

Measuring HIV/AIDS Related Stigma and
Discrimination among Population
in Tbilisi, Batumi and Zugdidi

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BSS	Behavioral Surveillance Surveys with Biomarker Component
BCC	Behavior Change and Communication
EU	European Union
FGDs	Focus Group Discussions
FSWs	Female Sex Workers
GIPA	Greater Involvement of PLHA
GIP	Global Initiative on Psychiatry
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
MSM	Men Who Have Sex with Men
NGO	Non-governmental Organization
PLHA	People Living with HIV/AIDS
S&D	Stigma and Discrimination
SHIP	STI/HIV Prevention Project in Georgia (funded by USAID; being implemented by Save the Children)
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS, 2001
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Forewords and Acknowledgments

HIV/AIDS related stigma has been hindering the successful implementation of HIV/AIDS prevention and treatment programs in many countries worldwide. Until far-reaching efforts to reduce stigma are made, stigma will remain a major obstacle to reducing the spread of HIV/AIDS and negative consequences attached to the disease.

To better understand the patterns and measure the level of social stigma, a survey “Measuring HIV/AIDS Related Stigma and Discrimination among Population in Tbilisi, Batumi and Zugdidi” was conducted within the framework of the project entitled: Joint Action against HIV Associated Stigma. The project is funded by the Delegation of the European Commission to Georgia, European Union and is being implemented by local NGO – Bemoni Public Union in partnership with Tanadgoma (“Support”) Centre for information and Counseling on Reproductive Health.

The overall objective of the project is to promote the reduction of psychological and social suffering of PLHA and to change negative attitudes toward double stigmatized social groups disproportionately affected by the HIV epidemic, especially female sex workers, injecting drug users and men who have sex with men.

First of all, we would like to acknowledge the contributions of the Delegation of the European Commission to Georgia, European Union for providing funds without which the survey “Measuring HIV/AIDS Related Stigma and Discrimination among Population in Tbilisi, Batumi and Zugdidi” would not have taken place.

One of the most challenging aspects of the survey was the fieldwork, especially in regions and we would like to thank the staff members of partner NGOs – Bemoni Public Union in Tbilisi, and Tanadgoma Center in Batumi and Zugdidi for their support.

We are indebted to research team members – Nino Badridze, George Geleishvili and Mzia Tabatadze for their dedication and professionalism. Their efforts to prepare and submit report in two languages with the aim to make survey findings accessible to wider audience are greatly appreciated.

We also wish to extend our special gratitude to David Kazaishvili, the Project Director for his excellent management and leadership that ensured smooth and successful implementation of the survey.

At last, but not least we also must recognize all those 793 volunteers who were willing to devote their time and kindly agreed to participate in the survey. Their responses were particularly important to achieve survey goals and helped researchers to elaborate evidence-based policy recommendations.

Introduction and Survey Goals

HIV/AIDS related stigma and discrimination (S&D) accompanying the AIDS epidemic from its inception have been hindering the successful implementation of HIV/AIDS prevention and treatment programs in many countries worldwide. It is well recognized that fear of and actual experience with stigma and discrimination reduce a person's willingness to practice prevention, seek HIV testing, disclose his or her HIV status to others, seek for care and support, begin and adhere to treatment. The ultimate effect of stigma, is the reduction of the life chances of the stigmatized through discriminatory actions (Gofman).

Stigma and discrimination are self-perpetuating. Stigma refers to prejudice and is based on beliefs. Persons are 'stigmatized' when another person thinks negatively of them because of something they have experienced or because they belong to a particular group. Discrimination occurs when actions are taken (or not taken) on the basis of a stigmatizing belief¹. Commonly, discrimination is not conceptualized as separate from stigma. By many experts, discrimination is defined as "enacted" stigma, the end result of the process of stigma (Craiel et al., 2000).

Measuring HIV related stigma quantitatively help policymakers, program managers, donors and other key stakeholders to determine underlying reasons of S&D, evaluate and identify most successful anti-stigma approaches and define how they should be applied in different contexts and among different populations.

To evaluate the extent of perceived HIV/AIDS related stigma in Georgia, a survey "Measuring HIV/AIDS Related Stigma and Discrimination among Population in Tbilisi, Batumi and Zugdidi" was conducted within the framework of the EU funded project: Joint Action against HIV Associated Stigma.

The major goal of the research was to assess the level of HIV awareness among general population and quantitatively measure stigma in the following key domains:

- Fear of casual transmission and refusal of contact with people living with HIV/AIDS
- Value and morality-related attitudes, blame, judgment and shame
- Enacted stigma (discrimination)
- Attitudes toward PLHA
- Disclosure of HIV positive status

Survey Methodology and Limitations

It is well-known that any researches aiming at providing reliable data on general population require deliberately selected methodology. One of the recognized methods for achieving nationally representative sample is a state-based randomization. In general, scientific literatures and international experts suggest that telephone survey of a randomly generated

¹ International HIV/AIDS Alliance; Family Health International; <http://www.aidsalliance.org>

sample of community members is routinely used for examining HIV/AIDS related S&D nationally.

A Random-digit-dialing (also called RDD) telephone survey commonly is easy to implement and highly recommended by international experts. However, taking into account some aspects of the Georgia context and study challenges, researchers agreed that a telephone survey would not have been a feasible solution for several reasons:

- Inaccuracy of telephone directories and lack of computerized registry system, especially for regions;
- Inaccurate data about the number of households without telephone lines in regions;
- Making long-distance calls in regions would have been costly especially considering the length of interviewing (around 30 minutes);
- Telephone survey is not commonly (if ever) used in Georgia and it would have been very difficult to achieve sufficient response rate with RDD;
- Usually, many Georgians are reluctant to talk to people they do not know on issues like STI/ HIV, etc. So, the possibility of selection bias would have been obvious;
- Participants' privacy might have been very limited during telephone survey especially in Georgia where people live in large families; that would have resulted in response bias.

Taking into account all these limitations, researchers made a decision to use a convenience sampling methodology that is easier and cheaper to implement. “**Convenience sampling** is used in exploratory research where the researcher is interested in getting an inexpensive approximation of the truth. As the name implies, the sample is selected because it is convenient. This non-probability method is often used during preliminary research efforts to get a gross estimate of the results, without incurring the cost or time required to select a random sample².”

Assuming that it would not have substantial impact on survey results, a convenience sampling methodology was considered to be suitable. However, all potential disadvantages associated with this methodology should also be recognized: possible sampling bias, less representative sample of the general population, limited generalizability of the survey results.

In total 793 participants completed the questionnaires in three cities of Georgia – Tbilisi, the capital city (where the majority of registered HIV infected people live), and Batumi and Zugdidi, the two cities in western Georgia, where relatively high HIV prevalence rate is observed among local residents. Out of 793 participants, 393 respondents were recruited in Tbilisi, 200 - in Batumi, and 200 respondents in Zugdidi.

Interviewing in Tbilisi took place in November, 2007. Researchers visited Zugdidi and Batumi in December, 2007. They were recruiting participants in streets, schools, restaurants, stations, grocery markets, etc. Age of respondents ranged from age 17 to 60. Refusal rate was around 20%. In most cases, the interviewer-administered survey mode was used: interviewers read out the questions and marked down the responses. Around 10% of all participants

² Designing Surveys and Questionnaires; David S. Walonick; A Public Service of StatPac Inc.

requested to allow them to complete the questionnaires independently without having interviewers observing them.

Distribution of study respondents by cities, age and gender is presented in the table #1 below.

Table #1

Research sites	Female respondents by age groups			Male respondents by age groups			Female and male respondents by age groups			Total
	<25	25-45	45+	<25	25-45	45+	<25	25-45	45+	
Tbilisi	70	136	31	48	81	19	118	217	50	385
Batumi	38	78	17	20	46	4	58	124	21	203
Zugdidi	25	50	29	36	45	20	61	95	49	205
Total	133	264	77	104	172	43	237	436	120	793

Survey Instrument

A structured questionnaire was elaborated and pre-tested (Appendix # 1). Some questions measured respondents' actual knowledge or personal experiences. Some questions used in the questionnaire were hypothetical aiming at assessing respondents' attitude and willingness to interact with a person with HIV/AIDS, such as sharing a meal, buying food, etc. There are several limitations that should be taken into consideration while utilizing hypothetical questions:

- Hypothetical questions may seem ambiguous and respondents may interpret them in different ways
- They may suffer from bias as respondents may provide responses that are correct and socially acceptable (social desirability bias)
- These questions usually do not capture the underlying cause of stigma and/or discrimination.

Completed questionnaires were analyzed using Statistical Package for Social Sciences (SPSS). Percentages were calculated to assess respondents' knowledge about HIV/AIDS and their attitudes toward people living with HIV/AIDS. Bivariate relationships between different groups were examined using Pearson Chi-square test.

Studies about HIV Related Stigma and Discrimination in Georgia

Recently two studies were conducted in Georgia to examine HIV related stigma and discrimination.

- I. In 2006-2007 within the framework of the GIP project entitled "Mental Health and HIV/AIDS Problems in Georgia" a survey was carried out to investigate the magnitude of stigma and discrimination towards PLHA in Tbilisi, Zugdidi, Kutaisi, Telavi and

Akhaltshikhe. The study was conducted by the project expert team with support from the Mental Health and HIV/AIDS Expert Centre in Georgia. The research combined qualitative and quantitative surveys among PLHA, medical personnel and youngsters³ (for brevity's sake, this survey in the report is referred to as "the GIP study"). The quantitative survey among university and college students measured their knowledge about HIV/AIDS and attitudes towards PLHA. Where comparable data was available, findings from both studies were examined against each other and are presented in the report below.

