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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN LIVING WITH HIV IN GEORGIA

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ABBREVIATIONS

AIDS- Acquired immunodeficiency syndrome

ART – Antiretroviral therapy/treatment

CCM- Country coordination mechanism

CSE- Comprehensive sexuality education

CSOs- Civil society organizations

EECA- Easter Europe and Central Asia

EWNA- Eurasian Women's Network on AIDS

HIV - Human immunodeficiency virus

HPV- Human papillomavirus

IPV- Intimate partner violence

LEA- Law enforcement agencies

MoE- Ministry of education

MoH- Ministry of health

PeP - Post-exposure prophylaxis

PreP - Pre-exposure prophylaxis

SRHR- Sexual reproductive health and rights

STIs- Sexually transmitted infections

UNDP- United national development program

WHO- World health organization

INTRODUCTION:

SRHR for Women Living with HIV

The sexual and reproductive health and rights (SRHR) of women living with HIV is fundamental to their well-being. Improving women's sexual and reproductive health and rights, prevention, diagnoses and treatment of HIV are important factors in contributing social justice, reducing poverty and promoting the social and economic development of communities and countries. Sexual and reproductive health services are uniquely positioned to address each of these factors. Gender plays an important role in determining a woman's vulnerability to HIV and violence and her ability to access treatment, care and support. The current scope of HIV interventions and policies needs to be expanded to make gender equity a central component in the HIV response. All women have the same rights concerning their reproduction and sexuality, but women living with HIV require additional care and counselling during their sexual and reproductive life cycle. Nowadays people on effective treatment can live as long as anyone else, have children born free of HIV and it's impossible to pass HIV onto sexual partners. These fundamental biomedical advances have all happened since 1995 and are greatly welcomed. Yet they cannot alone solve the complex realities of HIV for women. Even in countries where access to HIV care, treatment and support is generally good, women still experience violations of SRHR, and where women experience intersecting inequalities and violence because of race, age, ethnicity, disability, gender identity, sexual orientation, drug use, sex work, immigration status, socioeconomic status or other factors[1] (Dunaway et al., 2022).

The gender profile of the HIV has changed since it emerged. There were an estimated 17.8 million women aged 15 and older living with HIV in 2015, constituting 51% of all adults living with HIV. Adolescent girls and young women are particularly affected; in 2015 they constituted 60% of young people aged 15–24 years who were living with HIV, and they also accounted for 58% of newly acquired HIV infections among young persons in that age group. In many countries, women living with HIV do not have equitable access to good-quality health services and are also faced with multiple and intersecting forms of stigma and discrimination. Furthermore, women living with HIV are disproportionately vulnerable to violence, including violations of their sexual and reproductive rights[2] (WHO 2017).

In Georgia 2022 October data show a total of 9651 HIV/AIDS cases were registered in the Infectious Diseases, AIDS & Clinical Immunology Research Center (National AIDS Center), including 7206 men and 2445 women. The majority of patients are within the age group of 29-40. Currently the main mode of HIV transmission is through sexual contact (51.4%) with injection drug use being the second most common mode of transmission - 33.7%. Late diagnosis still remains a challenge and the main reason for HIV mortality, more severally affecting women[3]. Traditionally, for almost a decade, HIV prevention programs were focused on people who inject drugs, men having sex with men and people in sex worker. Majority of HIV target groups have been males. However, during the last years the prevalence of HIV infection is increasing among women and therefore, attempts to implement services adapted to their needs, including focus on SRHR, requires prioritization in regional and national agendas. There is limited data on the numbers of women who use drugs in the country, and no data on women in sex work at all when it comes to their HIV positive status, but numbers provided by AIDS Centre statistics state that at the end of 2021 out of all registered women living with HIV 24 were women who inject drugs. In 2018 the percentage of women who use drugs was between 0.19 - 0.59% amongst cases of women living with HIV. HIV prevalence amongst sex workers is 0.1% (National program data, 2021).

The past 30 years have also witnessed remarkable improvements in access to high-quality information and medical services, including services for prevention of mother-to-child transmission (vertical) of the virus. With care and treatment for HIV becoming more accessible, women living with HIV have become healthier, live longer, and make plans for a future that includes parenting. While many programs have focused on preventing mother-to-child transmission, the rights of women living with HIV to fulfil their sexual and reproductive health needs have been greatly overlooked. The area needs to be thoroughly researched and advanced in the national HIV agendas for better contributing the rights to SRH.

[1] https://journals.sagepub.com/doi/pdf/10.1177/17455057221080361
[2] file:///C:/Users/Medea/Downloads/9789241549998-eng%20(1).pdf
[3] https://aidscenter.ge/epidsituation_eng.html

WOMEN-LED RESEARCH "SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) OF WOMEN LIVING WITH HIV"

Implementing partners

The international charitable organization Eurasian Women's Network on AIDS (EWNA) was established in 2013. It was officially registered in Georgia on May 05, 2015. EWNA is a network of leaders and activists who advocate for the rights of women living with the human immunodeficiency virus (HIV) and vulnerable to HIV in the Eastern Europe and Central Asia (EECA) region. EWNA facilitates/conducts women's community-led researches on the sexual and reproductive health and rights of women living with HIV and provides technical assistance to carry them out.

Gvirila is a women led organization founded in 2020 by former TB patients, The goal of the organization is to: Provide evidence/analysis of the situation / needs of women with physical and mental health (chronic and non-chronic) problems, initiate interventions and advocate for women empowerment at the local and national levels, promoting sexual and reproductive health and rights of all women and girls including trans communities, raising public awareness on intersectional stigma related to TB/HIV, gender, violence prevention and management as well as other related issues, including contribution to elimination of harmful practices affecting women.

Women-led research "Sexual and reproductive health and rights (SRHR) of women living with HIV" is first of its kind in Georgia implemented by Women Association "Gvirila" in strategic partnership with Georgian Union of PLHIV "Real People Real Vision (LIFE2.0)" and direct financial and technical support of the international charitable organization Eurasian Women's Network on AIDS (EWNA) under the Global Fund SoS_project 2.0 (Sustainability of Services for Key Affected Populations in East Europe Central Asia and Balkan countries).

The research on Sexual and Reproductive Health and Rights of Women Living with HIV is a unique community-led survey. It is designed, planned and implemented by women living with HIV among women living with HIV for the purpose of improving the quality of services that are provided to those women. Therefore, planning and implementation, including data collection, analysis of findings, and advocacy of findings, are carried out directly by HIV-positive women. The underlying premise of the Sexual and Reproductive Health and Rights of Women Living with HIV study is that the well-being of HIV-positive women is based on an integrated approach to health and human rights. The right to sexual and reproductive health is an integral part of the right to health, and its provision is envisaged in two Sustainable Development Goals until 2030. The study contributes to generate evidence for HIV positive women to equally access to quality health care and be free of multiple forms of violence, stigmatization and discrimination that leads to violations of sexual and reproductive rights.

The goal of the research was to identify the key issues and needs of women living with HIV related to sexual and reproductive health through the prism of human rights, as well as to identify priorities for introduction of the measures to address the HIV epidemic, taking into account gender aspects and the rights of women living with HIV, into national strategies and action plans.

National research reference group (NRRG) was created strategically leading the process both of evidence generation and further advocacy. NRRG covered 10 representatives of the HIV positive women community. Several face to face meeting and online meetings were held to discuss adaptation of the research tools in line with the local context, mobilization as well as reach out of the respondents within various sub groups.

Research goals and objectives:

The goal of the survey is to identify the key issues and needs of women living with HIV related to sexual and reproductive health through the prism of human rights, as well as to identify priorities for introduction of the measures to address the HIV/AIDS epidemic, taking into account gender aspects and the rights of women living with HIV, into national strategies and action plans.

The objectives of the survey are to:

- Form a social portrait of women living with HIV in a country;
- Identify the impact of various life factors of women

living with HIV, including violence, on their sexual and reproductive health;

- Study the experience of women living with HIV in accessing sexual and reproductive health services;
- Identify the level of accessibility and utilization of sexual and reproductive health services by women living with HIV;
- Identify key factors affecting women living with HIV's access to and opportunities for various social services;

- Identify barriers to accessing medical and social services, legal assistance, government services for women living with HIV in order to preserve and maintain sexual and reproductive health of women living with HIV;

- Develop recommendations to uphold the rights and increase access of women living with HIV to sexual, reproductive health and other social services, as well as recommendations to address the HIV/AIDS epidemic through gender-sensitive and gender-transformative national strategies.

Research Methodology

Research methods: mixture of quantitative and qualitative methods: survey, focus group discussions, documenting life stories/cases.
The main research tool is the semi-structured questionnaire with closed, half-open and open questions, as well as additional information that explains and specifies in the questions that might be unclear. The questionnaire
consists of the preamble and three topical sections:

1.Social and demographic status of the respondents.

2.Experience of using sexual and reproductive health services. Experience in observance of human rights inhealthcare and access to justice.

3. Important spheres of the women's lives:

3.1. Healthy sex-life, access to sexual health services
3.2. Pregnancy, access to family planning and vertical transmission
3.3. Violence against women living with HIV
3.4. Mental health and HIV status
3.5. Burden of care
3.6. HIV treatment, side effects and diagnostics
3.7. Financial issues affecting access to services. The questionnaire provides explanations about the basic terms and expressions, namely: Sexual health, Sexual rights, Reproductive health, Reproductive rights, Reproductive care, Violence against women, Intimate partner violence.

(Annex 1 - Research design and the questionnaire attached).

Sampling/criteria used in the selection process of participants

Total number of the respondents covered 230 (N200[4]) from the size population of 1418[5] with the level of confidence 95% and margin of error 6%).

Participants met a number of characteristics (by self-declaration):

1.Women living with HIV (diagnosed) - Aged 18 and over; (totally 200 through Georgia)
- Experience of violence, rights violations and gender inequality
- Experience in accessing and successfully obtaining services to preserve or maintain sexual and reproductive health

2. Women living with HIV (diagnosed) - Aged 18 and over (21 respondents) who are
- service providers of governmental and nongovernmental organizations (9 providers), as part of the FGDs providing direct or indirect assistance to women living with HIV, including in the field of sexual and reproductive health and/or HIV response;.
- experts or activists in the field of sexual and reproductive health and/or HIV response;
- experts or activists in responding to situations of gender-based violence, violations of women's rights and gender inequality.

The criteria for exclusion of women living with HIV from the survey at each stage were:
- Being HIV negative
- Being below 18
- Participation more than once in each of the stages of the survey;
- Lack of informed consent to participate in the survey;
- The condition that does not allow understanding and answering the questions of the questionnaire/tool

Data analyses

Data analyses has been done through the annotating and coding for the generated evidence through focus group discussions and organized according to the preliminary developed structure. While quantitative data was generated through the questionnaires, managed through Excel and SPSS software, followed by creation of graphical representation, applying different functions. Charts and diagrams have been created, containing frequency counts or summary statistics over (groups of) cases and variables.

Maintaining confidentiality

All survey staff were trained in the protection of participants' privacy as part of the preparatory training and signed a Data Use and Privacy Agreement, which explained the procedures for dealing with data recording coding documenting and responsibility for the violation of the confidentiality principle.

Limitations

The main limitation of the research lied in the fact it did not reach all of the sub groups of women living with HIV for instance women who are in prison at the time of the field work, HIV-positive women who, for one reason or another, are not registered and/or do not receive treatment. Representatives of the ethnic minorities not able to speak in Georgian. The coverage of the different geographic areas were also disproportionally covered, especially those coming from rural areas.

Ethical committee approval

Respective documentation for the national ethics committee was developed and shared to the Institutional Review Board of Health Research Union which approved the research application and granted Women Association Gvirila with the official approval letter. (Annex 2)

SUMMARY:

Women-led research "Sexual and reproductive health and rights (SRHR) of women living with HIV" was conducted in 2022 in Georgia covering 200 respondents in the country, most of them, almost 70% in reproductive age (18 to 45 years old)- 34.7% state not being sexually active when 38.3% with one of more partners living with HIV. 31% gave birth after knowing their positive status. 2.55% have HIV positive children. Most of them with incomplete higher education, unemployed or unofficially employed. With support of the community leaders the research made it possible to cover women (8%) with sex work experience and (10%) ever using drugs.

Rights

Right to health as a prominent part need to be grounded in principles of gender equality. Providing sexual and reproductive health interventions for women living with HIV can have a positive impact on their quality of life. Only 45.41 % of the respondents experience the same service as any other women, when it comes to SRHR and only half of them are aware of sexual and reproductive health treatments, information, services and commodities that exist in the country. 42.35% of the respondents state they can't get free and quality sexual and reproductive health treatments, information, services or commodities, when they need them. What is of utmost importance, 37% of women, do not know their rights and do not know where to file complaints against actions of health care workers if their rights are violated in medical institutions. More than half of the respondents has no knowledge or belief on legal protection mechanisms, in case of their rights are violated. Women living with HIV have high unmet sexual and reproductive health needs due to barriers to access sexual and reproductive health services and non-enabling environment for experiencing fundamental rights to access to basic health services, that need to be well addressed on the national level programs by integrated, friendly, women oriented stigma free services.

Healthy Sex Life

When it comes to correlation of healthy sex life and access to sexual health services, range of the positive answers do not exceed 27%, maximum of which is the percentage of them responding on having sex without the fear of passing HIV on to the partner. Only 36% of the respondents are able to have sex without fear of getting pregnant and only 29% of the respondents access the products they need to have a good sex life. 37% of the respondents can never afford to buy the they need to have a good sex life. 38% of the respondents state they are never able to discuss in a friendly manner their HIV status with their partner(s). Thus it is utmost need to deal with enhancing the knowledge, understanding how sex life affect health and rights in general, as well as selfreflection and the ability to communicate the feelings, needs and desires, as the fundament of the wellbeing.

4 *Quantitative research component coverage*
5 *National program data 2021-cummulative number of women on Antiretroviral Treatment*

Pregnancy, access to family planning and vertical transmission

It is very interesting to observe how gender norm in general affect the development of the various services affecting their availability, accessibility, affordability and the quality. When positive trends are noticed with vertical transmission prevention and general antenatal care, which can be considered as the care for the future child. Nevertheless, gaps are reveled when it comes to access to family planning and abortion. Vertical transmission is eliminated in Georgia, and as most respondents confirm support regarding pregnancies and respective care. But when it comes to counseling on family planning, 55% state, they haven't been given any advice. 82.65 % of the respondents state they have had one or more unplanned pregnancy, while only 38.78 % of the respondents state, they have access to safe and free or affordable abortion. Assisted reproductive interventions access seem to be also problematic, like in general population. 54% of the respondents state they haven't regular check-ups/Pap smears for early detection of cervical cancer, 50% of the respondents state they don't pass regular breast screening, confirming lack of intersections with existing national programs, that is one of the directions to be considered as short term intervention.

Violence against women living with HIV

Violence against women and girls is one of the key drivers behind the increasing number of women and girls living with HIV. Physical violence, the threat or fear of violence, and the fear of abandonment interact with other gender-based economic and social inequalities to significantly increase women's vulnerability to HIV infection. 29.5% of women living with HIV have experienced violence from their partner or spouse. This share is considerably higher than the average for women in Georgia in general (13,6%) as stated in the National Study on Violence Against Women Implemented by UNDP in 2017. It is worth mentioning that not many women are aware of importance of the removing legal barriers, for instance 40% of the respondents state they don't know if laws which criminalize HIV transmission and/or sex work should be removed and 37% don't know if laws which criminalize drug possession should be removed. However, women turn to be very supportive towards existing medical and social support services. 67,8% of the respondents state that existence of 24/7 hotline is important. 70,9% of the respondents consider support groups necessary. 72% of the respondents state that professional counseling (doctor, psychotherapist, lawyer, social worker) is important while 63,78% of consider providing a minimum free support after rape including post-exposure prophylaxis, emergency contraception, STI screening, social assistance and counseling is utmost important.

