodox (47). However, studies in different contexts establish that lack of HIV related education contributes to higher disease prevalence, aggression and discrimination (48).

8.5. Health results

Studies conducted in different settings suggest that HIV positive women experiencing IPV are more likely to experience long antiretroviral therapy disruptions comparing with non-abused women (49, 50). The data collected during the FGDs for this study suggest quite similar findings. The women in this study who experienced either psychological or physical violence mentioned later suffering from tremendous negative health results. Eight out of twenty women in this study reflected on how their previous states of depression made them reluctant to follow

antiretroviral therapy, thus resulting in treatment disruptions which worsened their health states. These findings are alarming as prolonged therapy disruptions can lead to individual health drawbacks, and also put newly born children or HIV negative partners at risk of infection.

8.6. Trustworthiness

The credibility, or in other words the truth value of the study, is the main evaluation component of qualitative research, which describes the reader's confidence in the trustworthiness of the research findings (51). In order to establish trustworthiness, the research student has thoroughly described the study procedures. After each meeting with study participants the student made notes in order to capture the moods and emotional environment of each meeting. The collected data was read multiple times and compared with discussion notes in order to gain a deep understanding of the material. During the analysis the student was constantly consulting with her supervisor and co-supervisor in order to establish categories in the data which best reflected the material and to select meaningful quotes to support them.

To reach the criteria of dependability, during the discussions, the student, who is fluent in Russian, asked the questions herself and communicated with the majority of the participants herself. In a few situations, when the participant was not able to express herself in Russian, there was an interpreter available to assist. The local supervisor is an expert in her field of infectious diseases and has vast experience working at the HIV Patient Support Foundation, which helped to recruit participants in Georgia.

8.7. Ethical considerations

For allowance to perform this study, the ethical clearance was obtained from the Regional Committee for Medical and Health Research Norway (REK - 94905/2020) and from Institutional Review Board of the Infectious Diseases, AIDS and Clinical Immunology Research Centre (OHRP # IRB00006106) in Tbilisi, Georgia using anonymized and de-identifiable data released for this thesis. In order to receive these approvals from both research ethical commissions the research protocol, informed consent and discussion guide were submitted. Before each discussion, all study participants were informed about the topic of the

study, about their right to leave the study at any time without any explanation, and they were encouraged only to share as much information as they wanted in the group environment. Also, they were encouraged to contact a staff member of the support foundation if they would feel a need of any emotional support or debriefing after the end of the research.

Since the topic is highly sensitive, and the recall of painful past experiences has the potential to be distressing, after each FGD, the student - together with the staff working in patient's support foundation – held a debriefing coffee break, during which they discussed observing if participants were leaving the discussions feeling well and if there are any signs of distress caused by the FGDs.

With a sensitive topic like this, it is also important to ensure the personal mental wellbeing of the researcher. The student was constantly aware of her roles as a researcher and a woman and tried to maintain her focus strictly on the scientific analysis without personalizing the findings and being negatively emotionally affected. She was fortunate to be able to debrief regularly with the staff at the patient's support foundation which helped her to maintain her mental well-being after each emotionally heavy FGD.

9. STRENGTHS AND LIMITATIONS

9.1. Strengths

The main strength of this study is that it is a first qualitative research analysing the interconnection of two major issues, IPV and HIV, in Georgia. In general, scientific information on both of these issues is scarce and primarily quantitative. As a result, this study begins a process of raising awareness for public health professionals about the IPV experiences their result on health and other social issues among HIV positive women living with Georgia. The chosen FGD-based study design helped to reach best possible result with the given time and budget, also provided an emotional support for participants to open-up on the similar experiences and debrief with each other after each FGD during the coffee break. All FGDs were conducted at a HIV Patient Support Foundation, which provided a safe environment for participants. The discussions were conducted in Russian and Georgian languages so the participants were able to express themselves freely in a language they felt comfortable with.