- II. A survey "Vulnerability Assessment of People Living with HIV/AIDS in Georgia" was conducted in 2007 by the Strategic Research Institute. The research framework was developed and has been supported by the United Nations Development Programme (UNDP). The aim of the research initiative was to study the access of people living with HIV to education, healthcare, and employment in the country. The research involved structured in-depth interviews with PLHA (21 individuals), focus group discussions among representatives of health care system, education and employment sector as well as NGOs. Two non-governmental organisations working with PLHA – the AIDS Patients' Support Foundation, and New Way – assisted in conducting the focus groups and individual interviews⁴.

Until now, no other researches to investigate HIV related stigma and discrimination among general population in Georgia were carried out making our study relatively distinctive. Findings all three researches conducted in the country complement each other and provide valuable information to better understand the underlying reasons for stigma as well as multi-dimensional challenges and consequences associated with HIV stigma and discrimination in Georgia.

Survey Findings

HIV/AIDS Awareness

With the purpose to assess the level of knowledge on HIV/AIDS among general population in research sites, a set of seven standard questions was used. These questions are recommended by WHO and UNAIDS⁵. Very similar questions are being used to investigate the level of knowledge on HIV/AIDS for UNGASS indicators⁶. Those respondents who gave correct answers to all seven questions (questions #1-7) were considered as more knowledgeable about HIV/AIDS; hereinafter this group of participants is referred to as "well-informed" group. Those participants, who gave at least one incorrect answer to any questions from 1 to 7, were

³ HIV/AIDS Related Stigma and Discrimination in Georgia; Mental Health and HIV/AIDS Expert Centre in Georgia; Global Initiative on Psychiatry. Tbilisi, Georgia, June 2007

⁴ Vulnerability Assessment of People living with HIV/AIDS in Georgia; National Report; Final Draft; United Nations Development Programme; The Strategic Research Institute; Tbilisi 2007

⁵ HIV/AIDS Knowledge, Attitude and Practice Survey Tool, UNAIDS, 2006

⁶ Monitoring of Declaration of Commitment of HIV/AIDS; Guidelines on Construction of Core Indicator, 2008 Reporting; UNAIDS

considered as having less knowledge about HIV/AIDS and this group is referred to as “less-informed” group.

Analyzing survey questionnaires revealed that 24.3% (193/793) of all respondents in three cities were well-aware of HIV/AIDS (Table No 2). A noticeable difference was found among respondents by cities. The percentage of respondents who correctly answered all seven questions in the capital city was 31.7% (33.1% among male and 30.8% among female respondents). The level of knowledge on HIV/AIDS was about two times less among Batumi participants (14.3%). Besides, male respondents in Batumi are more likely to answer correctly all seven questions (16.7%) compared with female participants (13.0%). This indicator for respondents in Zugdidi reached 20.5% with slightly more difference by gender (25% of male correctly answered all seven questions vs. 16.2% of female respondents).

Table No 2: Percentage Distribution of respondents who gave correct answers to all 7 questions by gender and cities

City	Correctly answered all 7 questions (%)	% of male respondents correctly answering all 7 questions	% of female respondents correctly answering all 7 questions
Tbilisi	31.7% (122/385)	33.1% (49/148)	30.8% (73/237)
Batumi	14.3% (29/203)	16.7% (12/72)	13.0% (17/131)
Zugdidi	20.5% (42/205)	25.0% (25/100)	16.2% (17/105)
Total:	24.3% (193/793)	26.9% (86/320)	22.6% (107/473)

Figure 1: Distribution of well -informed respondents by cities (%)

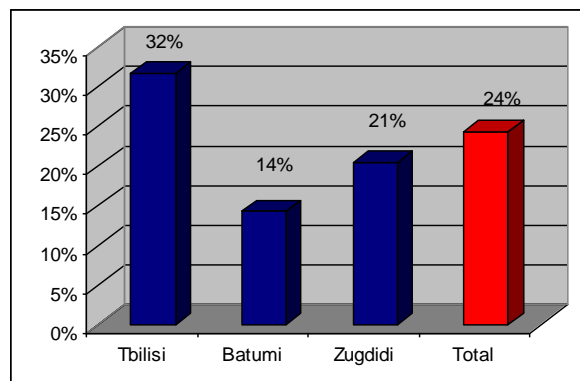
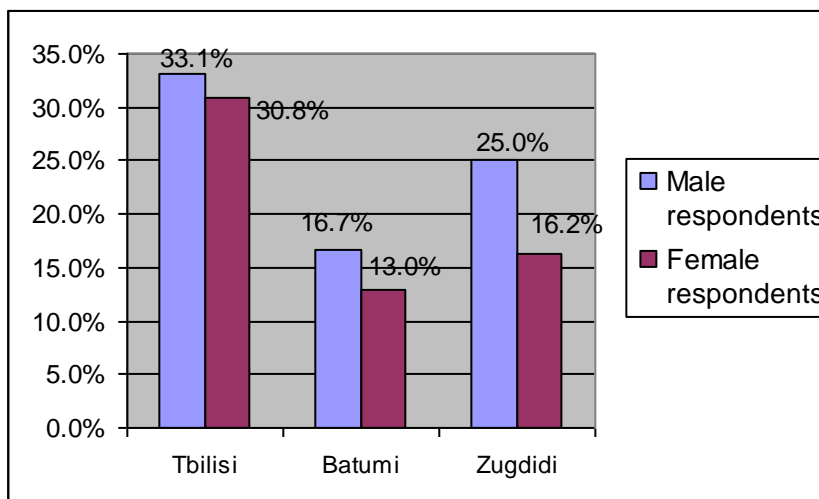


Figure #2 below demonstrates percentage distribution of well-informed respondents by gender in Tbilisi, Zugdidi and Batumi. As it is shown in the chart, male respondents who are well-aware of HIV/AIDS outnumber well-informed female respondents in all research sites. This difference is minimal in Tbilisi and Batumi, but is statistically significant for Zugdidi participants.

Figure 2: Percentage distribution of well-informed respondents by gender and cities



There is a slight, though not statistically significant difference in HIV knowledge by age groups (three different age groups were examined in the survey: respondents aged 18- 25, 26-45; and 46+). Young people from 18 to 25 years old were more likely to give correct answers than those in older age groups.

The survey demonstrated that people are most likely to give correct answers to questions on how HIV is transmitted (through unprotected sexual contacts) and how the risk can be reduced (having one uninfected, faithful partner, or condom use). They were less likely to have correct knowledge about how the virus cannot be transmitted.

The question “Can the risk of HIV transmission be reduced by having sex with only one uninfected, faithful partner?” was correctly answered by 88.7% of all participants. Percentage distribution of correct answers by cities is as follows: Tbilisi - 89.6%, Batumi - 86.7%, and Zugdidi - 88.8%. Indicators by age groups vary from 75% to 96%. Out of all respondents, best informed appeared to be females aged 46+ in Tbilisi (96%), and less informed were male respondents of the same age group in Batumi (75%).

Question # 2: “Can a person reduce the risk of getting HIV by using a condom every time they have sex?”

In total, 86.3% of respondents correctly answered the question. The highest rate of correct answer was found among Tbilisi respondents (91.4%) followed by that of Zugdidi (82.9%) and Batumi (76.9%) participants.

Questions No 4, 5 and 6 examined whether respondents had correct information about the risk of getting the virus through casual contact, saliva or sharing a meal.

Question 4: Can a person become infected through kissing an HIV positive person?
 Correct answer “No” was marked by 76.8%. Tbilisi respondents were more likely to know correct answer (86.2%) than people surveyed in Batumi (71.9%) and Zugdidi (63.9%).

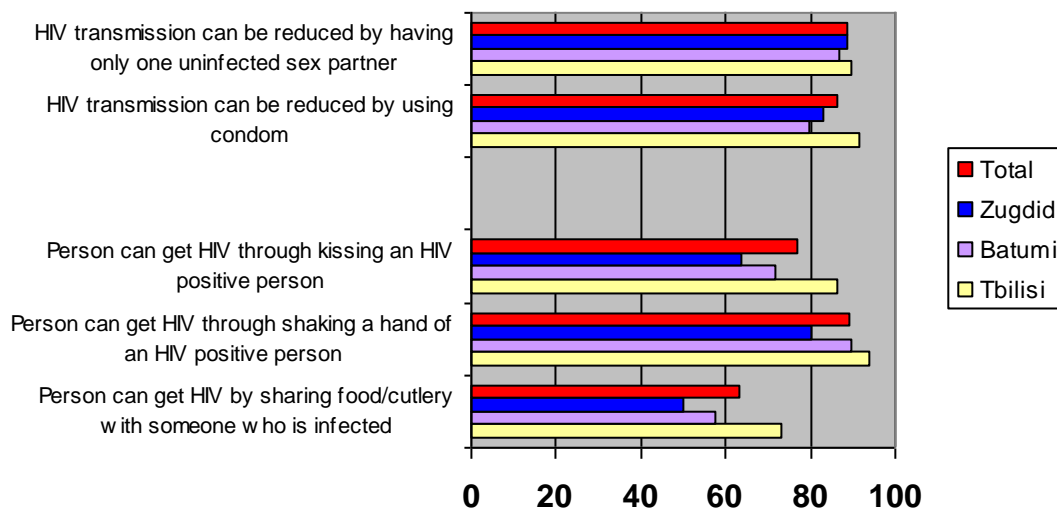
Question # 5: Can a person become infected by shaking hand of an HIV positive person?
 and Question # 6: Can one get HIV by sharing food/cutlery with someone who is infected?

Correct answer to the question 5 was given by 89.3% of respondents and 63.2% of surveyed people knew that HIV cannot be transmitted through sharing a meal with HIV infected people. Comparing survey data with the GIP study findings revealed that young people do not have adequate knowledge on how the virus is not transmitted³. Only half (49%) of young people surveyed reported that shaking hand of an HIV positive person is safe (vs. 89.3% in our survey); slightly more than one-thirds (35%) of youngsters participating in the GIP survey knew that HIV cannot be transmitted through sharing a meal with an HIV positive person (vs. 63.2% in our survey).

Question # 7: Can a person get HIV from mosquito bites?