Mental health and HIV status

When it comes to the mental health, it should be mentioned that the level of the stress among the cohort of the respondents is high even before HIV diagnosis, but level of depression (71%), feelings of rejection, including to accept one's diagnosis (68%) drastically increase right after the knowing the HIV positive status. The same trend is noticeable with Anxiety/fear/panic attacks (76%) Insomnia/ sleeping difficulty (67%) and post-traumatic stress disorder (for example, nightmares) 61%. The issue of mental health for women living with HIV is still relevant, despite the expansion of HIV treatment and care programs in Georgia somewhat including the component. The respondents themselves emphasized the need for specialized assistance after being diagnosed, and considered women oriented and gender sensitive consultations including with the psychologists as really important. As for peer to-peer groups is considered as also important, but individual work with the psychologies is named as the one of the best methods of protecting their psychological health. In many cases, women's psychological health issues emerge before they are diagnosed with HIV and are accompanied by risky behaviors before the acceptance of the status, which once again confirms vice versa correlation of vulnerability, violence and HIV.

Burden of care

Issues related to the daily lives of women living with HIV are important component in understanding the lifestyle and health of the women, who usually bear the burden of care for their own health and running their household. As most questions regarding household and lifestyle show, the way the burden of care is shared, exposes entrenched gender stereotypes, as women perform the bulk of household chores by themselves. For instance 41 % of the respondents state only they are busy with getting children ready to kindergarten/school in the morning; 68% of the respondents state only them cooking; 69% of the respondents are the only ones involved in housecleaning. Only 20% of the respondents state their husband/partner takes care of them inside/outside the home/in the hospital on a regular bases. 71% of the respondents state they never receive child care financial assistance (government help), 69% of the respondents claim they never receive child care non-state support (charitable/public organizations). The burden of caring takes the physical and financial resources, as well as place a heavier burden of family support and care on women and girls. Not only that affect access to services but, intersects with poverty with gender inequality. That makes women very vulnerable because of unequal access to economic resources, inequality in the sphere of work, including burden of care, due to economic dependence. In some cases above mentioned creates need to be involved in

sex work and migration. Thus social support services should be added layer of support for removing service access barriers as well as influencing vulnerability determinants affecting burden of care distribution. While in long term gender equality and empowerment mainstreaming in education and awareness raising interventions can be viewed as positive contributor.

HIV treatment, side effects and diagnostics

The vast majority of respondents – 85.2% reported that they visited personal doctor within a year's time, 38.7% out of them stating last visit period from 3-to 6 months. That mostly corresponds to the visits due to the viral load checkup. Most of them (82%) can name the viral load, even if not mention the exact number respondents could mention the correlation between the viral load and their immune system condition. More than half were not able to name the drugs they are taking but vast majority mentioned they are taking them regularly. It should be mentioned adherence to the treatment is very good among women compared to men and the trend was confirmed through the research. Pregnant women has good access to vertical transition program, showing good adherence, only 2,3% of women having positive children out of the cohort, and 83% out of them mentioned not taking ART while conception and pregnancy, the rest irregularly taking drugs, the trend related to mobility and respective access barriers.

Financial issues affecting access to services.

46 % of the respondents state they never count on access to lending services in any bank in Georgia. 54 % of the respondents state they never know how to start their own business and they never owned real estate and other property or where to refer to start the own business. 34 % of the respondents state that having a child has not never affected their career path while 41 % of the respondents state that having a child has not affected their income. Qualitative cross check shows the negative tendency of stated, as those women where already out of the market both for education and employment before even children were born, definitely putting them in more unfavorable position requiring more holistic support, including for their children through medical, social psychological dimensions.

MAIN FINDINGS:

1. Social and demographic status of therespondents

Most of the participants of the research were in reproductive age (18 to 45 years old) - 67.86%, while 32% above 45. Almost 46% of them from Tbilisi and nearby cities, while 54% from the West Georgia. (Distribution in Table 1). 34.7% state not being sexually active when 38.3% with one of more partners living with HIV. (Diagram N1). 35% married, 11% in a civil marriage and up to 29% divorced. 31% gave birth after knowing their positive status. A bit more 33% got to know their status while pregnancy. Only 2.55% have HIV positive children. Most of them with incomplete higher education unemployed or unofficially employed (Diagrams N2.1; 2.2).

TABLE N 1

CITY	PERCENTAGE
Abasha	0.51%
Batumi	14.80%
Chokhatauri	1.02%
Foti	2.04%
Gali	2.55%
Keda	1.02%
Khelvachauri	2.55%
Khobi	1.53%
Kobuleti	3.57%
Kutaisi	3.57%
Lanchkhuti	1.02%
Marneuli	1.02%
Mesitia	0.51%
Ozurgeti	2.55%
Rustavi	1.02%
Sachkhere	0.51%
Samtredia	0.51%
Senaki	1.53%
Tbilisi	43.88%
Tsalenjikha	0.51%
Zestafoni	0.51%
Zugdidi	13.27%

TABLE N 2

ADDITIONAL VARIABLES	PERCENTAGE
I do or have done sex work	8.16%
I inject/use or have injected/used drugs	10.20%
My sexual partner(s) injects/uses or has injected/used drugs	44.39%
I am/have been a client of opioid substitution therapy program	1.53%
I am/have been in prison	5.10%
I am/have been in a detention center	6.63%
I am living with disability	4.29%
I have or have had active TB	7.14%
I have or have had Hepatitis C	17.86%
I migrated from one country to another for economic resons	26.53%
I migrated from one country to another for political reasons	1.53%
I am lesbian, bisexual or have sex with women	2.55%
I am a trans woman	0.00%
I am married, or in a stable relationship	34.69%
I am an internally displaced person	7.41%
I am or have been homeless	7.14%
Other (optional)	2.55%

8% with sex work experience, 10% using drugs, 44% ever having partner with the drug use experience. 4% with disability, 26.5% with migration experience, 7% internally displaces. It is also worth mentioning that the research managed to cover women who had TB, and are/were on the HCV treatment, referred to Opioid Substitution Treatment. (Distribution in Table N2)

DIAGRAM N 1
Relationship Status

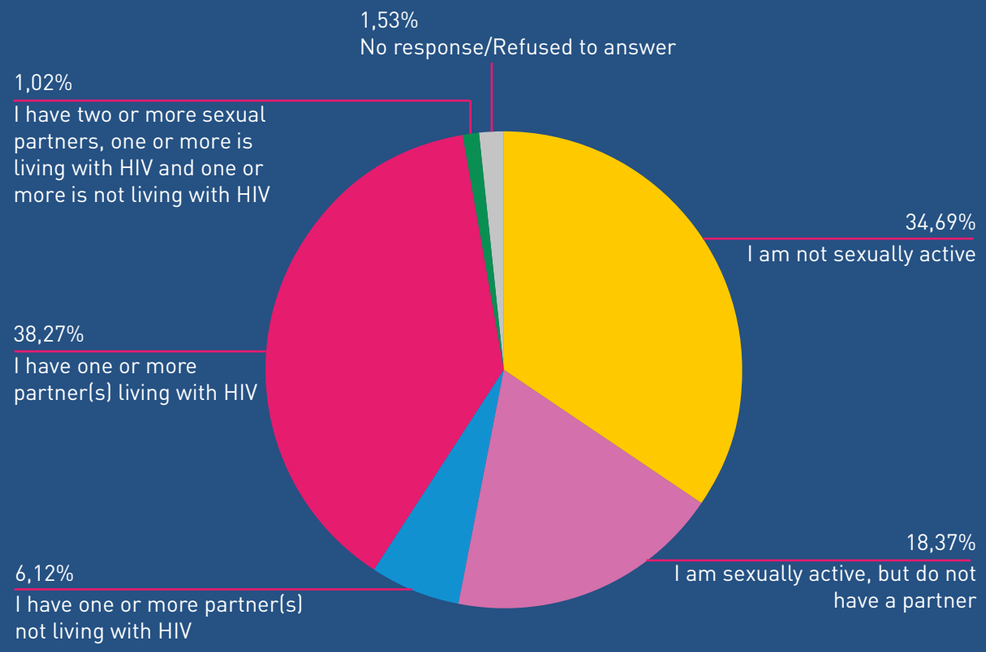


DIAGRAM N 2
Education

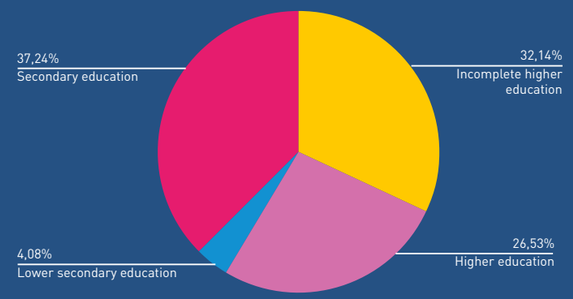
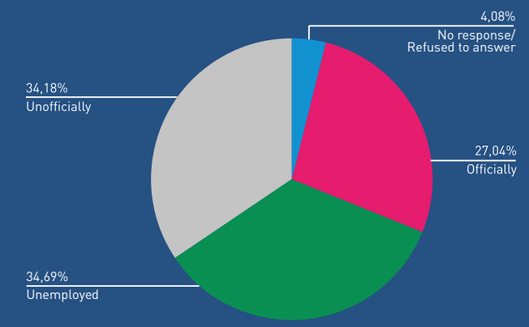


DIAGRAM N 3
Employment



2. EXPERIENCE OF USING SEXUAL AND REPRODUCTIVE HEALTH SERVICES. EXPERIENCE IN OBSERVANCE OF HUMAN RIGHTS IN HEALTHCARE AND ACCESS TO JUSTICE

Most of the women living with HIV "do not know"(52%) or "disagree" (30.61%) that health care providers do not disclose their HIV status or any other details without their consent. 37% of women, do not know their rights and do not know where to file complaints against actions of health care workers if their rights are violated in medical institutions. More than half of the respondents has no knowledge or belief on legal protection mechanisms, in case of their rights are violated. (Diagrams N3.1; 3.2; 3.3).

DIAGRAM N3.1

I trust the service providers not to share my HIV status or any other details about me without my permission

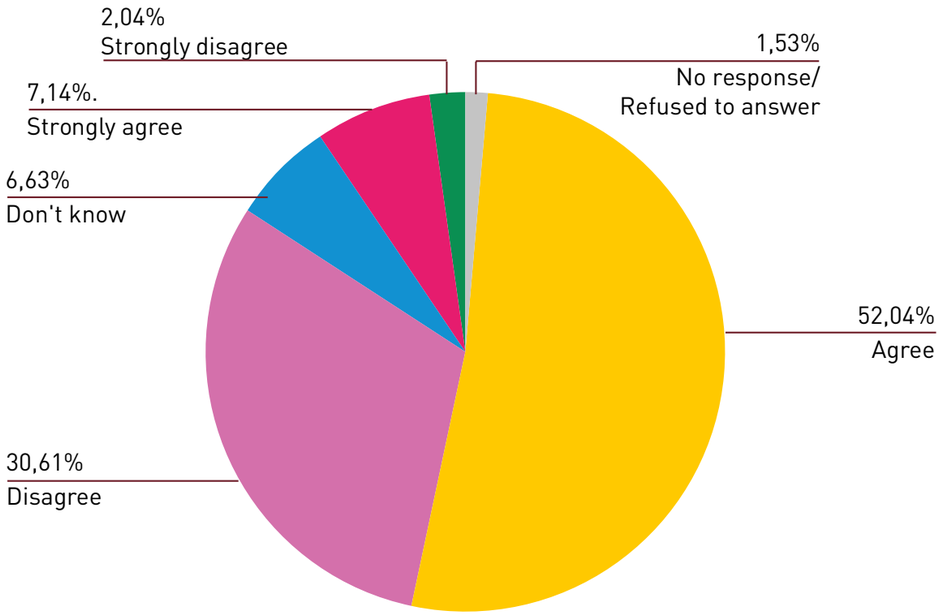


DIAGRAM N3.2

I know my rights, and if I experience a rights violation within the health service, I know where I can go to make a complaint

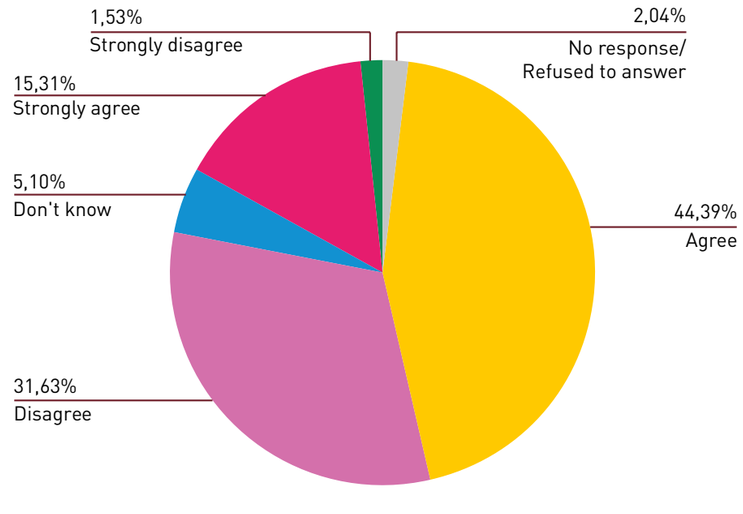
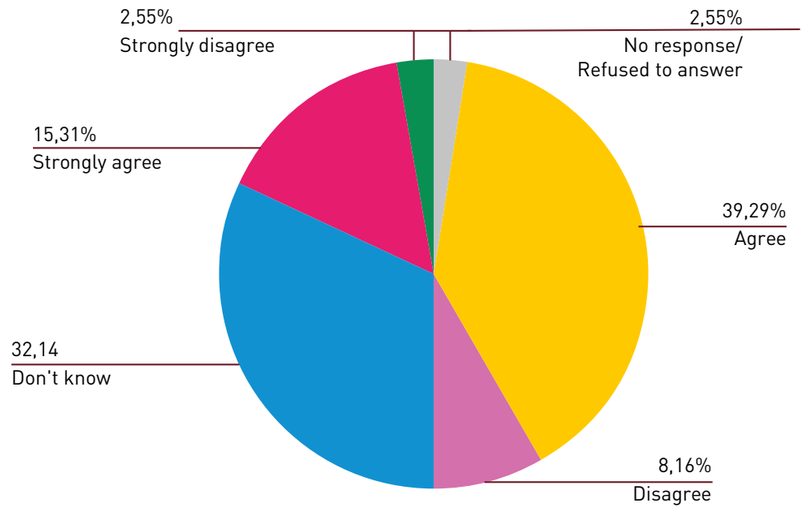


DIAGRAM N 3.3

If my rights as a woman living with HIV are violated, I know that I will receive the necessary legal protection



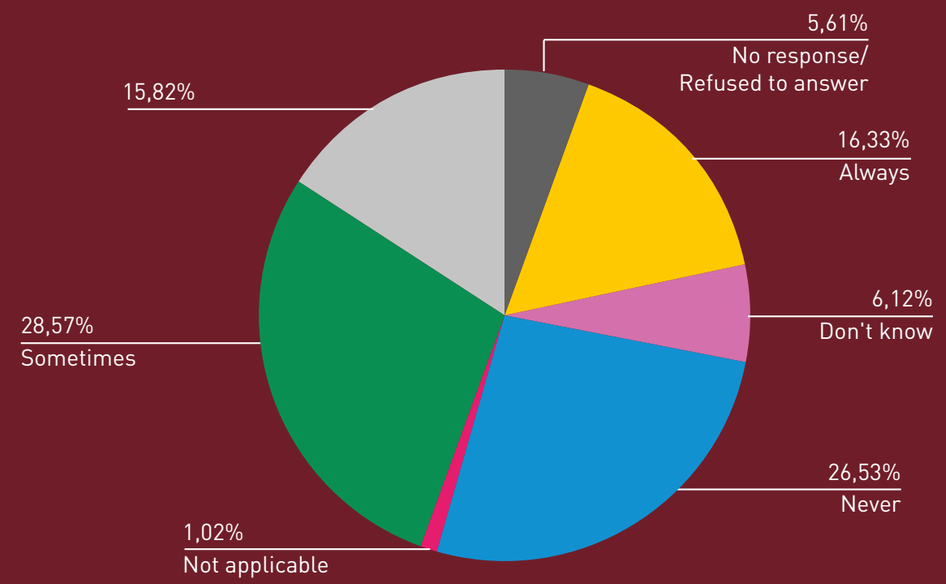
45 % of the respondents state they experience the same service as any other women, when they go for sexual and reproductive health services. 50.5% state they are aware of sexual and reproductive health treatments, information, services and commodities that exist in country. 42% of the respondents state they can't get free and quality sexual and reproductive health treatments, information, services or commodities, when they need them. Only 33,6% find the service providers well-trained and knowledgeable, friendly, and supportive. More than half (53%) of the respondents state - accessing sexual and reproductive health care they experienced has been good, and they have confidence in the advice and treatment they receive. 52% of the respondents state they believe their service provider offers a full range of choices for sexual and reproductive health care, including family planning options and prevention, diagnosis and treatment of sexually transmitted infections (STIs). Only 47,9% of the respondents state they are given all the information they need to make a decision about proceeding with a service or treatment, without feeling any pressure from the service provide. 52% trust the service providers not to share their HIV status or any other details without their permission. 41% of the respondents state their doctor listens to them, and gives advice based on their needs and realities as a women living with HIV.