9.2. Limitations

Violence inside the family is considered a taboo in Georgia. As a result, it might be that some women felt inhibited to share their personal stories in detail and may have agreed with more influential and active discussion participants. Nevertheless, the majority of the participants were very open and enthusiastic to share their experiences when it comes to violence or stigma connected with their HIV positive status. It is possible that individual interviews would have been a better design to explore the women experiences deeper than during the FGDs, however, that would have been more time and resource consuming and at the same time harder for participants to overcome their inhibitions to speak face to face with a researcher. Another limitation is that there were no male participants included in the study in order to provide their own perspectives and attitudes on HIV positive women and IPV. However, the research was designed to explore the IPV experiences of HIV positive women. Nevertheless, this is a small study conducted in the capital city of Georgia, thus the experiences of women living in rural settings remains unstudied. The study indicates that there are strong differences in attitudes towards women between urban and rural areas of Georgia, which makes rural-based studies critical for improving the clinical outcomes and sexual health for women living in remote parts of the country.

9.3. Directions for future research

The study was conducted in Tbilisi, the capital of Georgia, a setting chosen due to its highest prevalence rates of both HIV and IPV in the country. However, the discussions with study participants suggest that major differences may exist between Georgian regions and main cities when it comes to gender roles and their implications. Due to deeply rooted customs to hide family matters in private it is also highly possible that the real prevalence of HIV and IPV is much higher than presented in official statistics. As a result, future research on HIV and IPV conducted in Georgian regions is needed in order to properly study the situation in the whole country setting.

10. CONCLUSIONS

Both HIV and IPV are major global health issues of our modern times. The recent concerns about their interconnectivity has stimulated a growing amount of academic studies worldwide. However, the South Caucasus region has not received adequate scientific attention to date. This study illustrates that Georgian women are facing a double burden of HIV being a risk factor for and a result of IPV. The current legal system in the country does not protect women from marital rape which may correspond with increasing HIV prevalence rates in Georgia. At the same time, unequal gender norms, which to this day favour men and maintain stigma and taboo around 'family issues' such as domestic violence such that women face significant barriers when seeking help and trying to change the status quo. HIV and other STD education is also lacking in Georgian society. Education is crucial for STD prevention and reducing stigma about HIV and individuals living with HIV. However, in order to fully evaluate the situations of women living with IPV and HIV in the country, further research is required in rural settings of Georgia and using different study designs.

11. REFERENCES

1. United Nations Population Fund. (2017, September 18). Gender-based violence. Retrieved from: https://www.unfpa.org/gender-based-violence#
2. World Health Organization. (2012) Understanding and addressing violence against women Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf?sequence=1
3. Ott, M. (2017, November 21). Series: What does that mean? Gender-based violence. Retrieved from: https://www.womenforwomen.org/blogs/series-what-does-mean-genderbasedviolence?gclid=CjwKCAiAkrTjBRAoEiwAXpf9Cfz1hTtVBRUobra6kO7E35dHFlrODgHrBIdUnxKbdle0u55vF2wkBoCeAIQAvD_BwE
4. Heise L., Ellsberg M., Gottmoeller M. (2002) A global overview of gender-based violence. International Journal of Gynecology and Obstetrics (78) 5-14. DOI: 10.1016/S0020-7292(02)00038-3
5. World Health Organization. (2019, November 15). HIV/AIDS Key facts. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/hiv-aids
6. UNAIDS. (2018) Women and girls and HIV. Retrieved from: https://www.unaids.org/sites/default/files/media_asset/women_girls_hiv_en.pdf
7. World Health Organization. (2008). HIV/AIDS and mental health. Executive board 124th session provisional agenda item. Retrieved from: https://apps.who.int/gb/archive/pdf_files/EB124/B124_6-en.pdf
8. Li Y., Marshall C. M., Rees H. C., Nunez A., Ezeanolue E., Ehiri J. E. (2014) Intimate partner violence and HIV infection among women: a systematic review and meta-analysis. International Journal on AIDS Society. (13) DOI: 10.7448/IAS.17.1.18845
9. UNAIDS. (2004) The global coalition on women and AIDS. Retrieved from: https://data.unaids.org/gcwa/gcwa_backgrounder_en.pdf
10. Panchanadeswaran S., Sivaram S., Johnson S., Aylur S. (2008) Intimate partner violence is as important as client violence in increasing street-based female sex workers' vulnerability to HIV in India. The International journal on drug policy (19) 106. DOI: 10.1016/j.drugpo.2007.11.013
11. Hale, F. and Vazquez, M.J. (2010) Violence against women living with HIV: A background paper. Development connections, UNIFEM and the international community of women living with HIV/AIDS. Retrieved from: http://salamandertrust.net/wpcontent/uploads/2012/12/VAPositiveWomenBkgrdPaperMarch2011.pdf
12. Maman S., Mbwambo J., Hogan N., Kilonzo G., Campbell J., Weiss E., Sweat M. (2002) HIV positive women report more lifetime partner violence: findings from a voluntary counseling and festing clinic in Dar es Salaam, Tanzania. American Journal of Public Health (92) 1331-1337.
13. Mulrenan C., Colombini M., Howard N., Kikuvi J., Mayhew S. (2015) Exploring risk of experiencing intimate partner violence after HIV infection: a qualitative study among women with HIV attending postnatal services in Swaziland. BMJ Open (5) DOI: 10.1136/bmjopen-2014-006907
14. Murray, L. K., Haworth, M. D., Semrau, K., Singh, M., Aldrovandi, G. M., Sinkala, M., Thea, D. M. & Bolton, P. (2006) Violence and abuse among HIV-infected women and their children in Zambia: A qualitative study. The Journal of Nervous and Mental Disease, 194(8), 610-615. DOI: 0.1097/01.nmd.0000230662.01953.bc