It was found that most respondents still think that HIV can be transmitted from mosquito bites. This indicator greatly changed the general picture about HIV awareness among the study population. Only 43% of respondents in all three cities gave correct answer “no” to this question. It should be noted that this misconception was more prevailing among respondents in Batumi; only 33% of survey participants reported that HIV cannot be transmitted from mosquito bites. This indicator is about 1.5 times lower than those for respondents in Tbilisi (46.2%) and Zugdidi (48.8%).

Figure 3: Percentage of respondents correctly answering questions about HIV transmission ways



To assess the level of knowledge about HIV among study population, respondents also answered the following question: Can a healthy-looking person have HIV? Data analyzes

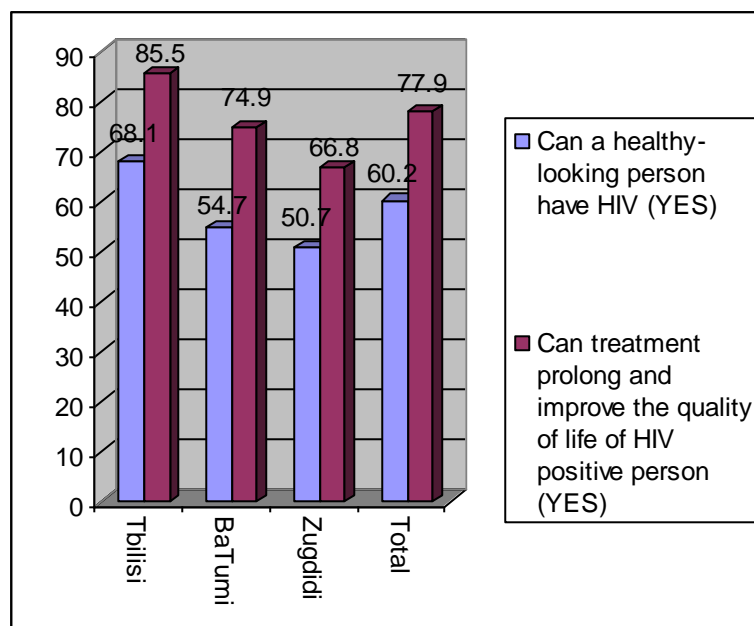
revealed that less than two-third of all participants (60.2%) are aware that HIV can be asymptomatic and infected person can look healthy. Respondents in Tbilisi were more likely to have correct information on the issue (68.1%) than respondents in Batumi (54.7%) and Zugdidi (50.7%).

Question # 8: Can treatment prolong and improve the quality of life of HIV positive person? Correct answer to this question was marked by 78% of respondents. The percentage of participants who were informed about advancements in AIDS treatment was highest among Tbilisi respondents (85.5%) and lowest for Zugdidi participants (66.8%).

Table No 3: Percentage distribution of correct answers to Questions No 3 and 8 by cities

Question (correct answer)	Tbilisi	Batumi	Zugdidi	Total
Can a healthy-looking person have HIV? (Yes)	68.1%	54.7%	50.7%	60.2%
Can treatment prolong and improve the quality of life of HIV positive person? (Yes)	85.5%	74.9%	66.8%	77.9%

Figure 4: Percentage distribution of correct answers to Questions No 3 and 8 by cities



As was indicated above, analyzing responses to all seven questions about HIV awareness revealed that 193 out of 793 respondents gave correct answers to all questions. Therefore, well-informed respondents account for around 24% of survey participants. In addition, it was found that the level of HIV knowledge is higher among Tbilisi participants followed by Batumi and Zugdidi respondents. It should be stressed that the knowledge about HIV among general population appeared to be higher than HIV awareness among sex workers and men

who have sex with men. Data generated through the Behavioral Surveillance Surveys among female sex workers⁷, IDUs⁸ and MSM⁹ demonstrated the following:¹⁰

- **Knowledge among FSWs:** only 4.3% of FSWs surveyed in Tbilisi and Batumi in 2006 gave correct answers to all five questions about HIV transmission (*1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected?*);
- **Knowledge among MSM:** none of the respondents among MSM participating in BSS conducted in Tbilisi in 2005 answered correctly all questions about HIV prevention;
- **Knowledge among IDUs:** injecting drug users were relatively well-aware of HIV than any other groups. Around 40% of all IDU respondents provided correct answers to 4 questions about HIV (*1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a person get HIV from mosquito bites? 4. Can a person get HIV by sharing a meal with someone who is infected?*). However, it should be taken into consideration that during the BSSs IDUs answered only 4 questions; thus, most likely, if all seven questions had been asked, the percentage of respondents giving correct answers to all questions would have been lower.

Moreover, comparing the survey results with the findings of the research conducted within the framework of the GIP Project³ revealed that the knowledge about HIV/AIDS among general population in Tbilisi, Batumi, and Zugdidi was higher than the level of HIV awareness among young people. In total 350 college and university students were interviewed during the GIP study conducted in Tbilisi, Kutaisi, Zugdidi, Akhaltsikhe, and Telavi. Only 17% of young respondents gave correct answers to all six questions about HIV transmission that is lower than the proportion of well-aware respondents in our survey (24%). Unfortunately, the question about the risk of HIV transmission from mosquito bites was not asked during the GIP survey. It is interesting to emphasize that most researches conducted in many countries worldwide have proven that respondents are least likely to give correct answer to the question regarding HIV transmission from mosquito bites. This conclusion was confirmed by our survey findings as well. Therefore, it can be assumed that if the question about mosquito bites had been asked, the percentage of young people correctly answering to all seven questions would have been even lower than 17%.

Question # 9: Can a person get HIV infection through taking care of AIDS patient? Correct answer “NO” was given by majority of respondents (86.3%).

⁷ Behavioral Surveillance Surveys with Biomarker Component among Street-based FSWs in Tbilisi and Facility-based FSWs in Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

⁸ Behavioral Surveillance Surveys with Biomarker Component among IDUs in Tbilisi and Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

⁹ Behavioral Surveillance Survey with Biomarker Component among MSM in Tbilisi, 2005; Global Fund

¹⁰ Monitoring the Declaration of Commitment on HIV/AIDS; Georgia Country Report 2006; United Nations General Assembly Special Session on HIV/AIDS

Question #10: Can a child get HIV through playing with an HIV positive child? Analyzing responses showed that almost 9 persons out of every ten know that the virus cannot be transmitted through playing with a child who is HIV positive.

Table No 4: Percentage distribution of correct answers to questions No 9 and 10 by gender and Cities

	Tbilisi (%)		Batumi (%)		Zugdidi (%)	
	Female	Male	Female	Male	Female	Male
<u>Question # 9</u> Can a person get HIV infection through taking care of AIDS patient? (No)	85.1	86.9	91.7	79.4	86.0	91.4
<u>Question # 10</u> Can a child get HIV through playing with an HIV positive child? (No)	95.3	92.4	86.1	85.5	82	89.5

Stigma and Discrimination towards PLHA

To investigate what are the common feelings and attitudes among general population towards HIV positive people, researchers used several questions recommended by different international guidelines.

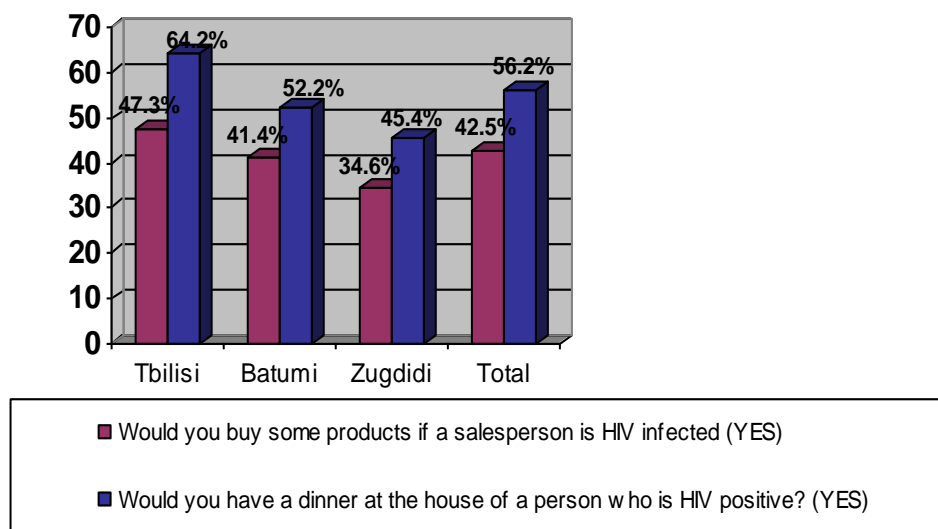
Question #11: Would you buy some fruits and vegetables or some other products if a salesperson is HIV infected?

More than half of surveyed people are afraid to buy products from HIV positive salespersons. Only 42.5% (337/793) of respondents gave positive answer. It should be emphasized that lowest percentage of positive answer (34.6%, 71/205) was received by respondents in Zugdidi. Female respondents in Batumi are 1.4 times more likely to buy some products from PLHA (45.8%, 60/131) compared with male respondents (33.3%, 24/72). Interestingly, the GIP survey showed that young people were more likely to have correct information about the risk of getting the virus through products bought from an HIV positive salesperson; 71% of young respondents in the GIP survey reported that they would not mind buying products from an infected salesperson.

Question #15: Would you have a dinner at the house of a person who is HIV positive?

Slightly more than half of respondents (56%, 446/793) reported they would not mind having a dinner at the house where one of the family members is HIV positive. No significant difference among responses by cities was observed (see the separate indicators by cities in the Figure below). We would like to stress that respondents in our survey appeared to be more confident that the sharing a meal with PLHA does not bear any risk of getting the virus than college and university students interviewed during the GIP survey (56% and 14%, respectively).

Figure 5: Percentage distribution of respondents giving correct answers to Questions 11 and 15 by cities



Question # 12: If a teacher is HIV positive should she/he be allowed to teach?