Conclusion: Women living with HIV have high unmet sexual and reproductive health needs due to barriers to access sexual and reproductive health services (SRHS) and non-enabling environment for experiencing fundamental rights to access to basic health services, that need to be well addressed on the national level programs by integrated, friendly, women oriented stigma free services.

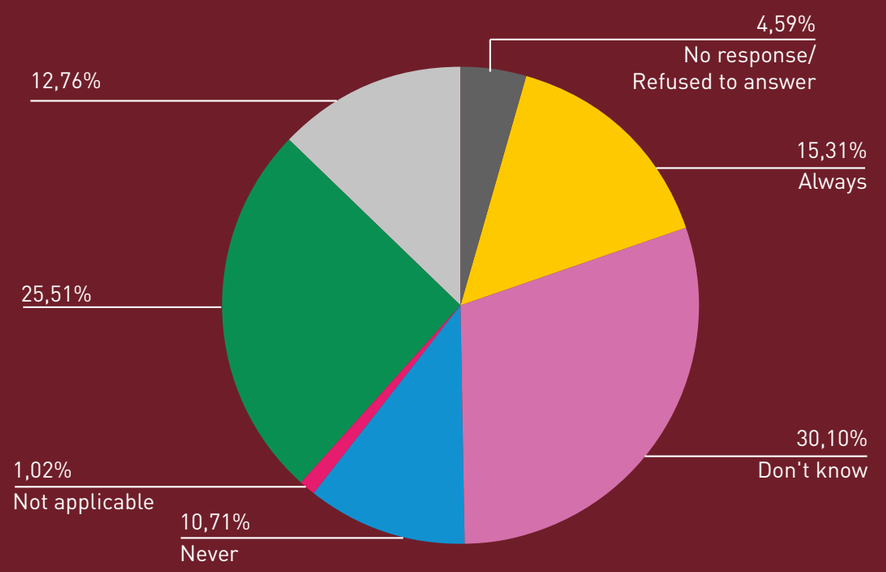
3. IMPORTANT SPHERES OF THE WOMEN'S LIVES:
3.1. HEALTHY SEX-LIFE, ACCESS TO SEXUAL HEALTH SERVICES

When it comes to correlation of healthy sex life and access to sexual health services, range of the positive answers do not exceed 27%, maximum of which is the percentage of them responding on having sex without the fear of passing HIV on to the partner. Only 25% state they can communicate and negotiate with the partner to use male condom, while 41% mentioned having no ability to use the female condom. Neglecting mainly refers to the questions regarding satisfaction, personal or regarding the partner, or the desire expressing and sex initiation. Only 11.7% of the respondents are always safe with the partner and 16% can talk about the sexual health with the service provider without the fear of judgment. The following outcomes is on the one hand reflects the taboo around all aspects related to sexuality and sex and on the other lack of comprehensive sexuality education among various generations. (Diagrams 3.1-3.4)

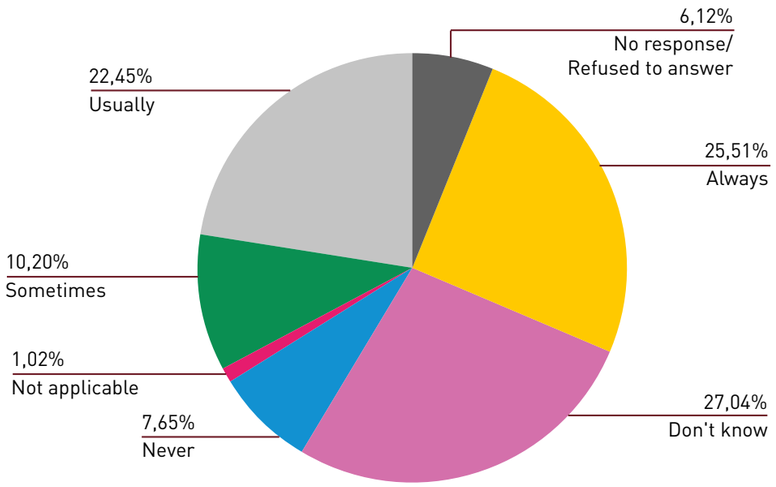
I AM ABLE TO TALK TO MY HEALTH CARE PROVIDER ABOUT MY SEXUAL HEALTH AND NEEDS



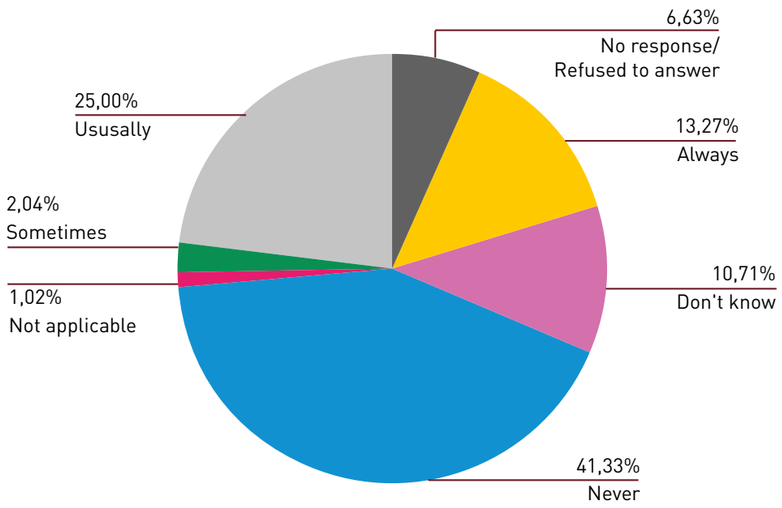
IF I HAVE AN STI I AM ABLE TO GET DIAGNOSIS AND TREATMENT FOR IT WITHOUT FEAR OF JUDGEMENT FROM THE HEALTH PROVIDER



MY PARTNER IS HAPPY TO USE A MALE CONDOM IF I WANT HIM TO



I AM ABLE TO USE A FEMALE CONDOM IF I WANT TO



Only 35% of the respondents state they want to have sex often/have strong feelings of sexual desire. 30,6% of the respondents state they usually find sex pleasurable for themselves and for their partner(s). 32% of the respondents state they only sometimes have sex when they want to – while the same percentage notes that they never have sex when they want to. 29% of the respondents state they sometimes find it easy to "come"/ have an orgasm during sex. 44% of the respondents state they don't know that their body makes enough lubrication (how "wet" you feel when you want to have sex). 30% of the respondents state they don't know where they can get information on sexually transmitted infections, safer sex, condom use, and contraception. Only 37% of the respondents state usually they are able to have sex without fear of getting any sexually transmitted infections (STIs) from their partner. Only 36% of the respondents are able to have sex without fear of getting pregnant and only 29% of the respondents access the products they need to have a good sex life. 37% of the respondents can never afford to buy the products they need to have a good sex life (see above). 38% of the respondents state they are never able to discuss in a friendly manner their HIV status with their partner(s).

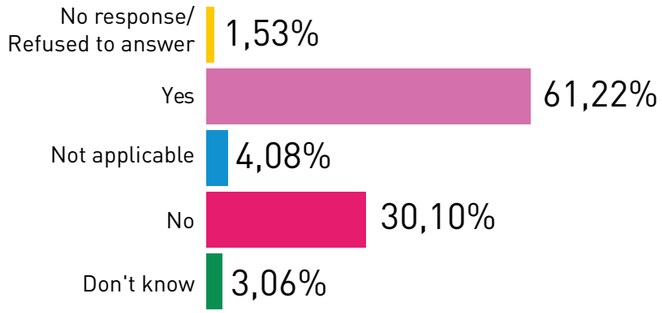
Conclusion: The section on healthy sex life shows the biggest gap when it comes to the knowledge, understanding how sex life affect health and rights in general as well as self-reflection and the ability to communicate the feelings, needs and desires, as the fundament of the wellbeing. Even in the mobilization phase, when there has been set of trainings for the field workers on the research tools, many of them mentioned the section would cause controversies. Even fully in a confidential and private environment respondent were intimidated, thus most of the questions were left unanswered or marked as non-applicable, when in a fact that is one of the universal sections factually applying to all. Thus the gaps revealed cannot be only dialed on the service level rather than should be approached through educational and empowerment women oriented initiatives covering sexuality.

3.2. PREGNANCY, ACCESS TO FAMILY PLANNING AND VERTICAL TRANSMISSION

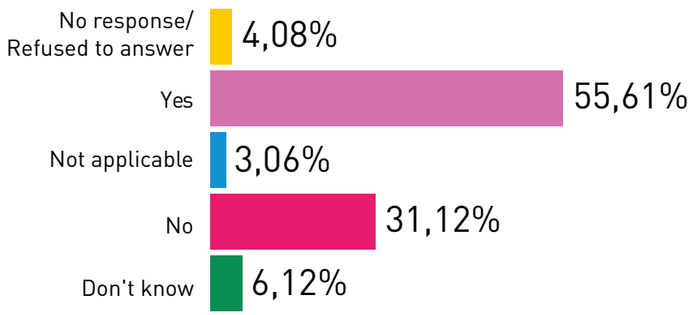
The situation is different though when it comes to pregnancy and vertical transmission, where more positive trends are observe, though there is still much space for improvement. The positive trends show 61% of the respondents have been supported by partner(s) to make choices about fertility (to decide whether or not to have a child/children). 55.% of the respondents state they have been supported by health provider to make choices about fertility. While 55.61% mention support by family and community to make choices about fertility, while still 39.29% of the respondents state they can talk to their doctor/service provider about their fertility desires. However, 52% of the respondents state they haven't are not been able to access free infertility treatment, assisted reproductive technology if need it (e.g. I.V.F.) 42.35 % of the respondents state they have chosen to test for HIV during pregnancy. 46.43 % of the respondents state they were given adequate counseling before and after the test for HIV. (Diagrams 3.2.1-3.2.4)

pregnancy. 46.43 % of the respondents state they were given adequate counseling before and after the test for HIV. (Diagrams 3.2.1-3.2.4)

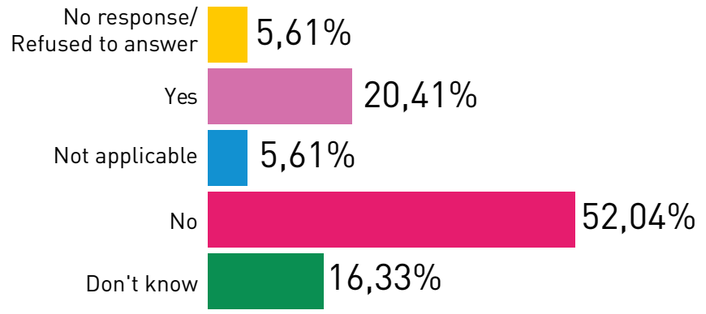
I HAVE BEEN SUPPORTED BY MY PARTNER(S) TO MAKE CHOICES ABOUT MY FERTILITY



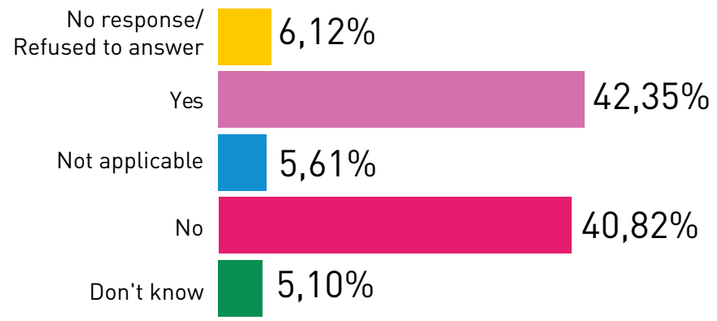
I HAVE BEEN SUPPORTED BY MY FAMILY AND COMMUNITY



I HAVE BEEN/AM ABLE TO ACCESS FREE INFERTILITY TREATMENT, ASSISTED REPRODUCTIVE TECHNOLOGY IF I NEED IT (E.G. I.V.F.)

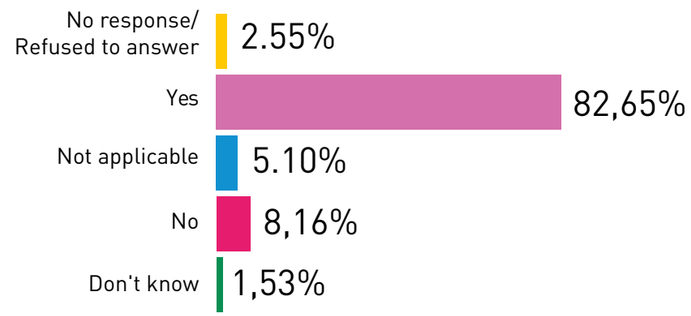


I HAVE CHOSEN TO TEST FOR HIV DURING PREGNANCY

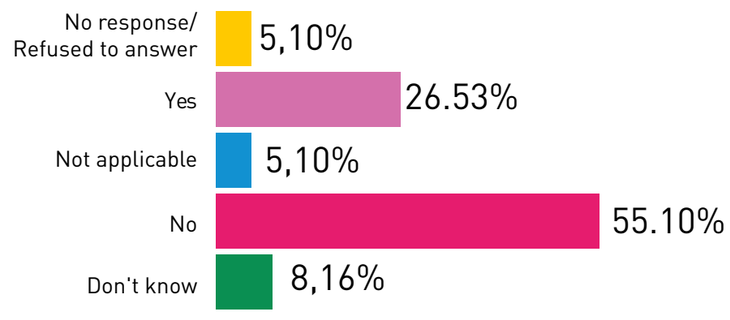


The counseling and information sharing on family planning methods and abortion still remain a gap. 55% of the respondents state they haven't been given counseling on family planning and advice on child spacing. 82.65 % of the respondents state they have had one or more unplanned pregnancy while only 38.78 % of the respondents state they have access to safe and free or affordable abortion, if need it 37.24 % of the respondents state they have access to post-abortion/-miscarriage care, if needed. Almost the same percentage of the respondents deny access to post-abortion/-miscarriage care. 51% of the respondents state they haven't been given advice on how to disclose their HIV status to their partner(s) and children. 51.5% of the respondents state they know they can speak to other women living with HIV who will give them advice on healthy motherhood if wanted. Only 47.96 % of the respondents state they have been able to make choices about where they want to deliver baby. 45.92% of the respondents state they have been supported to make decisions about how to feed baby. Only 39.80 % of the respondents state they can decide to have a(nother) child without fear of what people say, while only 38.78 % of the respondents state they can decide NOT to have a(nother) child without fear of what people will say. (Diagrams 3.2.5-3.2.8)