15. Khatchvani T. (2015) The impact of gender-related stereotypes on intimate partner violence in the South Caucasus comparative study of Azerbaijan, Georgia and Armenia (Master Thesis in Criminology) Malmo University. Malmo, Sweden

16. Mandl S., 2011 Women in Georgia. Peace, security and democracy from a women's rights perspective. Ludwig Boltzmann Institute of Human Rights. Retrieved from: https://bim.lbg.ac.at/files/sites/bim/Women%20in%20Georgia_Peace_Security_Democracy_0.pdf

17. United Nations Entity for Gender Equality and the Empowerment of Women (2015) Violence against women and domestic violence in Georgia. ISBN – 978-9941-0-8244-3. Retrieved from: http://www2.unwomen.org//media/field%20office%20georgia/attachments/publications/2015/english1.pdf?la=en&vs=4528

18. Dolidze N. (2014, December 24) Georgian women's movement to stop violence against women. Retrieved from: https://www.democracyspeaks.org/blog/georgian-women%E2%80%99s-movement-stop-violence-against-women

19. United Nations. (2018-2019) UN women annual report. Retrieved from: https://www2.unwomen.org/-/media/annual%20report/attachments/sections/library/2019/un-women-annual-report-2018-2019-en.pdf?vs=4621

20. World Health Organization. (2017) Georgia. Profile of health and well-being. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0020/351731/20170818-Georgia-Profile-of-Health_EN.pdf?ua=1

21. Kakhurashvili, I. (2018, April 3). HIV in Georgia: Is there any stigma. Retrieved from: http://www.afew.org/eecaaids2018/hiv-stigma-georgia-eng/

22. World Health Organization. (2014) HIV/AIDS treatment and care in Georgia. Evaluation report. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0003/269445/HIV_AIDS-treatment-and-care-inGeorgia.pdf

23. Waltermaurer E., Butsashvili M., Avaliani N., Samuels S., McNutt L. (2013). An examination of domestic partner violence and its justification in the Republic of Georgia. BMC Women's Health (13) DOI: 10.1186/1472-6874-13-44

24. Connell, R. (1987) Gender and Power. USA: Stanford University Press.

25. DiClemente R., Crosby R., Kegler M., (2002) Emerging Theories in Health Promotion Practice and Research. (1st ed.) USA: John Wiley & Sons, Inc.

26. Tbilisi Municipality City Hall (2018) Tbilisi in figures 2018. Retrieved from: http://tbilisi.gov.ge/img/original/2018/6/12/tbilisiinfigures.pdf

27. Agenda.de (2014, July 23). In numbers: domestic violence in Georgia. Retrieved from: http://agenda.ge/en/news/2014/1782

28. Ellsberg M., Heise L. for World Health Organization. (2005) Researching violence against women: a practical guide for researchers and activists. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/42966/9241546476_eng.pdf?sequence=1

29. Graneheim U., Lundman B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Education Today (24) 105-112. DOI: 10.1016/j.nedt.2003.10.001