On average, 60.5% of all respondents think that HIV infected teacher should be allowed to teach students at schools and universities.

Question # 13: If a student/pupil is HIV positive should she/he be allowed to study with others? Unfortunately almost one-fourth of respondents think that HIV positive children do not have a right to study with uninfected children. Positive answer was received from 76.3% of survey participants.

Question # 14: Would you continue working in the office where one of your colleagues turns to be HIV positive?

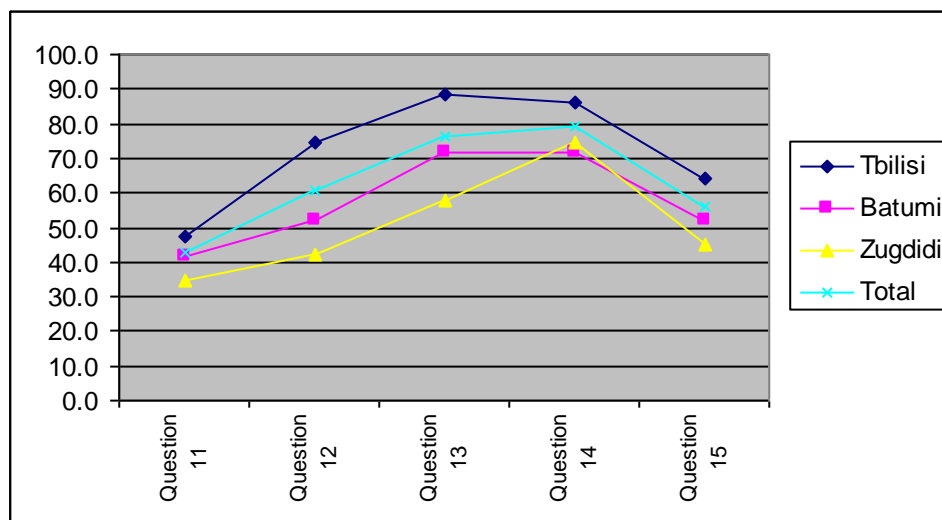
Data analysis showed that 79.4 percent (630/793) of respondents would not mind working in the office if one of his/her co-worker appears to be HIV infected. It was interesting to compare this result with the GIP survey findings. Surprisingly vast majority of students interviewed demonstrated quite negative attitude as only 18% of young respondents reported that they would not mind having an HIV-positive colleague.

Table No 5

	Questions (correct answer)	Tbilisi	Batumi	Zugdidi	Total
11	Would you buy some fruits and vegetables or some other products if a salesperson is HIV infected? (“Yes”)	47.3%	41.4%	34.6%	42.5%
12	If a teacher is HIV positive, should she/he be allowed to teach? (“Yes”)	74.5%	52.2%	42.4%	60.5%

13	If a student/pupil is HIV positive, should she/he be allowed to study with others? (“Yes”)	88.6%	71.4%	58.0%	76.3%
14	I can continue working in the office where one of my colleagues turns to be HIV positive? (“Yes”)	86.2%	71.4%	74.6%	79.4%
15	Would you have a dinner at the house of a person who is HIV Positive (“Yes”)	64.2%	52.2%	45.4%	56.2%

Figure 6: Percentage distribution of respondents correctly answering questions 11-15 by cities



Correlation between HIV awareness and attitudes toward HIV seropositivity

As it was mentioned above, those respondents who gave correct answers to 7 questions assessing participants’ knowledge about the virus were regarded as well-informed of HIV, and all remaining respondents are referred to as less-informed group. Data analyses have demonstrated that well-aware people are more likely to have rational position and compassionate attitudes toward PLHA.

Further analyses were performed to compare responses provided by respondents from each group. While answering the question “Would you buy some fruits and vegetables or some other products if a salesperson is HIV infected” - positive response was marked by 66.3% (128 out of 193) of respondents who were well-aware of HIV/AIDS. Among less-informed respondents only 34.5% (209/606) reported that they would not mind buying products from an HIV positive salesperson, which is two-times lower than corresponding indicator for well-informed respondents. The difference in responses by the level of HIV awareness was found statistically significant (Chi-Square 12.63; P= 0.002).

Statistically significant differences among respondents from well-informed and less-informed groups were also found in responses to the following questions: Question # 12 (If a teacher is

HIV positive, should she/he be allowed to teach? - Chi-Square 7.39; P= 0.025); Question # 14 (I can continue working in the office where one of my colleagues turns to be HIV positive? - Chi-Square 6.32; P= 0.04); Question # 15 (Would you have a dinner at the house of a person who is HIV positive? - Chi-Square 15.84; P=0.000); and Question # 16 (Would you go for treatment to an HIV positive doctor? - Chi-Square 9.74; P=0.008).

It should be stated that statistically significant difference was not found in responses to the Question # 13- "If a student/pupil is HIV positive, should she/he be allowed to study with others? It can be assumed that respondents from both groups were more tolerant with respect to HIV infected children and their rights to education. However, the possibility of Social Desirability Bias cannot also be excluded.

Table No 6: Percentage distribution of positive attitudes towards HIV infected people among well-informed and less-informed respondents

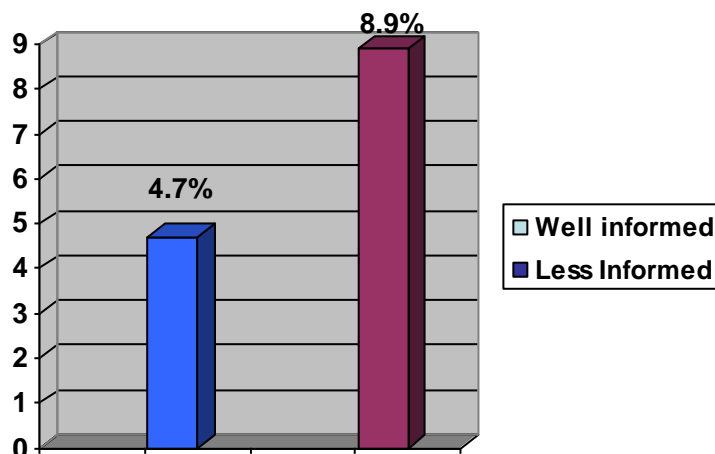
No	Questions	Well informed group		Less informed group	
		Yes	(%)	Yes	(%)
11	Would you buy some fruits and vegetables or some other products if a salesperson is HIV infected? ("YES")	128	66.3	209	34.5
12	If a teacher is HIV positive, should she/he be allowed to teach? ("YES")	165	85.5	317	52.3
13	If a student/pupil is HIV positive, should she/he be allowed to study with others? ("YES")	175	90.7	436	71.9
14	I can continue working in the office where one of my colleagues turns to be HIV positive? ("YES")	183	94.8	453	74.8
15	Would you have a dinner at the house of a person who is HIV positive? ("YES")	157	81.3	292	48.2
16	Would you go for treatment to an HIV positive doctor? ("YES")	98	50.8	130	21.5

Table No 7: Percentage distribution of negative attitudes towards HIV infected people among well-informed and less-informed respondents

No	Question	Well informed group		Less informed group	
		Yes	(%)	Yes	(%)
11	Would you buy some fruits and vegetables or some other products if a salesperson is HIV infected? (“NO”)	45	23.3	285	47.0
12	If a teacher is HIV positive, should she/he be allowed to teach? (“NO”)	18	9.3	192	31.7
13	If a student/pupil is HIV positive, should she/he be allowed to study with others? (“NO”)	16	8.3	103	17.0
15	Would you have a dinner at the house of a person who is HIV positive? (No)	25	13.0	203	33.5

The survey confirmed that HIV awareness has significant influence on public opinion and it shapes attitudes towards HIV positive persons. When asked - “If you find out that your friend is HIV positive, would you continue friendship with him/her? - 4.7% (9/193) of well-informed respondents told that they would NOT be willing to continue friendship with an HIV infected person. The same answer was given by 8.9% (54/606) of less-informed respondents.

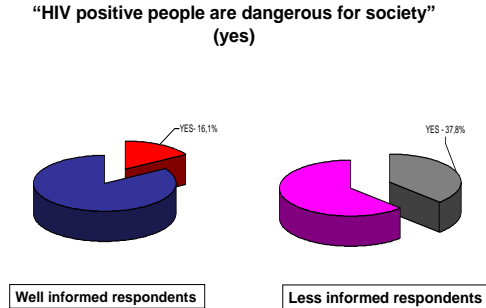
Figure 7: Percentage distribution of respondents who would not be willing to continue friendship with an HIV infected person



It also should be emphasized that despite of having sufficient knowledge about HIV/AIDS, 16.1% (31/193) of well-informed respondents still think that people living with HIV are dangerous to society. As was expected those who have less awareness of HIV were twice

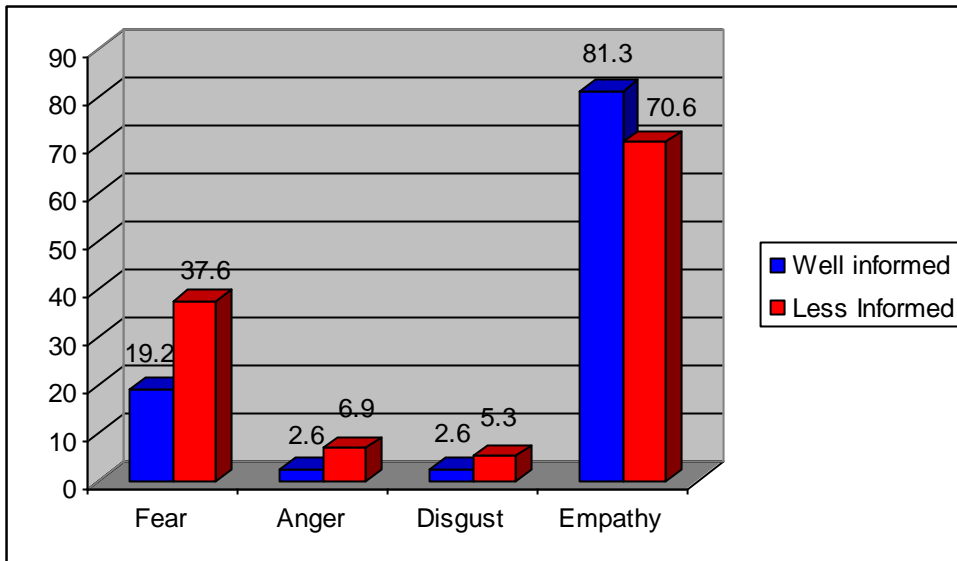
more likely to demonstrate negative attitude to PLHA; 37.8% (229/606) of less informed respondents think that infected people may create a threat to society.