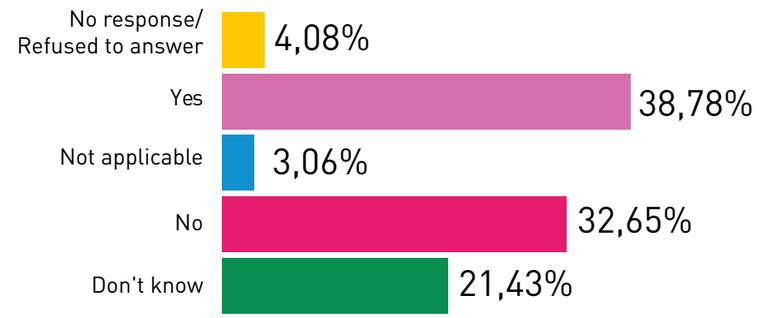
I HAVE HAD ONE OR MORE UNPLANNED PREGNANCY



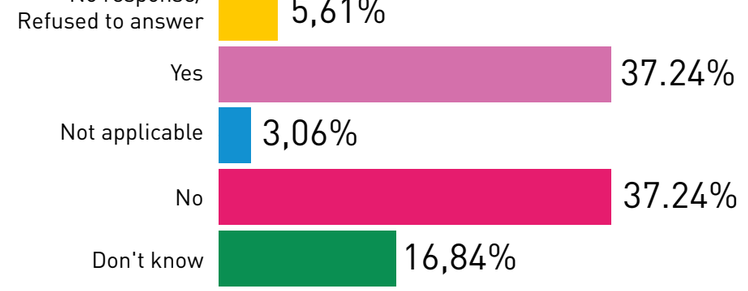
I HAVE BEEN GIVEN COUNSELLING ON FAMILY PLANNING AND ADVICE ON CHILD SPACING



I HAVE ACCESS TO SAFE AND FREE OR AFFORDABLE ABORTION, IF I NEED IT

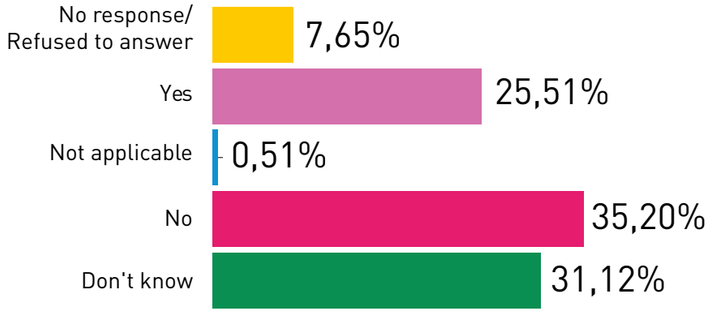


I HAVE ACCESS TO POST-ABORTION/-MISCARRIAGE CARE, IF I NEED

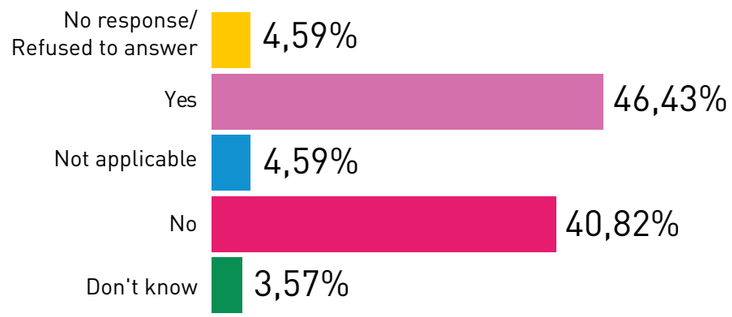


Only 48.98% of the respondents state they don't know if they can access the family planning/ contraception that they prefer and only 42.86% of the respondents state they are able to use the family planning/contraception that they prefer without resistance from their partner(s). 35.20% of the respondents state they haven't access to emergency contraception (the morning-after pill) if needed. 34.6% of the respondents state they don't know if they can access legal counseling on adoption choices. 38% of the respondents state they can access post-exposure prophylaxis, if partner needs it. 54% of the respondents state they haven't regular check-ups/Pap smears for early detection of cervical cancer. 50% of the respondents state they don't pass regular breast screening.
(Diagrams 3.2.9-3.2.10)

I HAVE ACCESS TO EMERGENCY CONTRACEPTION (THE MORNING-AFTER PILL) IF I NEED IT



I WAS GIVEN ADEQUATE COUNSELLING BEFORE AND AFTER THE TEST FOR HIV

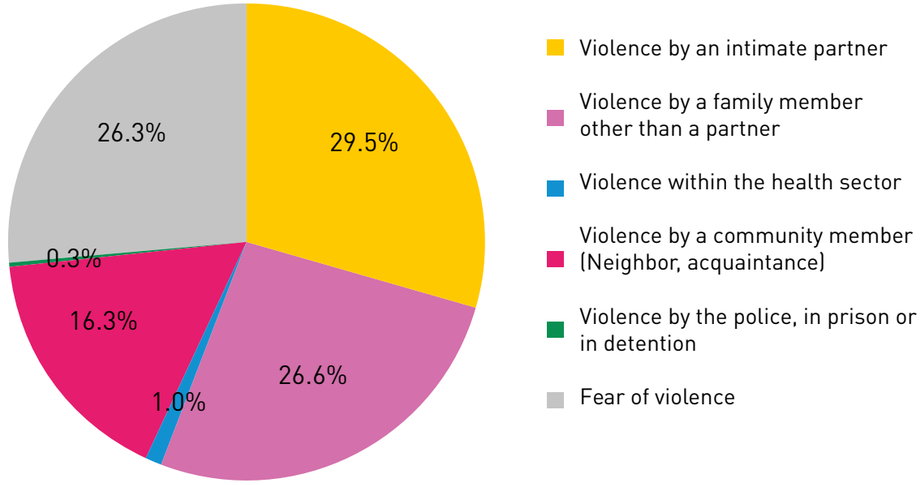


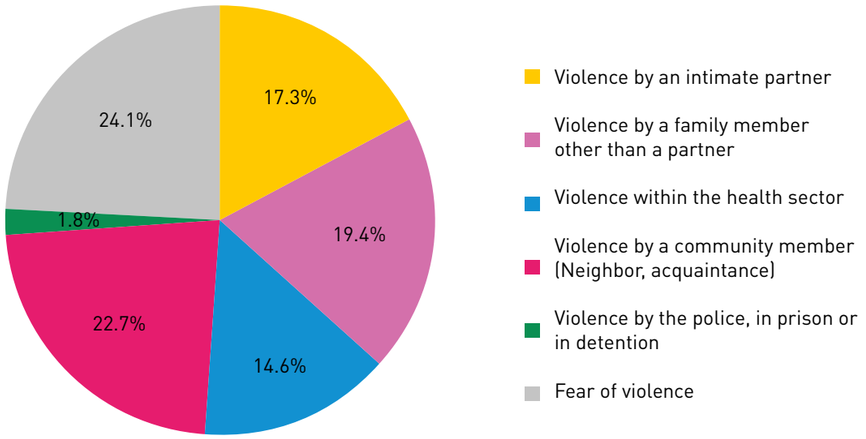
Conclusions: It is very interesting to observe how gender norm in general affect the development of the various services affecting their availability, accessibility, affordability and the quality. When positive trends are noticed with vertical transmission prevention and general antenatal care, that can be considered at least partly the care for the future child, big gaps are reveled when it comes to access to family planning and abortion. Assisted reproductive interventions access seem to also problematic. All stated above reflecting accessibility to the services being one of the most challenging in general population as well. The lack of intersections with existing cancer screening national programs should be also taken into account.

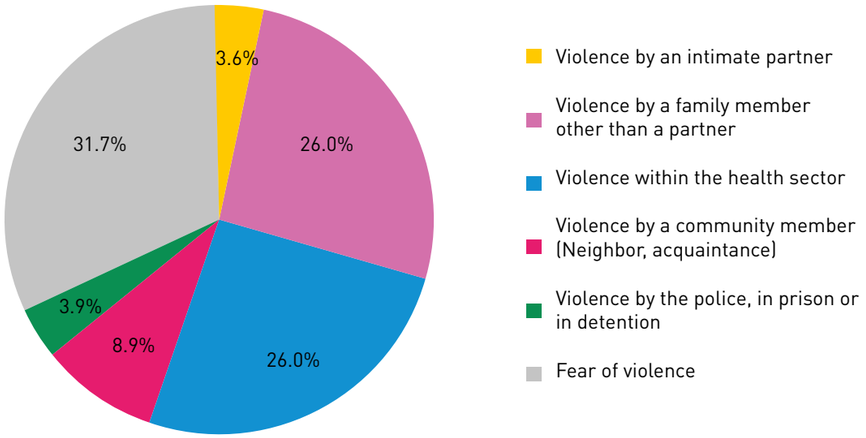
3.3. VIOLENCE AGAINST WOMEN LIVING WITH HIV

Violence against women and girls is one of the key drivers of HIV. 29.5% of women living with HIV have experienced violence from their partner or spouse. This share is considerably higher than the average for women in Georgia in general (13,6%) as stated in the National Study on Violence Against Women Implemented by UNDP in 2017. The fear of the negative attitudes and violence, being quite high even before the diagnosis (26.3%) increases up to 31.7% due to the HIV positive status. The basic strategy to deal with the mentioned, is to close the status from family members and communities, even with the medical service providers where possible. Women living with HIV name social protection among their highest priorities, along with the ability to secure care for their children and to independently earn their living, to have access to competent specialists (from medical doctors to lawyers), to be aware of the rights and problems of women living with HIV (and women from vulnerable groups), and to access support, through a hotline, support groups, and shelters. Most women do not see the criminalization of sex work, drug use or HIV transmission as institutional violence, and do not see how these laws are affecting access to services and the enjoyment of human rights. (Diagrams 3.3.1-3.3.3)

BEFORE HIV DIAGNOSIS







40% of the respondents state they don't know if laws which criminalize HIV transmission and/or sex work should be removed. 37% don't know if laws which criminalize drug possession should be removed. Only 8% of the respondents state it's important to remove laws which criminalize HIV exposure/transmission. While half of the respondents state it's important to ensure access to free rehabilitation and addiction treatment (alcohol, drugs). 65% of the respondents consider important to increase access to education and employment for women. 72,9% of the respondents state it's important to enhanced social protection for women and children while, 77% of the respondents consider important to ensure the availability of pre-school education. 37.7% of the respondents state it's important to Increase access to harm reduction programs for women who use drugs and sex workers by providing women-centered services. 68% of the want to focus the attention of healthcare workers on the rights of women living with HIV. 75,5% of the consider existence of centers/shelters with the possibility of round-the-clock accommodation, including with children important. 63% of the respondents state that existence of centers/shelters with the possibility of round-the-clock accommodation, including with children and for women who use drugs, sex workers and/or OST patients is important.

67,8% of the respondents state that existence of 24/7 hotline is important. 70,9% of the respondents consider support groups necessary. 72% of the respondents state that professional counseling (doctor, psychotherapist, lawyer, social worker) is important while 63,78% of consider providing a minimum free support after rape including post-exposure prophylaxis, emergency contraception, STI screening, social assistance and counseling is utmost important. 71,9% of the respondents state it's important to provide legal protection against all forms of violence against women. 71% of the respondents state it's important to recognize and address the issue of marital and date rape. 60,7% of the respondents want effective mechanisms for filing complaints and redress in case of violation of rights in the healthcare service.

Conclusion: Violence against women and girls is one of the key drivers behind the increasing number of women and girls living with HIV. Physical violence, the threat or fear of violence, and the fear of abandonment and destitution interact with other gender-based economic and social inequalities to significantly increase women's vulnerability to HIV infection. The interesting trend is that after being diagnosed with HIV the violence form the side of the intimate partner(s) decrease. While cross checking the latest through focus group discussion, several factors has been mentioned including break up and self-blame from the side of a partner. Yet the HIV diagnosis considerably increases the probability of being subjected to violence in all other spheres, specifically in the healthcare settings, which women have to deal with in order to secure timely and proper care and treatment, and to lead a productive life.
Another point to stress is the violence experienced from police including in prison or detection units, basically mentioned by the women with drug use and sex work experience which is relatively the same before and due to the diagnosis 26.6% and 26% respectively. That can be explained by the criminalization and penalization due to other status the fear to which prevail. Breaching the confidentiality and forced status opening is one of the basic source of fear. During focus group discussions that has also been mentioned as the main reason for having difficulties in mobilizing women activists around the advocacy needs. All activists who advocate openly with HIV positive status, are intersecting with the Women Who Use Drugs and in Sex Work communities and has experience of imprisonment. "We have nothing to lose- we are former prisoners it says it all" –has been stated by one of the respondents. 65% of the respondents consider important to increase access to education and employment for women. 72,9% of the respondents state it's important to enhanced social protection for women and children while, All mentioned above confirming the importance of intersectoral and intersectional approach of multi-facet and complex issue that is violence in all its forms of expression.

3.4. MENTAL HEALTH AND HIV STATUS

When it comes to the mental health, it should be mentioned that the level of the stress among the cohort of the respondents is high even before HIV diagnosis, but level of depression (71%), feelings of rejection, including to accept one's diagnosis (68%) drastically increase right after the knowing the HIV positive status. The same trend is noticeable with Anxiety/fear/panic attacks (76%) Insomnia/ sleeping difficulty (67%), post-traumatic stress disorder (for example, nightmares) 61%, and suicidal feelings (23%) -highest levels shown right after knowing the status and being relatively less when time passes in line its acceptance. While feeling of loneliness (63%), low self-esteem shame (73%) and strong sense of isolation (63%) Anorexia/ eating difficulty (37%), difficulty going out and socializing (52%) impacts for the long period of time. It was mentioned several times that the biggest driving factor for the motivation to overcome the conditions was wellbeing of children in a long term and other beloved people for those not having children. (Table 3.4.1)

DRUG AND/OR ALCOHOL ABUSE

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1.02%	15.82%	11.22%	41.84%	25.51%

DEPRESSION

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
33.16%	64.29%	71.43%	1.53%	1.53%

SHAME

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
24.49%	42.86%	73.98%	5.10%	1.53%

SELF BLAME

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
24.49%	39.80%	48.47%	30.61%	2.04%

LOW SELF ESTEEM

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
26.02%	48.47%	65.31%	5.10%	1.53%

FEELINGS OF REJECTION, INCLUDING TO ACCEPT ONE'S DIAGNOSIS

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
0.51%	27.04%	68.37%	4.08%	0.51%

A STRONG SENSE OF ISOLATION (FROM FRIENDS, FAMILY, PARTNERS)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
0.00%	24.49%	62.76%	7.65%	3.06%

ANXIETY/FEAR/PANIC ATTACKS

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
30.10%	76.02%	50.51%	1.53%	0.00%

INSOMNIA/DIFFICULTY SLEEPING

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
29.59%	66.84%	47.96%	4.59%	1.02%

ANOREXIA/DIFFICULTY EATING				
Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
3.06%	9.18%	37.24%	38.78%	3.57%

DIFFICULTY GOING OUT AND SOCIALIZING				
Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1.02%	29.08%	52.04%	11.73%	2.04%

LONELINESS				
Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
5.10%	30.10%	43.37%	20.92%	1.53%

SUICIDAL FEELINGS				
Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
5.10%	23.47%	10.20%	56.12%	4.08%

POST TRAUMATIC STRESS DISORDER (FOR EXAMPLE, NIGHTMARES)				
Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
25.00%	61.22%	40.82%	11.73%	4.08%

Conclusions: The issue of mental health for women living with HIV is still relevant, despite the expansion of HIV treatment and care programs in Georgia. The respondents themselves emphasized the need for specialized assistance after being diagnosed, and considered women oriented and gender sensitive consultations including with the psychologists as really important. As for peer to-peer groups is considered as also important, but individual work with the psychologies is named as the one of the best methods of protecting their psychological health. In many cases, women's psychological health issues emerge before they are diagnosed with HIV and are accompanied by risky behaviors before the expectance of the status, which once again confirms vice versa correlation of vulnerability, violence and HIV.

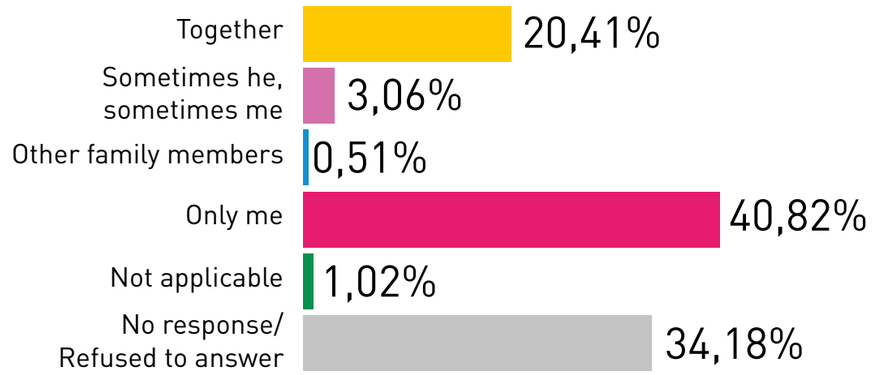
3.5 BURDEN OF CARE

Issues related to the daily lives of women living with HIV are an important component in understanding the lifestyle and health of the women, who usually bear the burden of caring for their own health and running their household. There is some level of independence/autonomy shown 40%[6] of the respondents stating they never are economically dependent on their partner.