30. Abzianidze T., Butsashvili M., Kajaia M., DeHovitz J., Kamkamidze G. (2019) Generational differences in current sexual behavior among Georgian reproductive-aged women. International Journal of Womens Health (11) 301-308. DOI: 10.2147/IJWH.S197473

31. World Health Organization. (2019, November 15). HIV/AIDS Key facts. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/hiv-aids

32. Campbell J. C., Baty M. L., Ghandour R. M., Stockman J. K., Francisco L., Wagman J. (2008) The intersection of intimate partner violence against women and HIV/AIDS: a review.
33. International Journal of Injury Control and Safety Promotion. 15(4) 221-231. DOI: 10.1080/17457300802423224
34. National Coalition Against Domestic Violence (NCADV) (2015) Facts about domestic violence and psychological abuse. Retrieved from: https://assets.speakcdn.com/assets/2497/domestic_violence_and_psychological_abuse_ncadv.pdf
35. Substance Abuse and Mental Health Services Administration (2014) Trauma-informed care in behavioral health services. Chapter 3. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK207191/
36. Patrikar S., Basannar D., Bhatti V., Chatterjee K., Mahen A. (2017) Association between intimate partner violence & HIV/AIDS: Exploring the pathways in Indian context. Indian Journal of Medical Research 145(6) 815-823. DOI: 10.4103/ijmr.IJMR_1782_14
37. Siemieniuk R., Krentz H., Gill M. J. (2013) Intimate partner violence and HIV: A review. Current HIV/AIDS Reports 10(4) DOI: 10.1007/s11904-013-0173-9
38. Centers for Disease Control and Prevention (2020, May 15) HIV Risk Reduction Tool. Retrieved from: https://wwwn.cdc.gov/hivrisk/decreased_risk/communication/disclosure.html
39. Hudgins T., Rao R. (2004) Republic of Georgia contraceptive availability assessment: Final Report. Retrieved from: https://www.rhsupplies.org/uploads/tx_rhscpublications/DOC42.pdf
40. World Population Review (2020). Rape statistics by country. Retrieved from: https://worldpopulationreview.com/countries/rape-statistics-by-country/
41. Meel B. (2005) Incidence of HIV infection at the time of incident reporting, in victims of sexual assault, between 2000 and 2004, in Transkei, Eastern Cape, South Africa. African Health Sciences 5(3) 207-212.
42. Japaridze S., Chitanava K., Aladashvili I., Duarte M. (2006) Violence against women in Georgia. Retrieved from: https://www.omct.org/files/2005/09/3072/cedaw36_vaw_in_georgia_en.pdf
43. Food and Agriculture Oganiziation of the United Nations (2018) Gender, agriculture and rural development in Georgia – country gender assessment series. Retrieved from: http://www.fao.org/3/ca0577en/CA0577EN.pdf
44. Ziemer U. (2020) Women's Everyday lives in War and Peace in The South Caucasus. (1st. ed)
45. Barkaia M., Waterston A. (2017) Gender in Georgia. Feminist Perspectives on Culture, Nation and History in the South Caucasus. USA: Berghahn Books
46. Hong S. Y., Thompson D., Wanke Ch., Omosa G., Jordan M., Tang A. M., Patta S., Mwero B., Mjomba I., Mwamburi M. (2012) Knowledge of HIV transmission and associated factors among HIV-positive and HIV-negative patients in Rural Kenya. Journal of AIDS and Clinical Research. 3(7). DOI: 10.4172/2155-6113.1000170
47. United Nations Population Fund. (2018, June 21). Breaking taboos around sexual and reproductive health in rural Georgia. Retrieved from: https://www.unfpa.org/news/breaking-taboos-around-sexual-and-reproductive-health-rural-georgia
48. Central Intelligence Agency (2020, May 21) The world fact book. Georgia. Retrieved from: https://www.cia.gov/library/publications/the-world-factbook/geos/gg.html
49. Cherutich P., Kaiser R., Galbraith J., Williamson J., Shiraishi R. W., Ngare C., Mermin J., Marum E., Bunnell R. (2019) Lack of knowledge of HIV status a major barrier to

HIV prevention, care and treatment efforts in Kenya: Results from a nationally representative study. PLOS One. 7(5). DOI: 10.1371/journal.pone.0036797