Figure 8: PLHA are dangerous for society



Survey data allowed to investigate how the attitudes towards PLHA among well-informed respondents differ from those among people who are less-aware of HIV/AIDS. Data analysis revealed that those respondents who are more knowledgeable about HIV/AIDS are more likely to empathize HIV infected people than those with less knowledge. In addition, percentage of those respondents who reported having negative feelings, such as fear, anger or disgust toward infected people was lower among well-informed respondents compared with less-informed participants.

Figure 9: Attitudes towards PLHA among well-informed and less-informed respondents

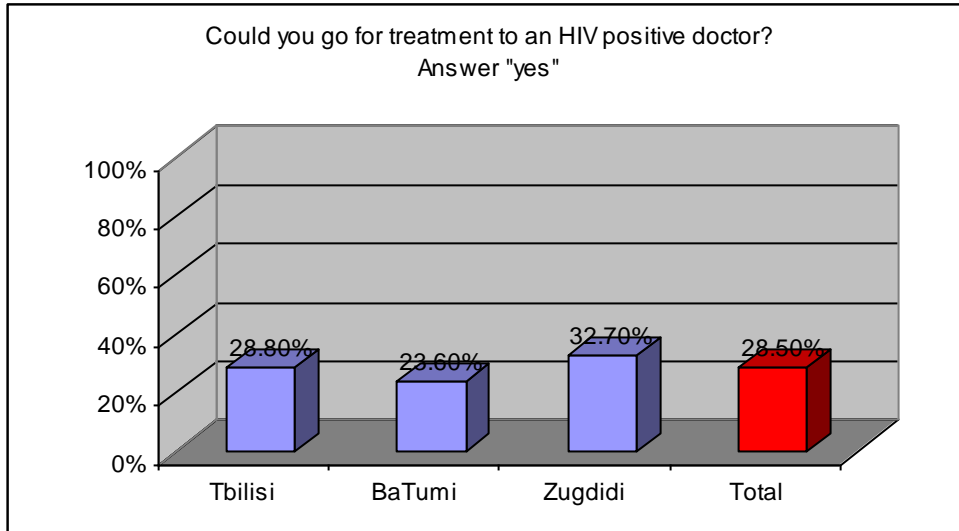


Question #16 – Would you go to an HIV positive doctor for treatment?

More than two-third of surveyed people in Tbilisi admitted that they would not go to an HIV positive doctor for treatment. Only 28.8% of respondents in the capital city reported they would not mind going to a doctor who is HIV positive. The same answer was given by

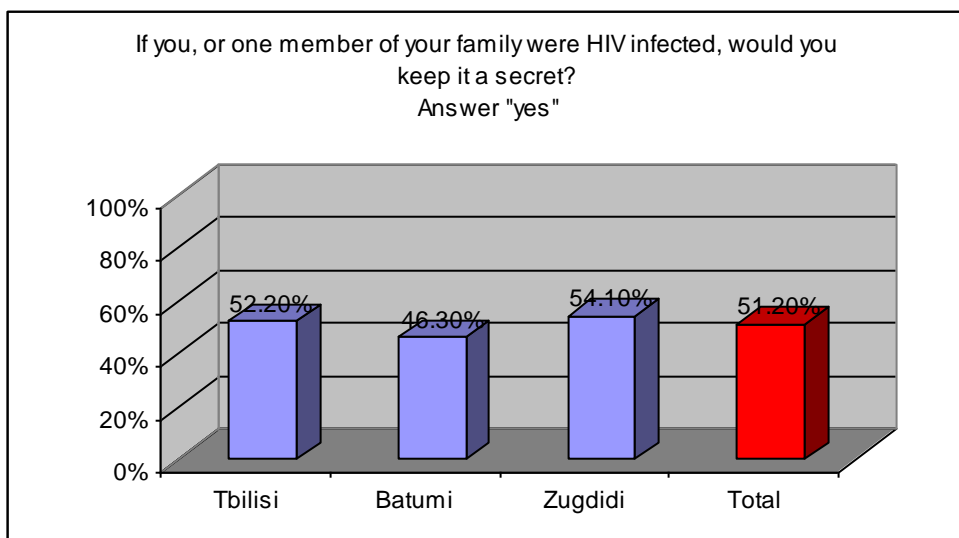
23.6% and 32.7% of respondents in Batumi and Zugdidi, respectively. No statistically significant difference was found in responses by gender or cities.

Figure 10: Attitudes towards HIV-positive doctors



Question #17: If you or one member of your family were HIV infected, would you keep it a secret? Positive answer was given by 52.2% of respondents in Tbilisi, 46.3% in Batumi and 54.1% in Zugdidi. On average half of survey participants (51.2%) in all three cities would keep their HIV positive status confidential. Findings are presented in the Figure 11 below.

Figure 11: Percentage distribution of respondents reporting that they would keep their HIV status a secret.



Question 18: If you were an HIV infected to whom would disclose your HIV status

Respondents were asked to answer the question: If you were an HIV infected, to whom would disclose your HIV status. There were several potential answers provided in the questionnaire. Respondents were allowed to mark all applicable responses.

In total, 878 interviewees answered the question: 377 respondents in Tbilisi, 208 in Batumi and 202 in Zugdidi. Analyzing data has shown that respondents in the capital city are more likely to share their HIV status with someone than respondents in regions. Though, this difference was not statistically significant. Majority of respondents (78.3%) reported they would not hide their HIV status from medical doctors. Percentage distribution of respondents by cities is as follows: 81.2% in Tbilisi, 77.9% in Batumi, and 73.3% in Zugdidi.

The next highest percentages of respondents reported they would notify sexual partners – 46.8%. This indicator is not very high given that according to the HIV/AIDS State Law all infected persons who know their seropositivity shall notify regular sexual partners (spouse, girlfriend). However, the study result was not unexpected. In general, a person who learns that she/he is HIV-positive is very stressed and only after a while, after receiving an adequate counseling from trained specialists, an infected person starts realizing his/her own personal (not only legal) responsibility to protect others and becomes convinced that notifying partner is important. Data analysis showed that relatively more respondents in Tbilisi (59.2%) think they would inform sexual partners if they were infected; this indicator is significantly lower for Batumi and Zugdidi (32.2% and 32.5%, respectively).

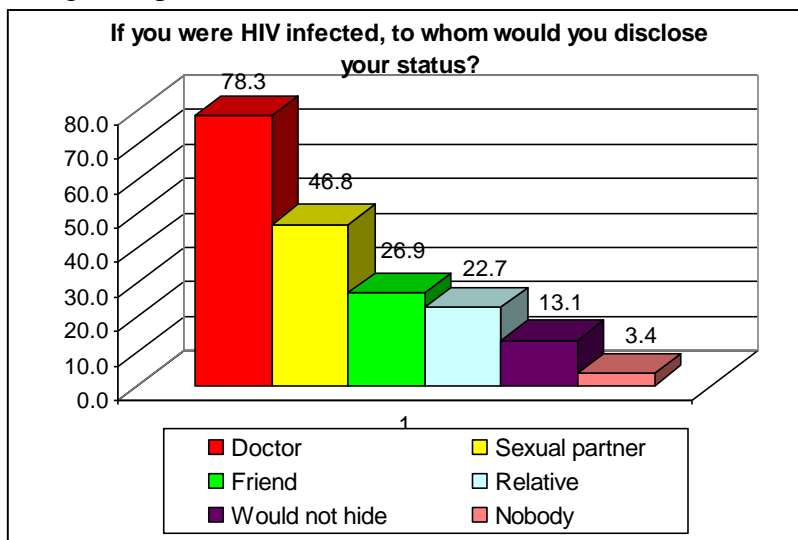
Relatively more respondents in Tbilisi (35%) reported they would not hide their HIV positive status with friends; fewer respondents in Batumi and Zugdidi (19.2% and 19.8% respectively) reported that they would be open with friends.

In total 22.7% of all interviewed people would tell that they are HIV-positive to their relatives or family members. Quite similar results were found among respondents in Tbilisi (28.1%) and in Zugdidi (24.3%); as for Batumi respondents, only one person in ten (11.5%) would disclose this information to relatives/family members.

In general, 20.2% of Batumi respondents do not think that HIV infected persons should hide their status. Percentage of participants giving such response in Tbilisi and Zugdidi was two-fold lower (10.3% in Tbilisi, and 10.9% in Zugdidi).

Quite small proportion of interviewed people (3.4%) reported that they would not tell anybody if they were infected; percentage distribution of those respondents by cities is as follows: 4.5% in Tbilisi; 1.0% in Batumi, and 4.0% in Zugdidi.

Figure 12: Disclosing HIV-positive Status



In addition to the possible answers provided in the questionnaires, three respondents reported they would feel secure to disclose their status with their priest; one young lady (aged <25) told that she would tell about her problem to her psychologist.

Question 19: If you would not disclose your HIV status to anybody, what would be the reasons?