41 % of the respondents state only they are busy with getting children ready to kindergarten/school in the morning; 68% of the respondents state only them cooking; 69% of the respondents state only they are involved in housecleaning. 54% of the respondents takes full charge on laundry and 70% of ironing. 26% of the respondents state only, their partner is visiting social services, officials, social security, pension fund, migration service, etc. (36 % of the respondents did not answer the question). 40 % of respondents state only they are attending parent-teacher conferences/children's events.

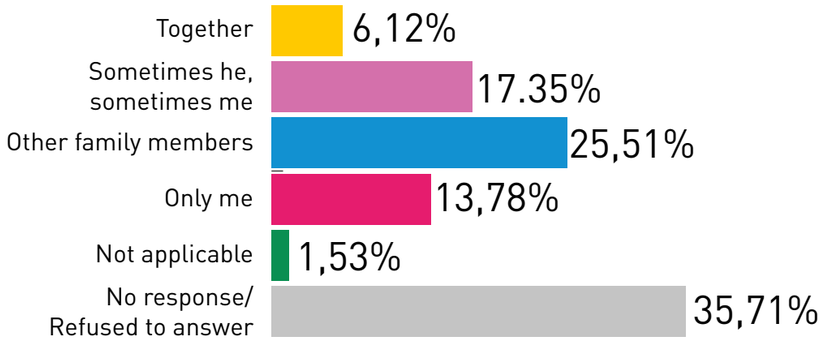
36% of the respondents visit a pediatrician/purchasing medicines for children alone, busy with purchase of household appliances, busy with organize of house parties. 41% of the respondents state only they are busy with purchase of foodstuffs/household chemical goods. 34% of the respondents state only they are busy with organize of parties outside the home. 23% of the respondents state they together implement family budget income distribution (58 % of the respondents did not answer the question). (Diagrams 3.5.1-3.5.5)

GETTING CHILDREN READY TO KINDERGARTEN/SCHOOL IN THE MORNING

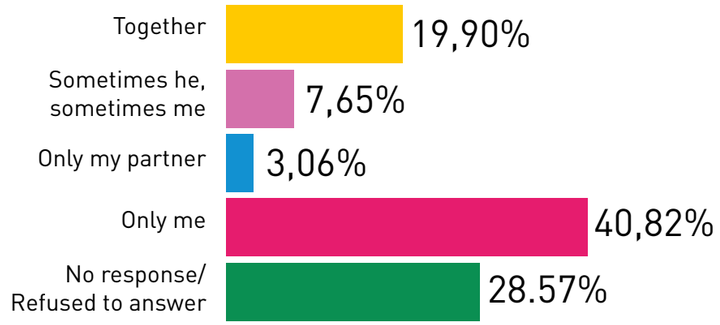


[6] *N of respondents 139*

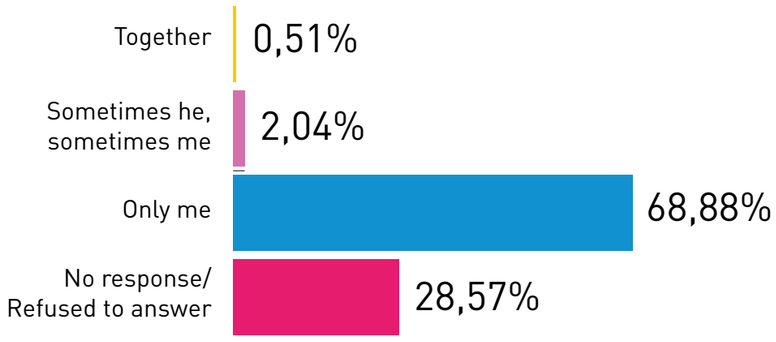
VISITING SOCIAL SERVICES, OFFICIALS, SOCIAL SECURITY, PENSION FUND, MIGRATION SERVICE, ETC



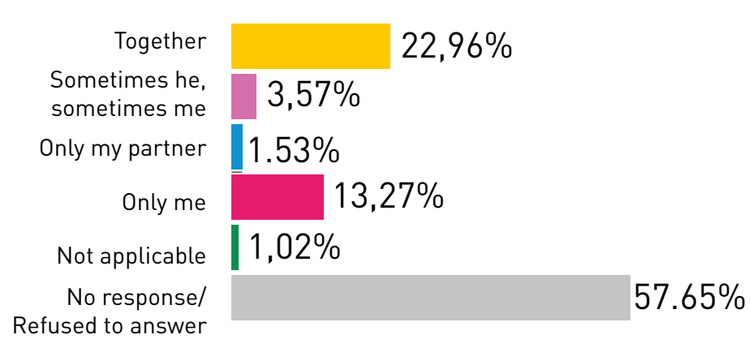
PURCHASE OF FOODSTUFFS/HOUSEHOLD CHEMICAL GOODS



HOUSECLEANING



FAMILY BUDGET INCOME DISTRIBUTION



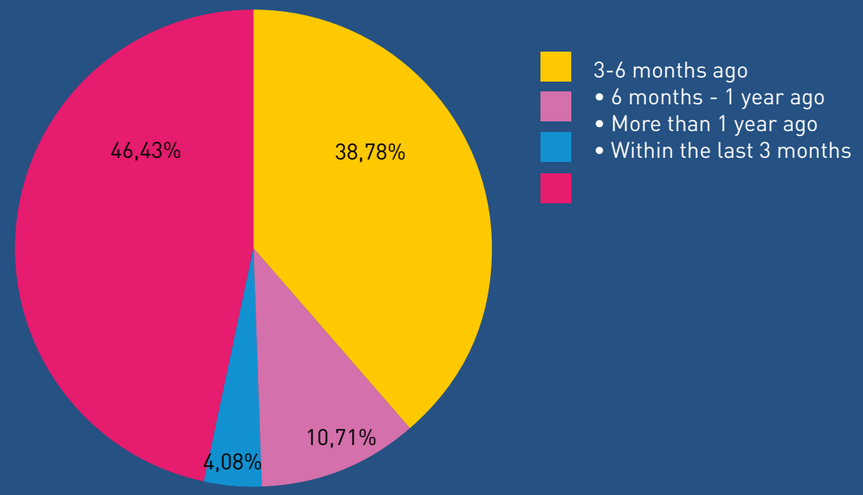
Only 20% of the respondents state their husband/partner takes care of them inside/outside the home/in the hospital on a regular bases. 71% of the respondents state they never receive child care financial assistance (government help), 69% of the respondents claim they never receive child care non-state support (charitable/public organizations). 75% of the respondents never receive support from the government to care for a sick husband/relative. Relatively less, 71% of the respondents state they never receive support from charitable/public organizations to care for a sick husband/relative including from community-based NGOs. The same trend is for children shared care. 34% of the respondents state only they take children from kindergarten/school in the evening. 52% of the respondents are busy with children's clothing shopping. 34% of the respondents state only they are responsible with payment of utility bills, same number of respondents are busy with visits to the hospital/communication with doctors/purchasing medicines for adult family members. 36% of the respondents state only they take care of sick children and adult members at home.

Conclusion: As most questions regarding household and lifestyle show, the way the burden of care is shared exposes entrenched gender stereotypes, as women perform the bulk of household chores by themselves, and men contribute when it is about money issues, big purchases, and the organization of leisure time, tendencies pretty much similar in the respective studies conducted within the EECA region. The burden of caring takes the physical and financial resources as well as place a heavier burden of family support and care on women and girls. Not only that affect access to services but, the intersection of poverty with gender inequality, makes women very vulnerable because of unequal access to economic resources, inequality in the sphere of work, including burden of care. Because of their economic dependence for some respondents, the need emerges to be involved in sex work and/or go in migration. Thus social support services should be added layer of support for removing service access barriers as well as influencing vulnerability determinants affecting burden of care distribution in short term. While in long term gender equality and empowerment mainstreaming in education and awareness raising interventions can be view as positive contributor.

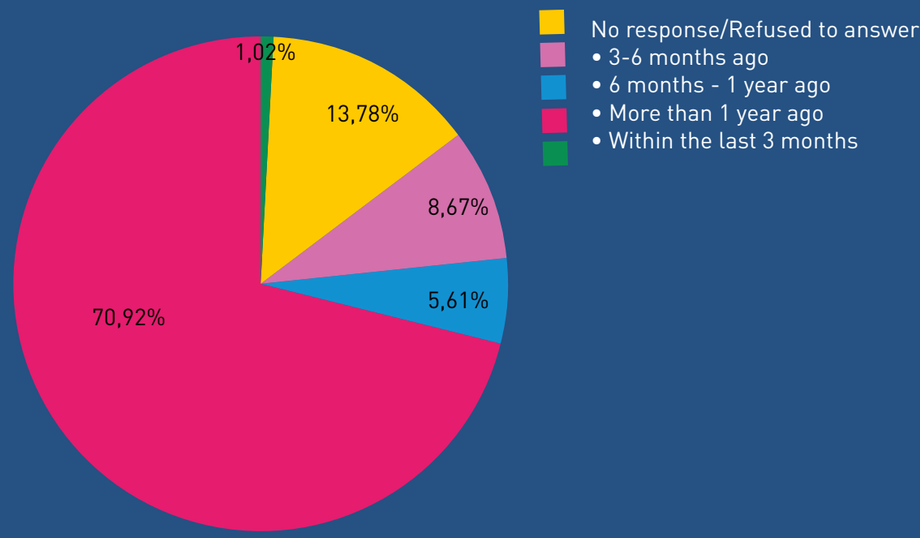
3.6. HIV TREATMENT, SIDE EFFECTS AND DIAGNOSTICS

The vast majority of respondents – 85.2% reported that they visited personal doctor within a year's time, 38.7% out of them stating last visit period from 3-to 6 months. That mostly corresponds to the visits due to the viral load checkup. Most of them (82%) can name the viral load, even if not mention the exact number respondents could mention the correlation between the viral load and their immune system condition. More than half were not able to name the drugs they are taking but vast majority mentioned they are taking them regularly. It should be mentioned adherence to the treatment is very good among women compared to men as stated in the general country statistics, the trend was confirmed through the research. (Diagram 3.6.1-3.6.2)

COUNT OF WHEN WAS YOUR LAST CHECK ON VIRAL LOAD?

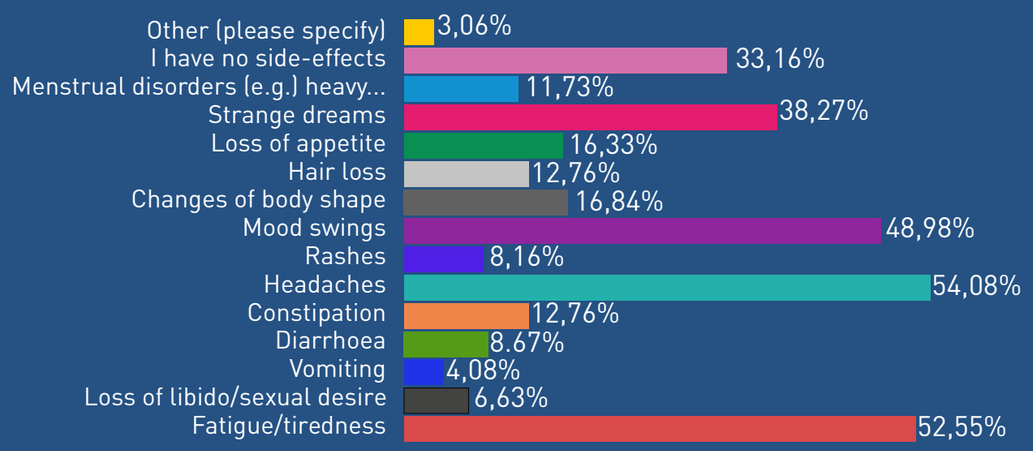


WHEN WAS YOUR LAST CHECK ON CD4 COUNT?



33.0% of women taking ART indicated the absence of side effects. Among the most common named are: headache – 54%, fatigue – 52.5%, mood swings – 49%, strange dreams- 38%. (Diagram 3.6.3)

DO YOU REGULARLY EXPERIENCE ANY OF THE FOLLOWING?

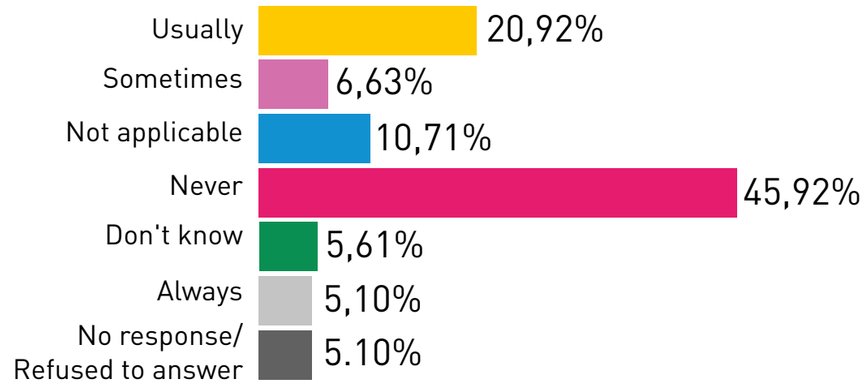


Conclusions: The treatment and adherence turn to be strong side of the national HIV programs, though only 33% mention not having any side effects at all the rest name conditions (33.0% of women taking ART indicated the absence of side effects. Among the most common named are: headache – 54%, fatigue – 52.5%, mood swings – 49%, strange dreams- 38%) that can be correlated to other factors that was also raised by the respondents during the focus group discussions. Pregnant women has good access to vertical transition program, showing good adherence, only 2,3% of women having positive children out of the cohort, and 83% out of them mentioned not taking ART while conception and pregnancy, the rest irregularly taking drugs, the trend related to mobility and respective access barriers.

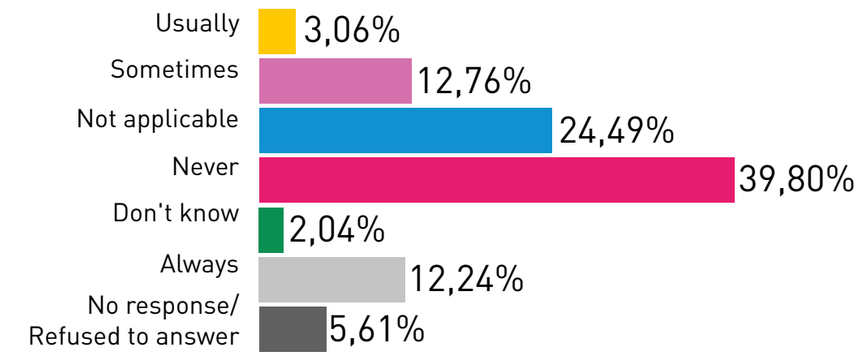
3.7. FINANCIAL ISSUES AFFECTING ACCESS TO SERVICES.