50. Fiorentino M., Sagaon-Teyssier L., Ndiaye K., Suzan-Monti M., Mengue M., Vidal L., Kuaban Ch., March L., Laurent Ch., Spire B., Boyer B. (2019) Intimate partner violence against HIV-positive Cameroonian women: Prevalence, associated factors and relationship with antiretroviral therapy discontinuity—results from the ANRS-12288 EVOLCam survey. Womens Health (London). DOI: 10.1177/1745506519848546

51. Kosia A., Kakoko D., Semakafu A., Nyamhanga T., Frumence G. (2016) Intimate partner violence and challenges facing women living with HIV/AIDS in accessing antiretroviral treatment at Singida Regional Hospital, central Tanzania. Special Issue: Gender and Health Inequality - intersections with other relevant axes of oppression. Retrieved from: https://www.tandfonline.com/doi/full/10.3402/gha.v9.32307%40zgha20.2016.9.issue-s4

52. Korstjens I., Moser A. (2018) Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. European Journal of General Practice (24) 120-124. DOI: 10.1080/13814788.2017.1375092

53. Marum E., Bunnell R. (2012) Lack of Knowledge of HIV Status a Major Barrier to HIV Prevention, Care and Treatment Efforts in Kenya: Results from a Nationally Representative Study. PLOs One 7(5) DOI: 10.1371/journal.pone.0036797

54. Shapatava E., Nelson K. E., Tsertsvadze T., Rio C., (2006) Risk behaviors and HIV, Hepatitis B, and Hepatitis C seroprevalence among injection drug users in Georgia. Drug Alcohol Depend. (82) 35-38. DOI: 10.1016/s0376-8716(06)80006-2

55. Trapero-Bertran M., Olivia-Moreno J. (2014) Economic impact of HIV/AIDS: a systematic review in five European countries. Health Economic Review. (4) DOI: 10.1186/s13561-014-0015-5

56. Hale, F. and Vazquez, M.J. (2010) Violence against women living with HIV: A background paper. Development connections, UNIFEM and the International Community of Women living with HIV/AIDS. Retrieved from: http://salamandertrust.net/wpcontent/uploads/2012/12/VAPositiveWomenBkgrdPaperMarch2011.pdf

57. Sisvadze N. (2017, August 4). Georgia's invisible brides. Retrieved from: https://www.tol.org/client/article/27101-georgias-invisible-brides.html

12. APPENDIX

12.1 Appendix 1: Informed verbal consent for study participants

Are you interested in taking part in the research project?

‘’HIV and intimate partner violence; a qualitative study from South Caucasus, Georgia’’

Date: _____

Name of Group Interviewed (Group code) _____

Data collection site: _____

Time of discussion: _____ to_____

No. of individuals participated: _____

Name(s) of Facilitator(s): _____

This is an inquiry about participation in a research project where the main purpose is to investigate the experiences of Georgian HIV patients when it comes to various kinds of IPV.

The connection between IPV and HIV/AIDS is indisputable. IPV may function as both a risk factor for intersection - reasoning direct transmission through sexual violence or inability to negotiate for male using condom, and a consequence of being HIV positive.

Both issues of HIV and IPV are acute in Georgia. For 8 years (2008-2017) percentage of women suffering from IPV is not showing significant decline, while prevalence of HIV is rising each year. However, there is no research conducted in South Caucasus that would investigate the connection between two issues and how one is resulting another.

Purpose of the project

To understand the connection between IPV and HIV in given area of Tbilisi, Georgia and contribute on filling knowledge gap by becoming a pioneer for qualitative academic studies on given issues in South Caucasus region.

You will participate on a focus group discussion led by Laurita Petrulyte, a Global Health student at NTNU, Trondheim, Norway and (names of personnel). You have been asked to participate in

a discussion because your experiences and opinion is relevant for our study. This focus group is designed to assess your current and past experiences on living with HIV and experiencing various forms of violence caused by your intimate partner. The discussion will take around an hour.