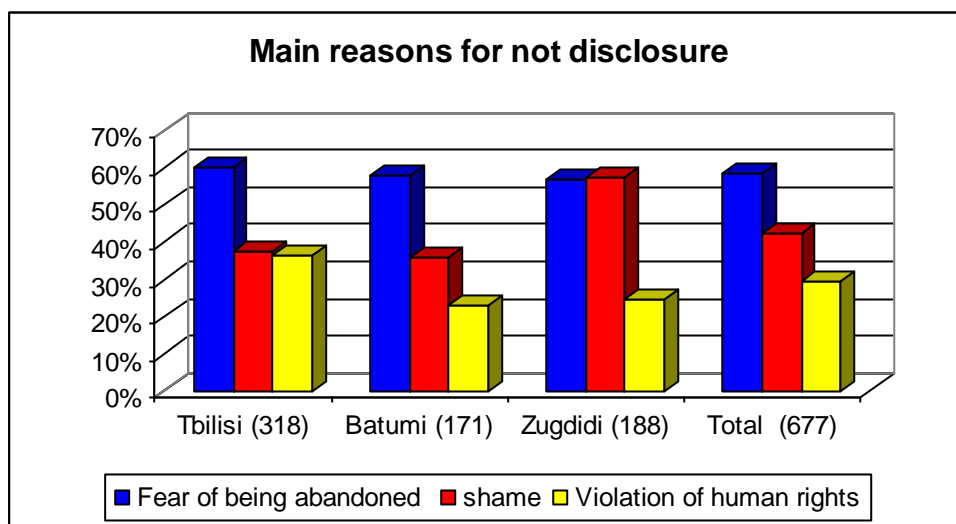
The next question in the research aimed at identifying major barriers that prevent infected people to disclose their positive status to others. According to the study instrument, only respondents who reported that they would not trust anyone to tell about their HIV positive status should answer this question. In total, the number of respondents who will keep their HIV status in secret was 27 in all three cities. After reviewing completed questionnaires, it was discovered that majority of respondents gave answer to this question. Analyzing responses of 667 participants has revealed that the main reason for not disclosing was a feeling of fear that she/he would get abandoned by beloved ones. So think 58.6% of all respondents; this indicator was almost similar for all cities: 60.1% for Tbilisi, 58.0% for Batumi, and 56.9% for Zugdidi.

Next most frequently cited reason was a feeling of embarrassment. In total 42.5% of participants reported they would hide HIV positive status to avoid the feeling of shame. The percentage of respondents giving this answer was highest in Zugdidi; the indicator by cities is distributed in the following way: 37.4% in Tbilisi, 35.7% in Batumi, and 57.4% in Zugdidi. This finding is very important as the feeling of shame attached to HIV infection, which itself represents a result of stigma, greatly contributes to formation of stigmatized and judgmental attitudes toward PLHA.

Reasons for not being able to disclose HIV positive status vary greatly. These reasons are complex, many of them act together and form individuals' attitude towards the problem. Data analysis demonstrated that many respondents think that infected person's human rights might

be violated if his/her HIV positive status is known. To protect their human rights, 30% of all respondents would not tell anybody if they were infected. This indicator is highest in Tbilisi (36.2%), and is fairly similar for Batumi and Zugdidi (22.8% and 24.5%, respectively). It should be noted that three respondents in Tbilisi and two in Zugdidi reported that due to fear of stigma and discrimination they would prefer to keep their HIV positive status confidential.

Figure 13: Main barriers to disclosing HIV-positive status to others



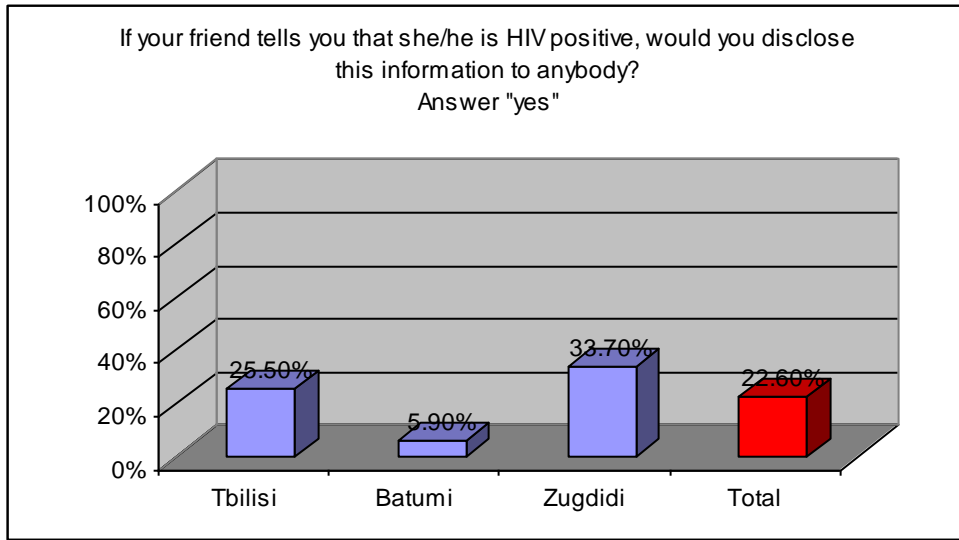
Question #20 – If your friend tells you that he/she is an HIV positive, would you disclose this information to anybody?

On average, in all three cities 22.6% of survey participants reported they would not keep the information a secret. Subsequently, more than 77% of respondents would keep the information confidential.

Answer “Yes” was given by 25.5% of respondents in Tbilisi, 33.7% in Zugdidi, and 5.9% in Batumi. Respondents in Batumi, compared with those from two other cities, were least likely to reveal their friend’s status to others, and the difference was found to be statistically significant.

In addition, it was revealed that in Tbilisi and Batumi men respondents were more likely to tell somebody that his/her friend is infected than women respondents. However, in Zugdidi female participants were more likely to mark answer “yes” than men.

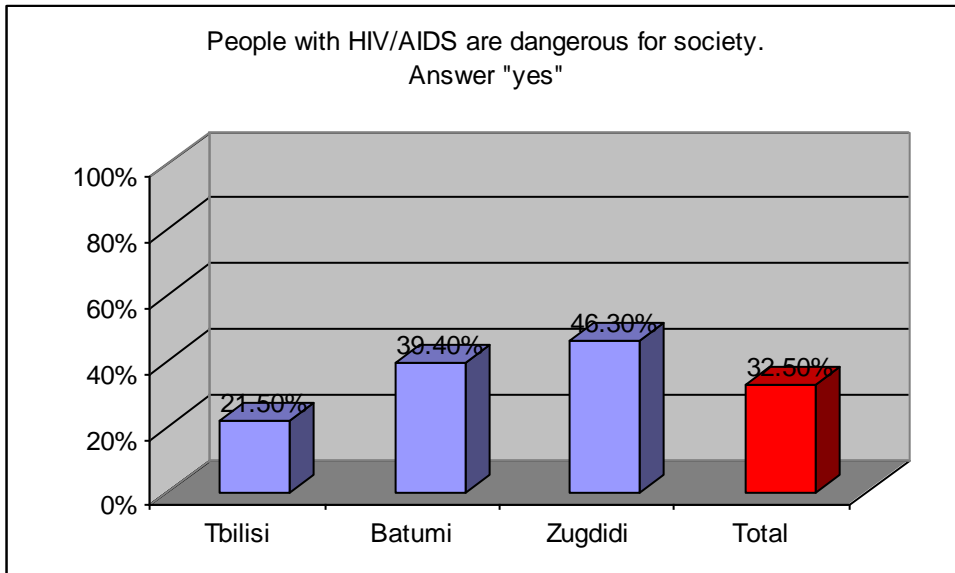
Figure 14: Disclosing friend's HIV-positive status to others



Question #21 – HIV Infected people are dangerous for society?

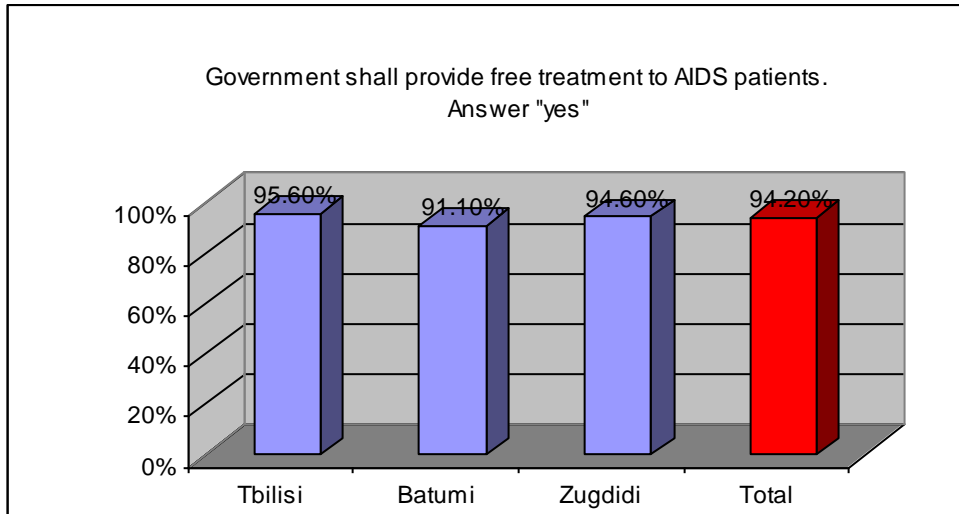
Respondents were asked whether they agree with the statement that HIV infected people are dangerous for society. Almost one-third of all participants (32.5%) regarded HIV infected people as dangerous. Percentage distribution by cities is as follows: Tbilisi - 21.5%, Batumi - 39.4%, and Zugdidi - 46.3%. It is apparent that people in regions are twice more likely to have wrong conception of the problem than respondents in the capital city.

Figure 15: Percentage distribution of respondents believing that PLHA are dangerous



Question # 22 – Government shall provide free treatment to AIDS patients.
 The vast majority (94.2%) of respondents agreed with the statement that governments shall ensure that all patients have access to free treatment. Very similar pattern in responses was observed across cities - 95.6%, 91.1%, and 94.6% in Tbilisi, Batumi, and Zugdidi, respectively.