Overall, the survey participants have a certain level of access to higher education. Almost 40% depend on their partner to varying degrees. Under such circumstances, the women are vulnerable to economic and other forms of violence from their partner and are limited in their ability to take both financial and reproductive decisions. Only 42.8% of the respondents state they never have the opportunity to combine study and work (distance learning) without financial losses in wages. But at the same time it should be mentioned that 46 % of the respondents state they never have access to higher education. While 48 % of the respondents state they never had autonomy over their real estate or other property. (Diagrams 3.7.1 and 3.7.3)

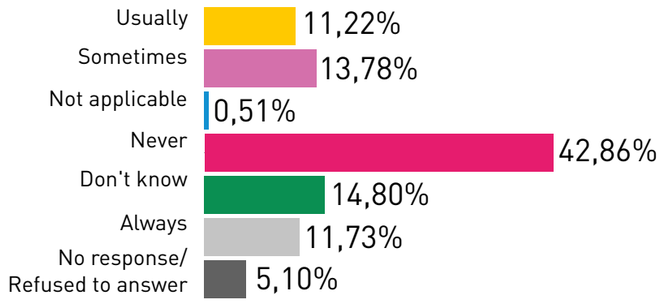
I HAVE ACCESS TO HIGHER EDUCATION



I AM ECONOMICALLY DEPENDENT ON MY PARTNER

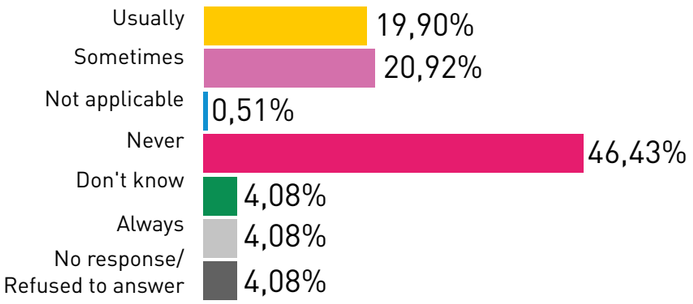


I HAVE THE OPPORTUNITY TO COMBINE STUDY AND WORK (DISTANCE LEARNING) WITHOUT FINANCIAL LOSSES IN WAGES

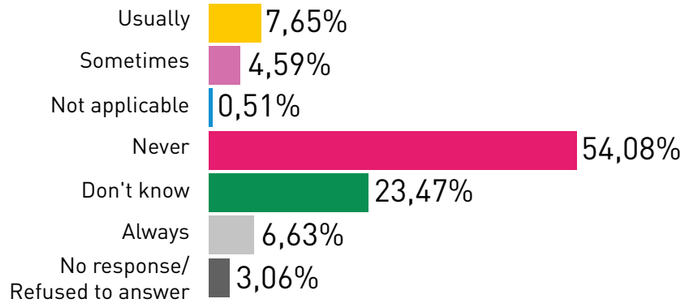


46% of the respondents state they never count on access to lending services in any bank in Georgia. 54% of the respondents state they never know how to start their own business if want to and they never owned real estate and other property or where to refer to start the own business. 34% of the respondents state that having a child has never affected their career path while 41% of the respondents state that having a child has not affected their income. Qualitative cross check shows the negative tendency of stated, as those women where already out of the market both for education and employment before children were born. (Diagrams 3.7.4 and 3.7.10)

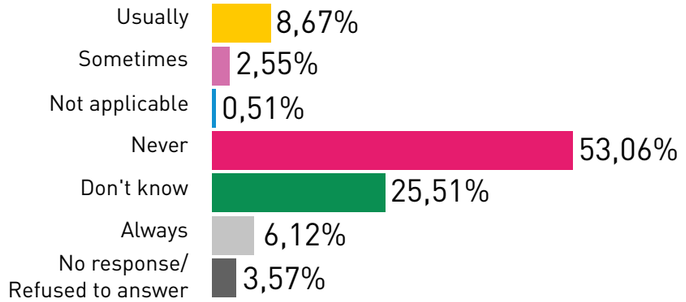
I HAVE ACCESS TO LENDING SERVICES IN ANY BANK IN GEORGIA



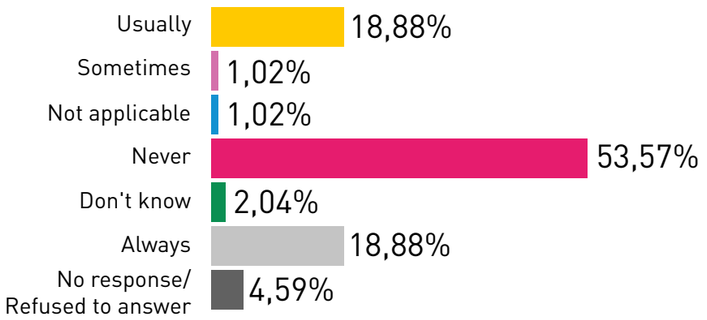
I KNOW HOW TO START MY OWN BUSINESS IF I WANT TO



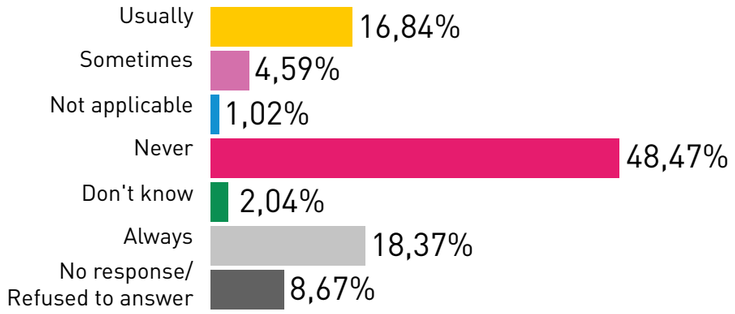
I KNOW WHERE TO ASK FOR HELP TO START MY OWN BUSINESS



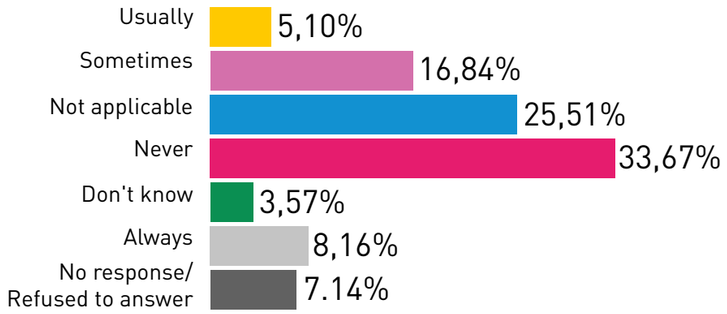
I OWN REAL ESTATE AND OTHER PROPERTY



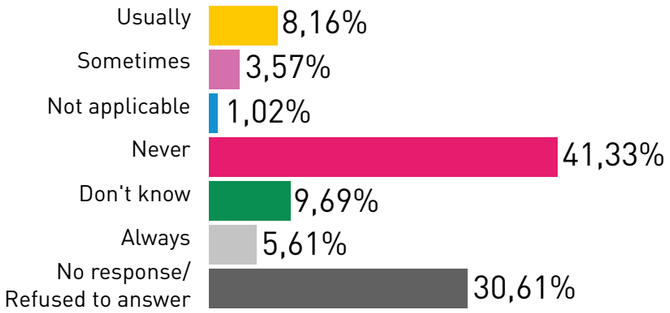
I HAVE AUTONOMY OVER MY REAL ESTATE OR OTHER PROPERTY



HAVING A CHILD HAS NOT AFFECTED MY CAREER PATH

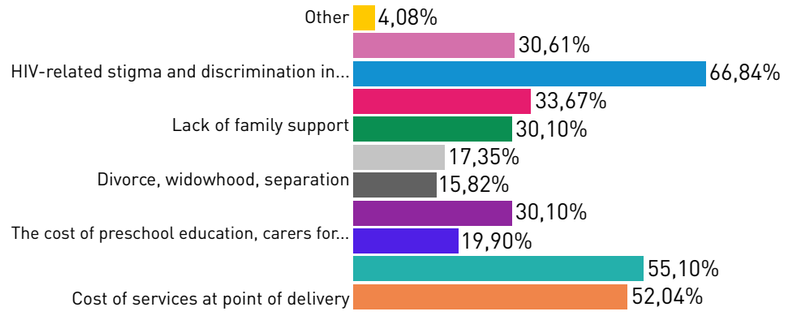


HAVING A CHILD HAS NOT AFFECTED MY INCOME



One of the biggest factors on access to SRHR services is HIV related stigma and discrimination at the workplace (66.8%). Many of the women named HIV related stigma in a wider context, but linked it to the workplace with the fear of the loosing of the job and respective income. Even the visits does not need to be that frequent, still 55% named cost of the travel as negative contributor as well as referral service costs (52%)[7]. Qualitative cross check reflected the issue, especially with the respondents from the regions as well as in regards to the covid19 context.
(Diagram 3.7.11)

ACCESS TO SERVICES. WHICH OF THESE ISSUES HAS THE BIGGEST IMPACT ON YOU OR OTHER WOMEN LIVING WITH HIV IN YOUR COMMUNITY TO ACCESS QUALITY SEXUAL AND REPRODUCTIVE HEALTH CARE AND WELL-BEING?



Concussion: Overall, the survey participants have a certain level of access to higher education, but still not well integrated in the working market, thus having some level of economically dependent on their partners or family members. Under such circumstances, the women are vulnerable to economic and other forms of violence as they are limited in their ability to take both financial and reproductive decisions. The employment support is poor, and there is a lack of opportunity to combine education and work without significant compromises and loses. Income and economic opportunities of half of the women surveyed do not have the knowledge and skills required to launch their own business not having access to the bank loans. Women generally do not own real estate or other property and/or do not take decisions about their real estate or other property. The share of the women who manage social benefits and child support is low and by the time they have children most of them are already out of the employment market, definitely putting those in more unfavorable position requiring more holistic support, on the one hand for women but also for their children through medical, social psychological perspective.

[7] *Note: Though mainstream services for HIV are free of charge, referral services are not any longer,SRHR never being part of it unless brief non sustainable NGO funds for small number of beneficiaries, reference to RPRV SAAF supported Medical Abortion Initiative.*

FOCUS GROUP DISCUSSIONS

To conduct surveys and discussions in 3 focus groups, 30 participants were engaged-all of them living with HIV. while almost every third involved in grassroots activism and/or service delivery and referral for more than 5 years. Unlike the quantitative research outcomes, that stressed medical and social support as the priority and not that much putting focus on the laws, policies and regulations, under focus group discussions, almost everyone mentioned the importance of having the policies in place that will ensure the provision of integrated HIV and sexual and reproductive health services and referrals.

The analysis of the responses of the focus group participants made it possible to structure the factors that help women from different groups gain full access to sexual and reproductive health and human rights services,. Treatment and support are decisive for full access to sexual and reproductive health services and related care when needed such as hepatitis C and/or tuberculosis, as well as special access to information and services for women with disabilities. Also, the issues of rights enforcement and improving access received the most support to services for HIV-positive women in prisons or in custody, including the full protection of their rights and keeping communication in line with integrity and dignity. Violence and discrimination against sex workers is worth mentioning. It is important to note that, a significant proportion of participants in focus group studies, regardless of their own belonging to a socially stigmatized group of women living with HIV, claim the importance of policies aimed at helping the most vulnerable categories of HIV-positive women, belonging queer women, those in sex work and/or using drugs, young people with the disabilities or mobile due to various context. Inclusiveness and the rights based approach should work for everyone.

Elimination of restrictive policies related to various variables as health status, age; access to methadone or buprenorphine for women living with HIV who use drugs, and pregnant women; services from sexual and reproductive health especially for queer women or other women living with HIV who have sex, those with disability or different mobility status, was stated as one of the most important, that differs the outcomes of quantitative part That can actually be explained by the fact activists and advocacy specialists where biggest part for the research qualitative component, them already having the knowledge and understanding the importance of the legal support before moving to the practices. It relates to various fields namely: comprehensive sexual education, special access to information and services for women with disabilities, access to treatment and support of adherence for women in prisons or in custody among all, stigma and discrimination on the one hand in connection with HIV on the other deal with intersectional stigmas, implementation of modern practical guidelines related to treatment and access to SRHR for all women mentioned at all possible and convenient settings.

Respondents quotes according to the research domain but pretty much intersecting:

Experience of using sexual and reproductive health services. Experience in observance of human rights in healthcare and access to justice.

"You know what is the hardest part, gynecologist telling you may be to go for abortion, and I know she is not for it in general. Well finally I feel she is at my side, supports me but why you need to mention this at first when I already share my feelings, that I already said that I want to have another baby... it is so painful."

Healthy sex-life, access to sexual health services

"We were forbidden to think and feel, I have older brother and everything was ok for him, but I could not even think about having a partner, it was so hard afterwards, I was intimidated even by my husband. So it is awkward that anyone ask me about please or what I feel in general, it is so unusual. I think it is something we need to get used to.... think about sexual desires".

Pregnancy, access to family planning and vertical transmission

"It was never easy, I mean when I was not HIV positive, I remember first time I need abortion, could hardly make it. But now there are so many things in my mind, and not only money issue, I am usually worried how any drug can influence, me being on treatment, having already burdened my body. My doctor (Note: personal doctor managing ART regimen) cannot know everything right, it is just not possible, but with the others I do not want to mention all those questions, I have no trust, do not want them to know I am positive".

Violence against women living with HIV

"He was physically violent, especially if drunk, but what I remember the best, first time he told me I was ugly and no one ever would look at me and I believed. When I had the courage to fight back once, telling that all what happened to me was his fault, he told me that was the price I paid for him being with me. I left him right away".

Mental health and HIV status

"I never had high self-esteem, even medium I guess. Even in childhood I was never clever enough, beautiful enough, I believed to be loved least among my siblings, that is why I guess I was depressed all the time and behaved harshly. My partner was the only one showing some affection to me, so I did not care that happened, he loves me, our daughter and when I felt like not handling any more, I immediately start thinking about them. They need me, in many ways, so I need to be strong there is no other way. I got used to live like that you know. I am depressed but strong and still live with hope."

Burden of care

"Are you kidding, is there any man doing anything at home? Really? I know no one, a single man who does anything at home. They used to work and bring money, now even that is not happening. Yes but try to do anything without their opinion...that is where there are the best , in thinking how to spend money you earned working like a donkey". (Note: Georgian expression denoting hard, non-stop work)

HIV treatment, side effects and diagnostics

"The treatment goes well, I regularly go to doctor for the checkups, now after prison it is ok, I care about nothing if I meet anyone I know, you have no confidentiality after prison, everyone know everything, the worst already happened."

Financial issues affecting access to services

"My job is everything to me, I have no idea, what happens if anyone knows I am HIV positive, I work in hospitality, I am sure I will have problems. I need the job, no one supports me, even if I miss a day that means I might not be able to feed my family. Thanks god I can still work that hard physically at my age. I know that can be once in three months but sometimes I shift my visit to doctor because, yes, not a single day I have not working recently and if not work that lots of staff to do at home. I do not know about laws, but I am sure women like me should have some financial support, especially if they have small children, I have no idea what I would have done if my children were in the age when they need physical presence all the time."

RECOMMENDATIONS:

HIV testing and counselling is the entry point to HIV-related care and support, including antiretroviral therapy. Knowledge of HIV status is essential for tailoring reproductive health care and counselling according to the HIV status of women and to assist in making informed decisions on the number, spacing and timing of pregnancies, use of contraceptive methods and infant-feeding practices. Information and counselling are critical components of all sexual and reproductive health services and support women in making these decisions and carrying them out safely and voluntarily. Complex factors of sexual and reproductive health of women living with HIV affect whether women's expression and experience of sexuality lead to sexual health and well-being or place them at risk of ill-health. High quality programs and services that address sexuality positively and promote the sexual health of women living with HIV are essential for safe and satisfying sexual lives. Violence, including sexual violence against women, is strongly correlated with women's risk of becoming infected with HIV. Violence against a woman can interfere with ability to access treatment and care, maintain adherence to antiretroviral therapy have access to basic SRHR services. Health services, including those focusing on HIV treatment, care and prevention, should be an entry point for identifying and responding to women who experience violence. Helping women living with HIV avoid unwanted pregnancies as well as protect them from Sexually Transmitted infections is a fundament right including access to information and services regarding dual protection. Specific recommendations of contraceptive methods individualized for each woman based on condition, treatment and desires and comfort also taken into account. Women living with HIV must safely and effectively use most contraceptive methods. Women living with HIV should have access to stigma free and friendly services when it comes to abortion including medical abortion. Quality and friendly service implies ability of communication of the service provider based on the intersectional needs women living with HIV might have.

Below recommendation are segregated according to the advocacy target audience, but at the same time can be cross cutting and needs intersectoral and intersectional coordination.