Confidentiality

With your permission discussion will be audio recorded to facilitate recollection purposes. However, we can assure that discussion will be kept anonymous as each one of participants will be given codes that will be used in all forms instead of using real names. Audio recordings will be safely held secure computer under password protection until being transcribed and destroyed (latest date of destruction June 2020). Transcription notes will not contain any personal information that would allow to identify participants in any way. The main researcher, Laurita Petrulyte, will be the only person who have access to audio recordings. We would like you to share your experiences only as much as you want to and feel comfortable to. If there be any questions that you will not like to answer, please, remember that you are not obliged to do so. You can leave the discussion at any time without any explanation.

Risks and benefits

We do not expect that participation on discussion would harm its participants in any possible way. The only purpose of the discussion is for researchers to learn from participant experiences and include them into a study that might hopefully help for others in the future.

Rules of discussion

• There are no right or wrong answers • You are not obliged to answer to all the questions if you are feeling not comfortable to do so • Participants do not have to speak in any particular order • When you want to tell something or share your experiences please do so, since we value each one of your opinions in the group. • You do not need to agree on other persons' opinions • If you have any other questions, please ask anytime • You may leave the discussion at any time without any explanation

Who is responsible for the research project?

Laurita Petrulyte, a master student in Global Health at the Norwegian University of Science and Technology (NTNU), her supervisor Professor Jon Øyvind Odland (NTNU), co-supervisor Dr. Ketevan Stvilia (National Centre for Disease Control and Public Health, Tbilisi, Georgia)

NTNU and National Centre for Disease Control and Public Health are collaborating institutions responsible for the research project.

Where you can find more information about study?

If you have any questions about the study project you may contact:

Jon Øyvind Odland

Professor in Global Health, MD, PhD Norwegian University of Science and Technology Trondheim, Norway Email: jon.o.odland@ntnu.no

Laurita Petrulyte

Student in M. Sc. Global health Norwegian University of Science and Technology Trondheim, Norway Permanent address: Ramygalos 116-59, Panevezys, Lithuania Email: laurita.petrulyte@gmail.com

Do you agree to take part in this research by participating in anonymous focus group discussion?

Agree ( ) Disagree ( )

I agree that I have read this consent to participant

_____

(Moderator's printed name)

_____

(Moderators's signature)

12.2. Appendix 2: Interview guide

Topic guide for focus group discussions on HIV patients experiences on various types of intimate partner violence before and after diagnosis

Discussion is planned to take around an hour – hour and a half.

Introductory question

I am going to give you a couple of minutes to think about your own experiences when it comes to different forms of intimate partners (boyfriend, husband) violence in your community. Maybe someone would like to share their experience?

How would you describe intimate partner violence?

Probe for:

• What different forms of violence do you know?

• How do you think, are these things that you have mentioned are usual among women with HIV positive?

Causal exercise (around 30 min): (to encourage participants to think about different types of violence women with HIV are experiencing, reasoning behind these acts)

Now, I will give for each of you some cards with situations that real women have experienced (cards with different forms of domestic violence). Moreover, we divided board into two columns – before HIV and after HIV. Please, read your cards, think for a few minutes and place them to one column or another, regarding whether you think these experiences are happening more often before or after gaining HIV positive status. If you think that some situations are happening equally often before and after, please place them on the middle line.

Now, let's discuss what do we have on the board:

Do you think HIV patients are facing more/less violence in their close environment?

Probe for:

o Are these acts the same? What are the differences between them?

What do you think are the reasons behind violence against HIV positives? Why HIV status is causing violence in family/relationship? – Discussion facilitator writes the answers on the board, may group them into broader interconnected groups

Probe for:

o Disclosure

o Alcohol or drug usage

o Possibility to transmit the disease to partner/children

How do you think violence is resulting to health status of HIV patients?

Probe for:

o Disturbance in daily medication taking/ doctor check-ups

o Long healing process/infections

o Mental health conditions

How do you think is it possible for HIV patients in your community to receive help if they are suffering from domestic violence at home?

Probe for:

o Do they feel afraid/encouraged to seek help? Why?

o Are they afraid for anonymity of their status/situation at home?

o Places where they can go to seek help?

o How do you think is there enough places where people can seek for help?