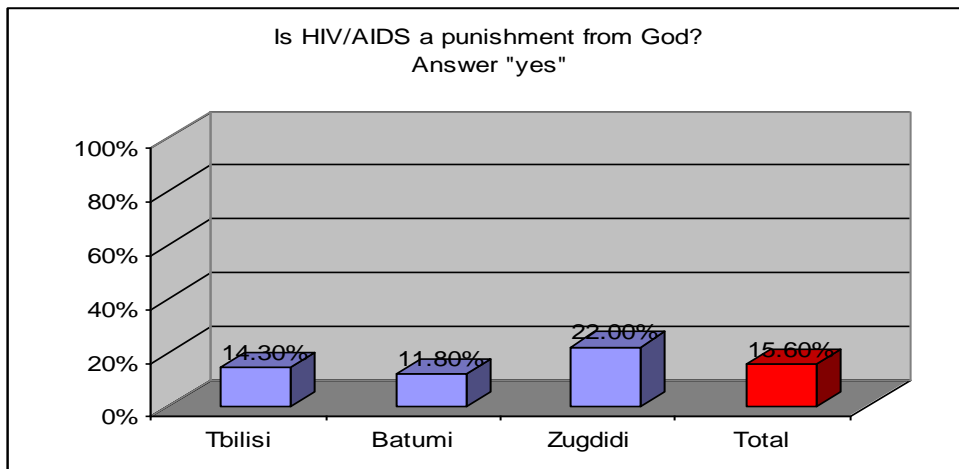
Figure 16: Percentage distribution of respondents believing that government shall provide free treatment to AIDS patients



Question # 23 – HIV infection is a punishment from God.

The belief that HIV infection is a punishment from God still prevails in many communities. Data demonstrated that 15.6% of all respondents agree with the statement. Highest percentage of judgmental attitudes was observed in Zugdidi (22.0%); relatively small proportion of respondents in Tbilisi and Batumi (14.3% and 11.8%, respectively) regarded HIV infection as a punishment from God.

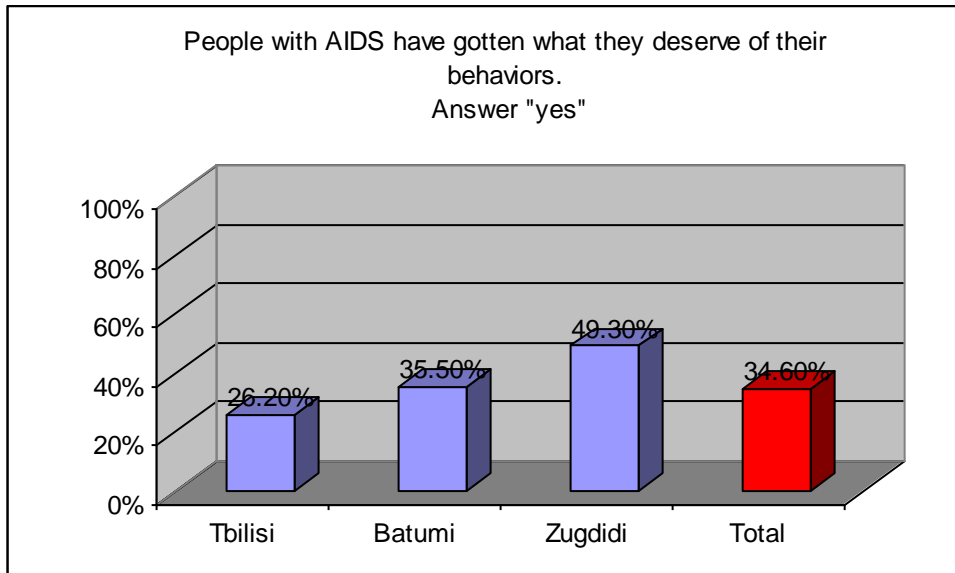
Figure 17: HIV infection is a punishment from God



Question #24 – People with AIDS have gotten what they deserve because of their behaviors.

In total 34.6% of study participants think that people acquired HIV infection because of their immoral or illegal behaviors. More judgmental attitude was demonstrated by respondents in Zugdidi (49.3%) compared with survey participants in Tbilisi and Batumi (26.2% and 35.5%, respectively).

Figure 18: Percentage distribution of respondents thinking that PLHA have deserved HIV/AIDS



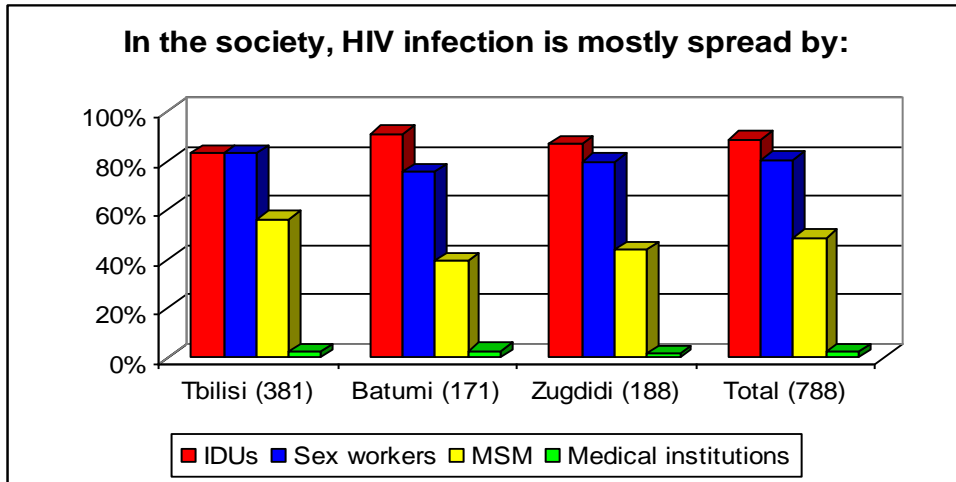
At the initial phase of the AIDS epidemic, the infection was associated with certain groups of societies, namely men who have sex with men. After spreading the infection to other groups, people started making assumptions and judgment about how the infection is being spread to general public and which groups of societies are to be blamed.

The study investigated which groups were blamed by respondents for the spread of HIV infection to broader groups of society. The vast majority of respondents (88.8%) reported that injecting drug users were responsible for the spread of HIV to general public in Georgia. IDUs were accused by 83.5% of participants in Tbilisi, 91.2% in Batumi and 86.7% in Zugdidi. This response is a reflection of official statistics of registered HIV cases in the country. Injecting drug users account for approximately 60% of all officially registered HIV cases.

It should be noted that according to the available statistical information in the country, very few cases of HIV infection were found among female sex workers. The data generated through Behavioral Surveillance Surveys (BSSs) conducted among female sex workers in Tbilisi and Batumi has demonstrated that the prevalence of HIV among female sex workers does not exceed 1%⁷. In addition, BSSs data suggest that the vast majority of FSWs almost always use condoms during sex with paid clients. Furthermore, FSWs reported that in most cases when condoms are not used, having unprotected sex is demanded by male clients.

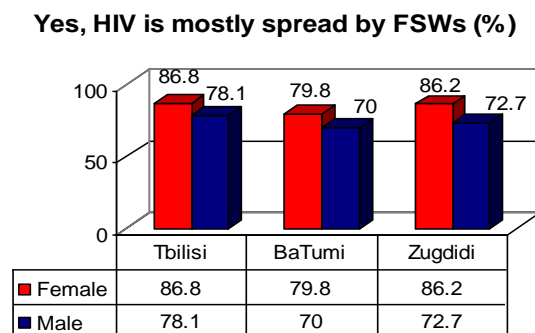
Despite this, 80.5% of all 788 respondents surveyed reported that female commercial sex workers are responsible for the spread of HIV to general public. Percentages were high and quite similar in all cities: 83.5% of all Tbilisi respondents, 75.5% of the Batumi participants and 79.8% of the Zugdidi respondents mentioned that FSWs are one of the main groups contributing to the spread of HIV in Georgia. No difference in responses by age groups was found.

Figure 19: Main groups to be blamed for HIV/AIDS



It was interesting to find out that percentage of surveyed women blaming FSWs in HIV/AIDS epidemic was higher than that among male participants. This tendency was maintained across cities. For example: 86.8% of female respondents in Tbilisi (vs. 78.1% among male respondents) think that FSWs are responsible for expanding HIV infection to general public; this indicator among female participants in Batumi was 79.8% (vs. 70% among male respondents); and 86.2% among women surveyed in Zugdidi (vs. 72.7% among male participants in Zugdidi). Even though this difference was not found to be statistically significant, it reflects the difference in attitudes of men and women towards commercial sex business in general.

Figure 20: Percentage distribution of respondents blaming FSWs by cities and gender



Only few respondents (2.3%) think that HIV in Georgia is spread through medical procedures and/or the negligence of health care providers.

Question # 26: Feelings towards PLHA

Study revealed that in all three cities majority of respondents, regardless age and gender, show compassion to HIV infected people. In total, 76.1% of survey participants reported being compassionate toward them; however it should be noted that the percentage of people empathizing PLHA in Zugdidi was significantly lower (59.7%) compared with respondents in Tbilisi (86.6%) and Batumi (74.1%).

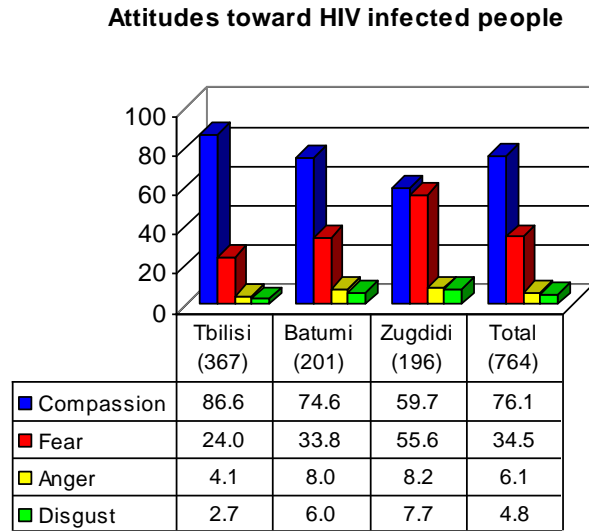
Certain portion of respondents reported that they feel fear toward HIV infected individuals. This indicator was lowest in Tbilisi (24%); it slightly increased for Batumi participants (33.8%) and reached 55.6% among the respondents in Zugdidi. The feeling of fear toward infected people was even more prevalent among students interviewed under the GIP study: 76% of students surveyed reported they fear PLHA³ (vs. 34.5% in our survey).