Recommendation for Ministry of Internally Displaced persons from Occupied Territories, Labor, Health and Social affairs:

- Ensure systems in place supporting capacity building and accountability level of health workers at health-care facilities, so that they provide high-quality services based on dignity, respect and non-discrimination for girls and women living with HIV throughout their lives to eliminate biased interactions affecting access to services
- Build enabling patient/client oriented environment for available, quality, affordable and accessible counselling and information to assist women to understand their own rights and SRH options in terms of their individual and various needs
- Guarantee universal safety measures in all medical facilities (for example, sterilization or use of new equipment for each patient, regardless of the HIV status of the previous patient)
- Support with the social packages (coverage of transportation and/or care related expenses) increasing access to SRHR services.
- Integrate Sexually transmitted infection (STI) and family planning services HIV care settings
- Provide access to a full range of age-appropriate contraceptives, including morning after pills and access to safe abortion for HIV+ women in all need settings including prisons and Harm reduction service points with flexible hours
- Provide services taking into account the relationship between antiretroviral therapy (ART) and family planning options
- Study and provide services taking into account (understanding) the impact of HIV and/or ART on libido and sexual satisfaction of women living with HIV at all stages of life
- Study and provide services with an understanding of how HIV and/or ART cause menstrual cycle disorders, including the occurrence of heavy/irregular/long/painful menstruation; and other gynecological issues, including fibroids
- To study and provide services with an understanding of how HIV and/or adherence to ART affect the onset, course and duration of menopause in women, living with HIV

mental health issues faced by girls and women living with HIV (including chronic anxiety and depression) in service planning and delivery

- Implement reliable and up-to-date recommendations on pleasurable sex and the possibility of conceiving a child in couples with the same or different HIV status
- Support in child care, regardless of children's HIV status
- Ensure immediate first-line support for women who have experienced intimate partner violence and sexual assault
- Ensure integrated care for women experiencing intimate partner violence within existing health services rather than as a stand-alone service especially at the bases of the state or NGO run shelters the staff of which needs to know how to address the need of women living with HIV, those who use drugs or have experience of sex work.
- Provide training of health-care providers in sexual health knowledge and in the skills of Brief Sexually related Communication and Harm reduction
- Ensure systems in place that support only voluntary disclosure of the status and maintaining confidentiality principle
- Ensure interventions and services supporting women living with HIV, especially those using drugs or in sex work who are considering voluntary HIV disclosure should include discussions about the challenges of their current situation, the potential associated risk of violence, facilitating disclose more safely, and linking to available violence prevention and care services
- Promote and provide the participation of sexual partners (men and/or women) in access to sexual and reproductive health services for HIV+ women (for example, HIV counseling and testing of couples, status disclosure, family planning, mental health)
- Promote and provide sexual health, well-being, safety and sexual satisfaction including of promoting dual protection and access to PreP, PeP, as well as sexologist and psychologies support where needed
- Routinely promote and provide breast and cervical cancer screening and HPV vaccination among young HIV positive women as well as monitoring of the referral
- Increase awareness and build referral to safe abortion services including Medical Abortion for women living with HIV and using drug putting focus on no harm of drug/substance interaction
- Integrate SRHR services in universal insurance packages
- Ensure all respective services, HIV treatment, SRH, antenatal and maternal health, harm reduction is in line with the WHO latest evidence based standards and in line with the other intersectional vulnerability determinants as age, mobility, co infection management, gender identity and expression, sexual orientation, disability, imprisonment etc.
- Integrate SRHR services in universal insurance packages
- Ensure all respective services, HIV treatment, SRH, antenatal and maternal health, harm reduction is in line with the WHO latest evidence based standards and in line with the other intersectional vulnerability determinants as age, mobility, co infection management, gender identity and expression, sexual orientation, disability, imprisonment etc.

Recommendation to Law Enforcement Agencies:

- Decriminalize the transmission of, non-disclosure of HIV status
- Decriminalize the drug use and undertake reforms regarding low level drug use offending especially taking into account vulnerabilities women face
- Decriminalize organizing and/or managing sexual services and abolish punitive and/or administrative regulation of sex work
- Enforce privacy protection and institute policy, laws and norms that prevent discrimination and promote tolerance and acceptance of people living with HIV
- Endorse programs for educating representative of law enforcement agencies on public health, gender sensitive, and women centered approaches when it comes to HIV, drug use, harm reduction and sex work to recognize and uphold the human rights of key populations and to be held accountable if they violate these rights, including perpetration of violence
- Build the networking, cooperation and referral among health, women rights and justice institutions, allowing community visits and seminars on rights based approach
- Adopt right based and public health approach when working with women living with HIV, using drugs and in sex work
- Endorse programs on preventing violence against

women via partnership with community-led organi zations

- Monitor violence against women through community reporting and redress mechanisms to provide justice
- Provide/make referral to all persons who experience violence. In particular, persons experiencing sexual violence should have timely access to comprehensi ve post-rape care in accordance with WHO guidelines
- Provide legal literacy and legal services vulnerable and marginalized women so that they know their rights and applicable laws and can receive support from the justice system

Recommendation to Ministry of Education and Science of Georgia:

- To improve access to age-appropriate Comprehensi ve Sexuality (CSE) Education at schools
- Support provision of Comprehensive Sexuality to- pics though lifetime by Civil Society Organizations for groups having no access to CSE irrespective their age
- Implement awareness raising and educational inter- ventions to shift social norms relating to violence, stigma, heritage through various subjects including "Society and Me"
- Coordinate with Media and Civil society groups for joint activities on awareness raising and educational interventions to shift social norms relating to violen- ce, stigma, heritage etc.

Recommendations to CSOs:

- Advocate and lobby for the recommendations /advo- cacy asks drafted under the sections dedicated to MoH, MoE, LEA etc
- Build capacity of the community of women living with HIV and the development of peer-to-peer services/ interventions
- Provide job orientation and skill building interventi- ons for women living with HIV
- Advocate for the initiatives and coordinate with Banks and local businesses to provide entrepreneurship pro- jects and respective loans for women living with HIV
- Provide psychosocial support interventions, such as support groups and peer support, provided by, with, and for women living with HIV
- Coordinate with Media for joint activities on awaren- ess raising and educational interventions to shift so- cial norms relating to violence, stigma, heritage etc.
- Conduct women empowerment intervention suppor - ting participation of women living with HIV in the de- signing and delivery of SRHR services
- Provide social support and home care services in co- ordination with the local municipalities
- Built networking and referral among donor/state fun- ded HIV/ SRHR /Harm reduction / IPV prevention services.

Recommendation to CCM/The Global Fund:

- Integrate Funding for contraception, safe abortion and STIs treatment for women living with HIV, for wo- men who use drugs and in sex work, also affected by TB as well as sexual partners of drug users in the national HIV/TB programs

USEFUL LINKS:

» **Eurasian Women's Network on A**
https://ewna.org/

» **Georgian Union of PLHIV "Real People Real Vision" (LIFE2.0)**
https://www.lifetwo0.org/

» **Georgian AIDS and Clinical Immunology Research Center**
https://www.aidscenter.ge/

» **Georgian National HIV strategy plan 2019-2022**
http://www.georgia-ccm.ge/wp-content/uploads/Georgia-HIV-AIDS-National-Strategic-Plan-2019-20222.pdf

» **Country Coordinating Mechanism (CCM) in Georgia**
http://www.georgia-ccm.ge/?page_id=1830&lang=en

» **Women Fund in Georgia**
https://www.womenfundgeorgia.org/en/Main

» **Georgian Harm Reduction Network**
https://ghrn.ge/news.php?lang=eng

» **Tanadgoma**
https://tanadgoma.ge/

» **Committee on the Elimination of Discrimination against Women**
https://www.ohchr.org/en/treaty-bodies/cedaw

» **SRHR in Georgia /UNFPA**
https://georgia.unfpa.org/ka/topics

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» **Moroz, S. (2017) Human Rights of Women Living with HIV in Ukraine. Retrieved from**
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» **Georgian National HIV strategy plan 2019-2022**
http://www.georgia-ccm.ge/wp-content/uploads/Georgia-HIV-AIDS-National-Strategic-Plan-2019-20222.pdf

» **Georgian AIDS and Clinical Immunology Research Center. logical data October 2022 Retrieved from**
https://aidscenter.ge/epidsituation_eng.html

ANNEX 1

Basic questionnaire for the quantitative research

Eurasian Women`s Network on AIDS

THIS QUESTION REQUIRES AN ANSWER.

1.I understand that filling in the survey,I give my consent for my responses to be used in publications.
Please, highlight "I agree" to be able to continue

1	I agree	You continue the survey
2	I disagree	The survey is over

THIS QUESTION REQUIRES AN ANSWER.

2. I am a woman living with HIV.
Please, highlight "I agree" to be able to continue

1	Yes	You continue the survey
2	No	The survey is over

PART 1 – PERSONAL DATA

Please tell us about yourself.

1. Country where I am living now	2. City, village	3. Age

4. Relationship Status
Please highlight one answer:

1. I am not sexually active
2. I am sexually active, but do not have a partner
3. I have one or more partner(s) living with HIV
4. I have one or more partner(s) not living with HIV
5. I have two or more sexual partners, one or more is living with HIV and one or more is not living with HIV

5. Special issues.
Please highlight all that apply to you:

1. I do or have done sex work
2. I inject/use or have injected/used drugs
3. My sexual partner(s) injects/uses or has injected/used drugs
4. I am/have been a client of opioid substitution therapy programme
5. I am/have been in prison
6. I am/have been in a detention centre
7. I am living with disability
8. I have or have had active TB
9. I have or have had Hepatitis C
10. I migrated from one country to another for economic reasons
11. I migrated from one country to another for political reasons
12. I am lesbian, bisexual or have sex with women
13. I am a trans woman
14. I am a heterosexual woman
15. I am married, or in a stable relationship
16. I am an internally displaced person
17. I am or have been homeless
18. Other (optional) _____

6. Marital status

1. Single
2. Married
3. In a civil marriage
4. Divorced
5. Widow

7. I have _____children,

1. of whom I gave birth to _____children, having and HIV-positive status,

2. of whom _____ children have HIV.

8. I learned about my HIV status during pregnancy:
YES _____
NO _____

9. Education
1. Lower secondary education
2. Secondary education
3. Incomplete higher education
4. Higher education

10. Occupation
1. Student
2. Employed in the commercial sphere
3. Civil servant
4. Entrepreneur
5. Unemployed
6. Housewife
7. Retiree. The amount of the pension _____
8. Other _____

11. I am _____ employed

1. Officially
2. Unofficially
3. Unemployed

PART 2 - HUMAN RIGHTS

12. Please tell us about your experience of accessing sexual and reproductive health services as a woman living with HIV

(Please choose one answer for each statement and mark with an X)

No.	Statement	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
1	I experience the same service as any other women, when I go for sexual and reproductive health services	1	2	3	4	98
2	I am aware of sexual and reproductive health treatments, information, services and commodities that exist in my country	1	2	3	4	98
3	I can get free and quality sexual and reproductive health treatments, information, services or commodities, when I need them	1	2	3	4	98
4	I find the service providers well-trained and knowledgeable, friendly, and supportive	1	2	3	4	98
5	My experience of accessing sexual and reproductive health care has been good, and I have confidence in the advice and treatment I receive	1	2	3	4	98
6	I believe my service provider offers a full range of choices for sexual and reproductive health care, including family planning options and prevention, diagnosis and treatment of sexually transmitted infections (STIs)	1	2	3	4	98
7	I am given all the information I need to make a decision about proceeding with a service or treatment, without feeling any pressure from the service provider	1	2	3	4	98
8	I trust the service providers not to share my HIV status or any other details about me without my permission	1	2	3	4	98
9	My doctor listens to me, and gives advice based on my needs and realities as a women living with HIV	1	2	3	4	98
10	I know my rights, and if I experience a rights violation within the health service, I know where I can go to make a complaint	1	2	3	4	98
11	If my rights as a woman living with HIV are violated, I know that I will receive the necessary legal protection	1	2	3	4	98

13. Please feel free to give more information on your experience of accessing your sexual and reproductive health and human rights if you would like to

14. What would you like to say to decision makers and policy makers in Georgia about how they can help to promote and protect your sexual and reproductive health and human rights? Please try to be as specific as possible

15. What are the most important issues that you would like to see addressed in the legal and normative acts in order to make them the most useful tool? Please be as specific as possible

PART 3 – CONTEXT AND REALITIES FOR WOMEN LIVING WITH HIV

3.1. Healthy sex life

Women living with HIV have the same right and possibility as all women to enjoy a healthy, safe and satisfying sex life, free from force, coercion, discrimination or violence.

16. Please tell us about your sex experience

(Please choose one answer for each statement and mark with

No.	Statement	Always	Usually	Sometimes	Never	Don't know	Not applicable
1	I want to have sex often/have strong feelings of sexual desire	1	2	3	4	98	99
2	I find sex pleasurable for myself and for my partner(s)	1	2	3	4	98	99
3	I have sex to satisfy my partner	1	2	3	4	98	99
4	I initiate sex with my partner(s) and make suggestions about how we have sex	1	2	3	4	98	99
5	I have sex when I want to	1	2	3	4	98	99
6	I have sex when my partner(s) want(s) to	1	2	3	4	98	99
7	I find it easy to "come"/have an orgasm during sex	1	2	3	4	98	99
8	My body makes enough lubrication (how "wet" you feel when you want to have sex)	1	2	3	4	98	99
9	I know where I can get information on sexually transmitted infections, safer sex, condom use, and contraception	1	2	3	4	98	99
10	I am able to have sex without fear of getting any sexually transmitted infections (STIs) from my partner	1	2	3	4	98	99
11	If I have an STI I am able to get diagnosis and treatment for it without fear of judgement from the health provider	1	2	3	4	98	99
12	I am able to have sex without fear of getting pregnant	1	2	3	4	98	99
13	I am able to have sex without fear of passing on HIV to my partner(s)	1	2	3	4	98	99
14	I feel safe with my partner(s)	1	2	3	4	98	99
15	I am able to talk to my health care provider about my sexual health and needs	1	2	3	4	98	99
16	I am able to access the products I need to have a good sex life (e.g. lubricants, dental dams, female condoms, male condoms, contraceptives)	1	2	3	4	98	99
17	I can afford to buy the products I need to have a good sex life (see above)	1	2	3	4	98	99
18	I am able to discuss in a friendly manner my HIV status with my partner(s)	1	2	3	4	98	99
19	My partner is happy to use a male condom if I want him to	1	2	3	4	98	99
20	I am able to use a female condom if I want to	1	2	3	4	98	99

17. As a woman living with HIV, what has helped you MOST to achieve a satisfying and enjoyable sex life?

18. What has been the BIGGEST barrier to you enjoying a satisfying sex life, or what do you think most urgently needs to change?

19. What would improve your sexual health, safety, well-being and pleasure? (These could be psychological, physical, sexual, spiritual financial, legal and/or institutional support – or something else. It's entirely up to you.) Please try to be as specific as possible.

3.2. Pregnancy and fertility

As women living with HIV, we have the same right as all women to make choices about when and whether we would like to have children, and to do this in a safe, informed and supportive environment, knowing that we can be healthy mothers to healthy children - or can be supported in our choice not to have children if we don't want to.