Concluding question

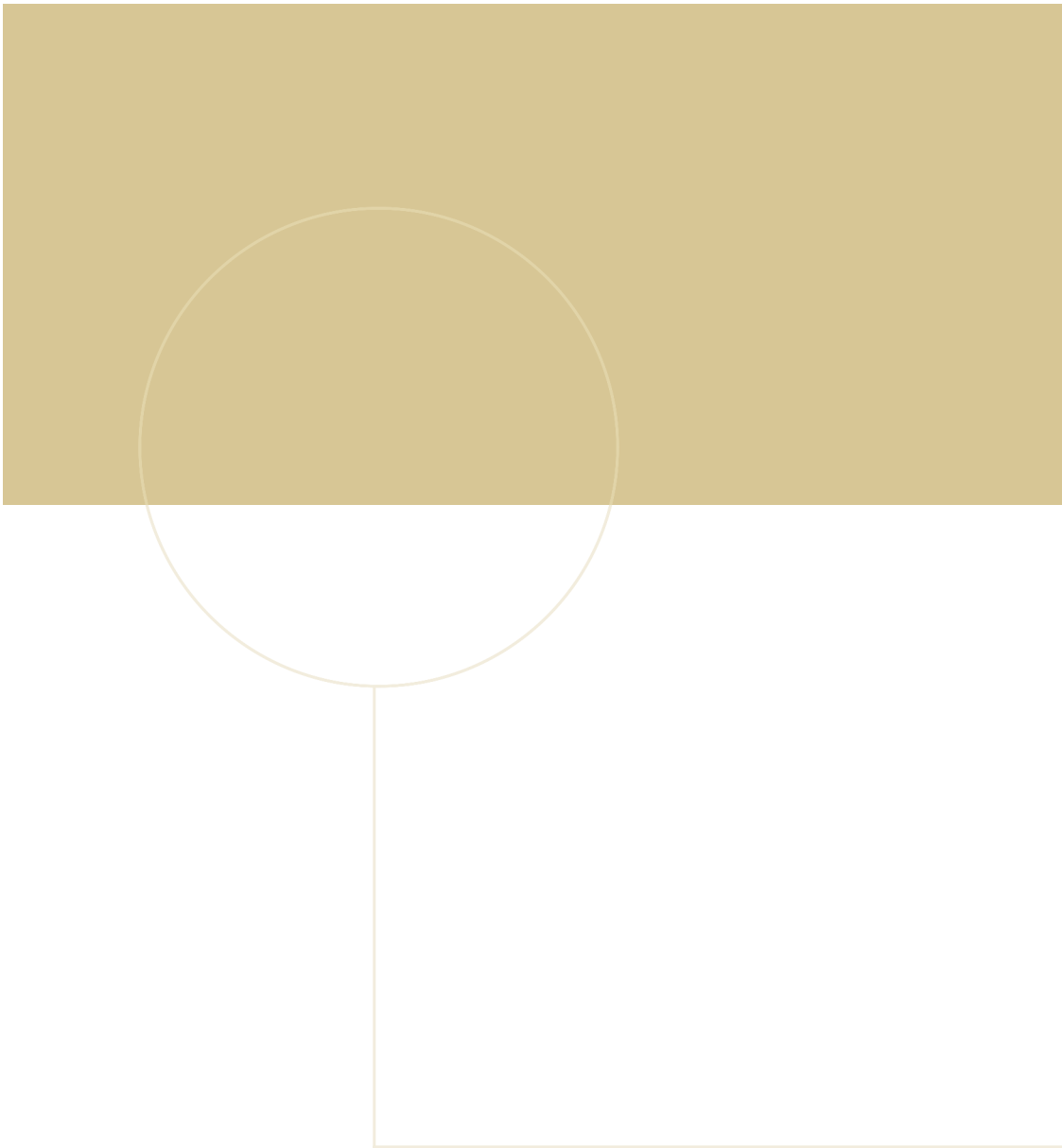
From all the things that we have discussed today, what do you think are the most important issues you would like to express when it comes to domestic violence against HIV patients in your community? Do you have anything to add?

Conclusion

• Thank you so much for participating. It was very valuable for us to hear your thoughts.

• We know that it is not easy to speak on such a sensitive topic, but we hope that you understand that only by sharing your thoughts and experiences you may help for yourself and future women in your community.

• I would like to remind, that if you will have any further questions or comments featuring this research you may reach out to discussion facilitators with contacts provided at your formal consent and that all your comments will be kept anonymous as well.



NTNU

Norwegian University of
Science and Technology