20. Please tell us about your experiences of pregnancy and fertility as an HIV-positive woman

(Please choose one answer for each statement and mark with an X)

No.	Statement	Yes	No	Don't know	Not applicable
1	I have been supported by my partner(s) to make choices about my fertility (to decide whether or not to have a child/ children)	1	2	98	99
2	I have been supported my by health provider to make choices about my fertility	1	2	98	99
3	I have been supported by my family and community to make choices about my fertility	1	2	98	99
4	I have been given advice about safe conception (getting pregnant without putting myself or my partner at risk of transmission of HIV or other sexually transmitted infections)	1	2	98	99
5	I have been given support with safe conception (without putting myself or my partner at risk of transmission of HIV or other sexually transmitted infections)	1	2	98	99
6	I can talk to my doctor/service provider about my fertility desires	1	2	98	99
7	I have been/am able to access free infertility treatment, assisted reproductive technology if I need it (e.g. I.V.F.)	1	2	98	99
8	I have chosen to test for HIV during pregnancy	1	2	98	99
9	I was given adequate counselling before and after the test for HIV	1	2	98	99
10	I have been given counselling on family planning and advice on child spacing	1	2	98	99
11	I have had one or more unplanned pregnancy	1	2	98	99
12	I have been given advice on how to disclose my HIV status to my partner(s) and my children	1	2	98	99
13	I have access to safe and free or affordable abortion, if I need it	1	2	98	99
14	I have access to post-abortion/-miscarriage care, if I need it	1	2	98	99
15	I know I can speak to other women living with HIV who will give me advice on healthy motherhood if I want to	1	2	98	99
16	I have been able to make choices about where I want to deliver my baby	1	2	98	99
17	I have been supported to make decisions about how to feed my baby without fear of what people will say	1	2	98	99
18	I can decide to have a(nother) child without fear of what people will say	1	2	98	99
19	I can decide NOT to have a(nother) child without fear of what people will say	1	2	98	99
20	I can access the family planning/contraception that I prefer	1	2	98	99
21	I am able to use the family planning/contraception that I prefer without resistance from my partner(s)	1	2	98	99
22	I have access to emergency contraception (the morning-after pill) if I need it	1	2	98	99
23	I can access legal counselling on adoption choices	1	2	98	99
24	I can access pre-exposure prophylaxis, if my partner needs it	1	2	98	99
25	I can access post-exposure prophylaxis, if I need it	1	2	98	99
26	I have regular check-ups/Pap smears for early detection of cervical cancer	1	2	98	99
27	I do regular breast screening	1	2	98	99

21. Prevention of mother-to-child transmission of HIV

No.	Statement	Yes	No	Don't know	Not applicable
1	I took ARV at the time of conception	1	2	98	99
2	I started taking ARV as a prophylaxis during pregnancy	1	2	98	99
3	I did not take ARV throughout my pregnancy	1	2	98	99
4	I took ARV only in childbirth	1	2	98	99
5	My child took syrup in the first days of his/her life	1	2	98	99
6	I am provided with artificial formulas by the children's polyclinic/AIDS Centre	1	2	98	99
7	My baby had a PCR before he/she was 2 months old	1	2	98	99

22. Describe the BEST experience you have had to support your decisions and desires about having children – or not having children

23. What has been the BIGGEST barrier for you to make choices about you fertility desires?

24. What would improve your reproductive health and human rights?
(Psychological, physical, sexual, spiritual financial, legal and/or institutional support – or something else)**. Please try to be as specific as possible.**

3.3. Violence against women

25. I have experienced violence from a sexual partner or spouse
(please mark all the answers that apply with an X)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

B: Violence from a member of my family/neighbours
could include: refusing to share food/utensils; name-calling; blame; rejection; abandon ment; physical violence like hitting, kicking, or pulling hair; a member of the family or neighbour touching, kissing or making you have sex when you don't want to.

26. I have experienced violence from a member of my family/neighbours
(please mark all the answers that apply with an X)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

C: Violence in the community
could include: gossip, bad words, rejection, avoidance, children being stigmatized or avoided; being attacked or beaten by a stranger; being touched or made to have sex with someone who is not your partner when you don't want to; being raped because of your sexual orientation or gender identity ("corrective rape"); hate-motivated violence against trans women; any form of violence against sex workers by clients or strangers.

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

27. I have experienced violence in the community
(please mark all the answers that apply with an X)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

D: Violence in a health setting

could include: rude or judgmental service providers; denial of medical care; being asked how you came to be HIV-positive; disclosing your status without your consent; making you take an HIV test wit hout telling you or without asking for your consent; refusing to give you all the information about available services; forced/coerced abortion or sterilization; making you wait until other clients have been seen; being refused a certain type of contraceptive, even when it is available; placing in separate or isolated rooms.

28. I have experienced violence in health settings
(please mark all the answers that apply with an X)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

E: Violence from the police/military/prison or detention services

could include: police harassment; arrest without giving a reason, or because you are carrying con doms, lubricant or clean injection equipment; threat of or actual sexual violence or rape by police, pri son/detention guards, military personnel; denial of health care in prison or detention; disclosure of HIV status; refusal to provide services.

29. I have experienced violence from the police/military/prison or detention services
(please mark all the answers that apply with an X)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

30. I have experienced fear of any form of violence
(please mark all the answers that apply with an X)

Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	2	3	4	98

31. Please tell us about any of these experiences of violence in more detail.

32. If you have experienced any of these forms of violence, were you able to access support services, and did they help you to deal with the situation/experience?

33. What do you think are the most important ways to address or prevent these forms of violence?
(Please choose one answer for each statement and mark with an X)

No.	Statement	Critical	Important	Less important	Don't know
1	Remove laws which criminalise sex work	1	2	3	98
2	Remove laws which criminalise drug possession	1	2	3	98
3	Remove laws which criminalize HIV exposure/transmission	1	2	3	98
4	Ensure access to free rehabilitation and addiction treatment (alcohol, drugs)	1	2	3	98
5	Increase access to education and employment for women (entrepreneurship education, vocational training, scholarships, free courses, interaction with employment centres)	1	2	3	98
6	Provide for enhanced social protection for women and children (social benefits, free infant formula, prescriptions for free medicines, health resorts, especially for children with disabilities)	1	2	3	98
7	Ensure the availability of pre-school education (eliminate turns in kindergartens)	1	2	3	98
8	Increase access to harm reduction programmes28 for women who use drugs and sex workers by providing women-centred services	1	2	3	98

9	Focus the attention of healthcare workers on the rights of women living with HIV (through training of health-care workers on working with HIV+ women, introduction of courses in medical schools/institutes/universities, conducting trainings in hospitals and polyclinics)	1	2	3	98
10	Increase access to quality support services for women survivors of violence (including sexual violence):				
10.1	Centres/shelters with the possibility of round-the-clock accommodation, including with children	1	2	3	98
10.2	Centres/shelters with the possibility of round-the-clock accommodation, including with children and for women who use drugs, sex workers and/or OST patients	1	2	3	98
10.3	24/7 hotline	1	2	3	98
10.4	Support groups	1	2	3	98
10.5	Professional counselling (doctor, psychotherapist, lawyer, social worker)	1	2	3	98
11	Provide a minimum free support after rape including post-exposure prophylaxis, emergency contraception, STI screening, social assistance and counselling	1	2	3	98
12	Provide legal protection against all forms of violence against women (free attorneys to handle litigations, street lawyers for women who use drugs and sex workers, mobile response teams, engagement with law enforcement to reduce police violence)	1	2	3	98
13	Recognize and address the issue of marital and date rape (analyze, build evidence, conduct education campaigns)	1	2	3	98
14	Provide effective mechanisms for filing complaints and redress in case of violation of rights in the healthcare service (hotline of the Ministry of Health of Georgia or the oblast department of health, monitoring of violations and reports of public/patient organisations to coordination/supervisory boards)	1	2	3	98
15	Other (please specify_____)	1	2	3	98

3.4. Mental health and HIV

Many women living with HIV experience mental health problems, and this can impact on our ability to have a healthy sex life and about ability to make choices about our fertility desires and to claim our human rights.
Please think about whether you have experienced any of the following for extended periods of time – i.e. more than the usual "ups and downs" of life.

34. I have experienced extended periods of:

(choose the answer for each issue)

No.	Statement	Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don' t know
1	Depression	1	2	3	4	98
2	Shame	1	2	3	4	98
3	Self blame	1	2	3	4	98
4	Low self esteem	1	2	3	4	98
5	Feelings of rejection, including to accept one's diagnosis	1	2	3	4	98
6	A strong sense of isolation (from friends, family, partners)	1	2	3	4	98
7	Anxiety/fear/panic attacks	1	2	3	4	98
8	Insomnia/difficulty sleeping	1	2	3	4	98
9	Anorexia/difficulty eating	1	2	3	4	98
10	Difficulty going out and socializing	1	2	3	4	98
11	Loneliness	1	2	3	4	98
12	Suicidal feelings	1	2	3	4	98
13	Post traumatic stress disorder (forexample, nightmares)	1	2	3	4	98
14	Drug and/or alcohol abuse	1	2	3	4	98

35. Please tell us more about the impact of these experiences on your sexual and reproductive health and human rights

36. What do you think is the best way of supporting women living with HIV to deal with mental health issues?

3.5. Burden of care

36.1 The burden of care for other family members often falls on the shoulders of women living with HIV.? Mark each line with an X only once.

No.	Statement	Before my HIV diagnosis	Since my HIV diagnosis	Because of my HIV diagnosis	Never	Don't know
1	I take care of a sick husband/partner at home	1	2	3	4	99
2	I take care of a sick husband/partner living with HIV at home	1	2	3	4	99
3	I take care of a sick child at home	1	2	3	4	99
4	I take care of a sick child living with HIV at home	1	2	3	4	99
5	I take care of sick relatives at home	1	2	3	4	99
6	My husband/partner takes care of me at home when I am sick	1	2	3	4	99
7	I take care of a sick husband/partner outside the home/in the hospital (I call a doctor, an ambulance, arrange transportation, collect medical tests, buy and deliver medicines, assist with medication, provide post-operative care, etc.)	1	2	3	4	99
8	My husband/partner takes care of me outside the home/in the hospital (calls a doctor, an ambulance, arranges transportation, collects medical tests, buys and delivers medicines, assists with medication, provides	1	2	3	4	99
9	I receive child care financial assistance (government help)	1	2	3	4	99
10	I receive child care non-state support (charitable/public organisations)	1	2	3	4	99

11	I receive support from the government to care for a sick husband/relative	1	2	3	4	99
12	I receive support from charitable/public organisations to care for a sick husband/relative	1	2	3	4	99
13	I receive help and support from women living with HIV to care for a sick husband/relative	1	2	3	4	99
14	I receive help and support from women living with HIV to care for a sick child	1	2	3	4	99

37. This question is to be answered only by those of you who **has a partner** and has been living with him **in the same territory for the last 3 months** (mark each line with an X only once)

No.	Activity	Only me	Only my partner	Together	Sometimes he, sometimes me	Other family members	Not applicable
1	Getting children ready to kindergarten/ school in the morning	1	2	3	4	5	99
2	Cooking	1	2	3	4	5	99
3	Housecleaning	1	2	3	4	5	99
4	Laundry	1	2	3	4	5	99
5	Ironing	1	2	3	4	5	99
6	Taking children from kindergarten/school in the evening	1	2	3	4	5	99
7	Purchase of foodstuffs/household chemical goods	1	2	3	4	5	99
8	Purchase of household appliances	1	2	3	4	5	99
9	Children's clothing shopping	1	2	3	4	5	99
10	Payment of utility bills	1	2	3	4	5	99
11	Organisation of house parties	1	2	3	4	5	99
12	Organisation of parties outside the home	1	2	3	4	5	99
13	Attending parent-teacher conferences/ children's events	1	2	3	4	5	99
14	Visiting a paediatrician/purchasing medicines for children	1	2	3	4	5	99

15	Visits to the hospital/communication with doctors/purchasing medicines for adult family members	1	2	3	4	5	99
16	Taking care of sick children at home	1	2	3	4	5	99
17	Taking care of sick adult family members at home	1	2	3	4	5	99
18	Visiting social services, officials, social security, pension fund, migration service, etc.	1	2	3	4	5	99
19	Family budget income distribution (who should spend and for what)	1	2	3	4	5	99

3.6. HIV treatment and side-effects

Our sexual and reproductive health and human rights can also be affected by our experience of accessing anti-retroviral medicine (ARVs). If we have access to ARVs when we need them, and are able to take them regularly with food (in case of such prescriptions), we can stay well.

In this section, we ask you to reflect on some of these issues in relation to ARVs and our sexual and reproductive health and human rights.

38. How often do you see your doctor/HIV service provider?

39. When was your last check on CD4 count?
(please highlight one answer)

1. Within the last 3 months
2. 3-6 months ago
3. 6 months – 1 year ago
4. More than 1 year ago
5. Never

40. What is your CD4 count? _____(if you don't know, just write it so)
41. Are you taking antiretrovirals (ARVs)? YES_____ NO _____

42. If yes, what is the name of your medication?
_____

43. If no, please explain why
_____

44. Do you regularly experience any of the following?
(Please highlight as many as apply):

1. Fatigue/tiredness
2. Loss of libido/sexual desire
3. Vomiting
4. Diarrhoea
5. Constipation
6. Headaches
7. Rashes
8. Mood swings
9. Changes of body shape
10. Hair loss
11. Loss of appetite
12. Strange dreams
13. Menstrual disorders (e.g.) heavy bleeding, very long or painful periods)
14. I have no side-effects
15. Other (please specify)

_____

45. When was your last check on viral load?
(please highlight one answer)

1. Within the last 3 months
2. 3-6 months ago
3. 6 months – 1 year ago
4. More than 1 year ago
5. Never

46. What is your latest viral load? _____ (if you don't know, just write it so)

47. Are there any problems with having an undetectable viral load? If so, please explain in your own words.

7. Income and economic opportunities

48. Income. Please indicate your personal monthly income
(including salaries, pension, child allowances, financial assistance to IDPs, etc.) _____GEL

49. Number of members of your family living in the same household (area) _____people

50. Indicate the monthly income of your family _____GEL

51. Indicate the desired level of average monthly income
(how much you need for a prosperous life, including to take care of your own health) GEL

52. Access to services. Which of these issues has the biggest impact on you or other women living with HIV in your community to access quality sexual and reproductive health care and well-being? (please highlight all that apply)

1. Cost of services at point of delivery
2. Cost of travel to access services
3. Pre school other education related cost for the chirlder
4. Unequal inheritance and property rights
5. Divorce, widowhood, separation
6. Cost and burden of care for other family members
7. Lack of family support
8. Economic dependence on partner(s), family members
9. HIV-related stigma and discrimination in the workplace
10. Discrimination in the workplace based on gender, age or presence/lack of children
11. Other

53. Economic opportunities. Please choose one answer for each statement and mark with an X

No.	Statement	Al-ways	Usu-ally	Someti mes	Never	Don't know	Not applica-ble
1	I have access to higher education	1	2	3	4	98	99
2	I am economically dependent on my partner	1	2	3	4	98	99
3	I can apply to the employment centre if necessary	1	2	3	4	98	99
4	I have the opportunity to combine study and work (distance learning) without financial losses in wages (for example, losses — unpaid leave during the session)	1	2	3	4	98	99
5	I can take free (or at a price that I can afford) courses for additional specialty/to acquire new skills	1	2	3	4	98	99
6	I easily find a job (within my specialty or not)	1	2	3	4	98	99
7	I experienced sexual harassment during my studies	1	2	3	4	98	99
8	I experienced sexual harassment in the workplace	1	2	3	4	98	99
9	I have access to lending services in any bank in Georgia	1	2	3	4	98	99
10	I know how to start my own business if I want to	1	2	3	4	98	99
11	I know where to ask for help to start my own business	1	2	3	4	98	99
12	I own real estate and other property	1	2	3	4	98	99
13	I have autonomy over my real estate or other property	1	2	3	4	98	99
14	I receive social benefits (including child allowances) and manage them inde-pendently/freely/without coercion	1	2	3	4	98	99
15	Having a child has not affected my career path	1	2	3	4	98	99
16	Having a child has not affected my income (I have received all maternity benefits, there are prospects for salary increase in the future)	1	2	3	4	98	99

54. What are the priority changes in policy and practice that would help address these financial issues?

ANNEX 2

Ethic Committee Approval Letter

ჯანმრთელობის კვლევის კავშირი

Health Research Union

IRB Approval Letter

14/06/2022

PI: **Medea Khmelidze**

Women's association "Gvirila"
26 Petre Iberi Street, Apt 26, Tbilisi 0179, Georgia

IRB#: 2022-04
Title of the project: **Sexual and reproductive health and rights (SRHR) of women living with HIV.**

Level of review: Full

Date of review: 13/06/2022

Dear Mrs. Khmelidze,
This letter is to officially notify you that the Institutional Review Board (IRB) of the Health Research Union has reviewed the proposed project **"Sexual and reproductive health and rights (SRHR) of women living with HIV"** and approved it for the Protection of Human Subjects. It is the Board's opinion that you have provided adequate safeguards for the rights and welfare of the participants in this study.
You are authorized to implement this study as of the **Date of Final Approval 13/06/2022**. This approval is **Valid Until: 13/12/2022.**

You should notify the IRB immediately if any unanticipated problems or adverse events involving risks to the participants or others occur. You should report to the IRB any changes in the study procedures/protocol/data collection tools/consent forms before they are implemented. If the project continues beyond the expiration date of the approval your study will be due to review.

If you have any questions, please contact HRU IRB +995 32 2144447 or email at: info@hru.ge.

George Abashidze, MD, PhD
Chair
IRB00009520; IORG0005619

THANK YOU FOR YOUR ANSWERS! STAY HEALTHY AND SAFE!

SUGDIDI 2022

GRAPHIC DESIGNER:
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