It is worth to mention that respondents were allowed to mark more than one answer. Therefore, some responses overlapped revealing that small portion of surveyed people who reported being compassionate toward infected persons, did not hide that they also had a feeling of apprehension toward PLHA.

It should also be emphasized that small portion of respondents showed quite negative attitude and admitted that they were angry at infected people. Such respondents account 4.1% in Tbilisi; this judgmental attitude was twice more likely among the participants in Batumi and Zugdidi (around 8% in each city).

Furthermore, unfortunately, some respondents reported they disgust HIV positive people. This very negative attitude was reported by 2.7% of respondents in Tbilisi, and again, this indicator was higher among participants in Batumi and Zugdidi (6% and 7.7%, respectively). However, respondents in our survey were much more tolerant to the HIV/AIDS affected population than young students participating in the GIP study; 29% of students reported they disgusted PLHA³.

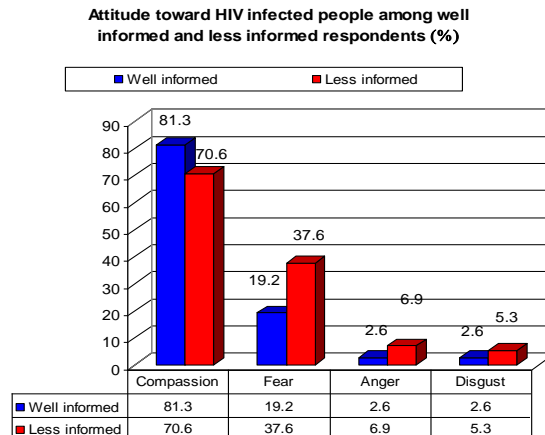
Figure 21: Respondents' attitudes towards PLHA



Researchers in the study became interested to examine the difference in attitudes among respondents who were relatively well-aware of HIV/AIDS and those who had little knowledge about the disease.

Additional analysis was performed for two categories of respondents: those respondents who gave correct answers to all seven questions (questions No1-7) were regarded as well-aware, and those participants who gave at least one incorrect answer to any questions from 1 to 7, were regarded as less-aware of HIV/AIDS. As it was expected, respondents who were well-aware of HIV were more likely to show compassion to HIV infected individuals and very few of them reported having a feeling of fear, anger or disgust toward HIV positive people. On average, 81.3% of well-informed participants are compassionate; however, despite the quite good knowledge they had about HIV transmission ways 19.2% reported that they fear infected people. It should be noted that feeling of being frightened was twice more likely among less-informed respondents (36.7%). Percentage of respondents who reported having feeling of anger or disgust toward PLHA was two times higher in respondents from less-informed group compared with well-informed participants. The findings are demonstrated in the Figure below.

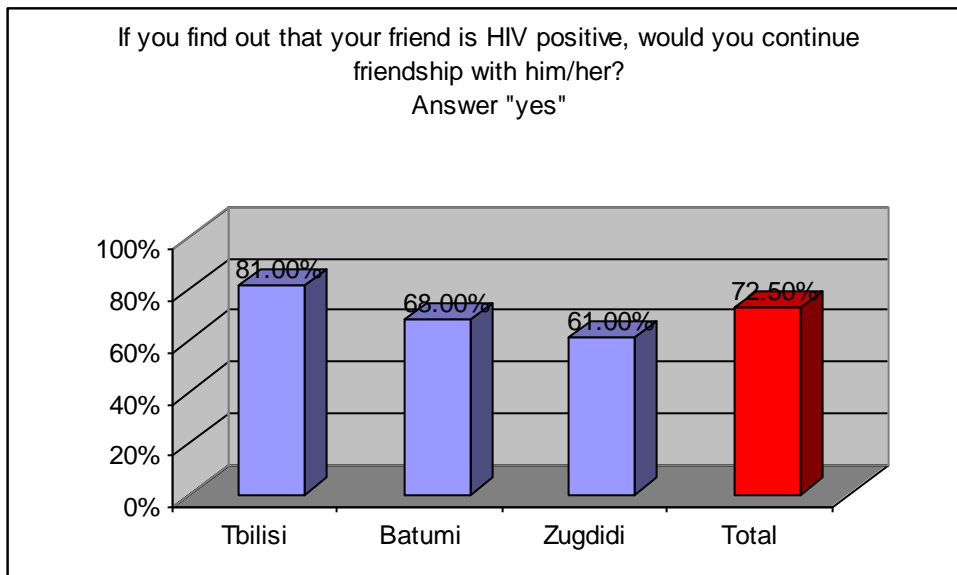
Figure 22: Attitudes towards PLHA among well-informed and less-informed groups



Question # 27 – If you find out that your friend is HIV positive would you continue friendship with him/her?

When asked if they would continue friendship with a person who is HIV positive, 72.5% of all respondents in three cities told that they would do so. Percentage distribution of positive response by cities is as follows: 81% of study participants in Tbilisi, 68% in Batumi, and 61% in Zugdidi. Thus, it can be assumed that HIV positive status will not have negative impact on interpersonal relationships. This finding can be plausibly explained by two assumptions: one of which is that local socio-cultural attitudes and friendship traditions is stronger than HIV related stigma; on the other hand, there might be a bias caused by the fact that respondents provided “correct,” socially more acceptable answer rather than true opinions (Social Desirability Bias). Further researches, in-depth interviews and FGDs could be more informative and useful to develop better understanding of people’s social behaviors.

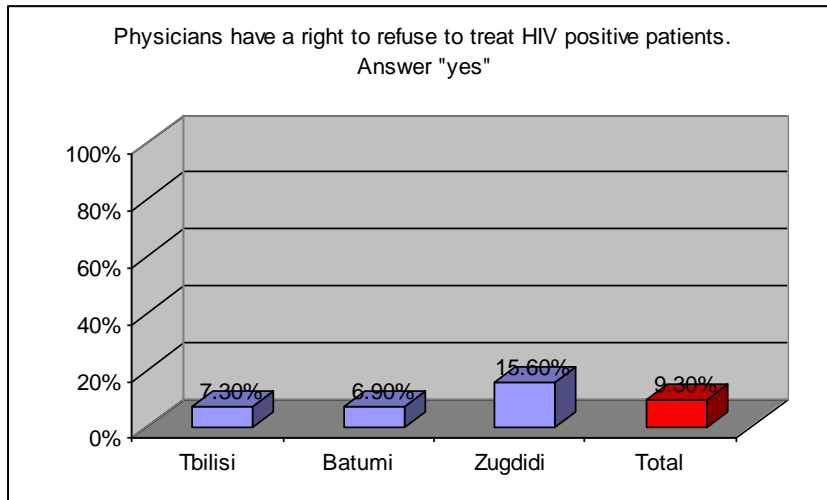
Figure 23: Attitudes towards HIV-positive friends



Question # 28 – A physician has a right to refuse to treat an HIV positive person.

In general, most respondents think that denial of medical services only on the basis of HIV positive status is not justifiable. However, one in every ten participants (9.3%) thinks that a physician has a right to refuse to treat a person who is HIV positive. Percentage distribution by cities is as follows: 7.3% in Tbilisi, 6.9% in Batumi and 15.6% in Zugdidi. It is visible that survey participants in Zugdidi were more likely to show negative attitudes toward those infected by HIV. This stigmatizing attitude was even more prevalent among female respondents in Zugdidi than in male population.

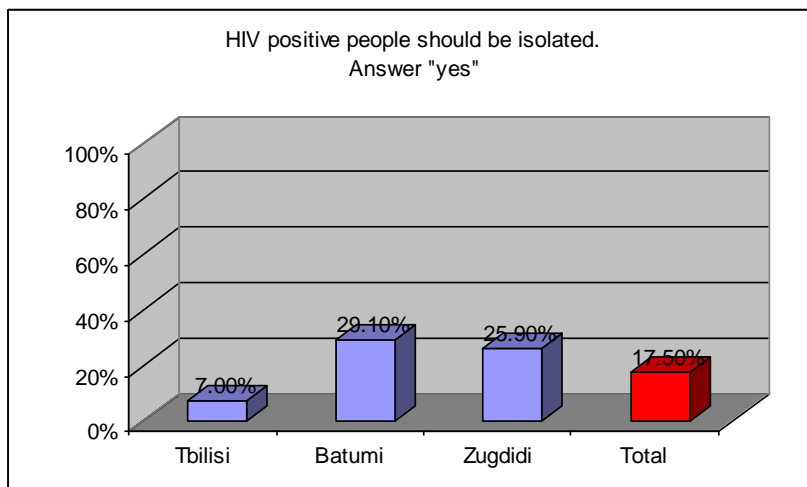
Figure 24: Percentage distribution of respondents reporting that doctors have a right to refuse to treat HIV infected patients



Question # 29 – HIV positive people should be isolated

It was quite unexpected that 17.5% of participants agreed that HIV positive people should be isolated from the rest of society. Furthermore, proportion of those who showed extremely discriminatory attitude against PLHA was higher among respondents in regions than those interviewed in Tbilisi. Almost one-third (29.1%) of people surveyed in Batumi and more than one-fourth (25.9%) of respondents in Zugdidi favored the idea of isolating HIV positive people. This indicator was 3-4 times lower among respondents in the capital city. Researchers also looked at the GIP survey results³. Out of 350 students interviewed 32% reported that they would like to have PLHA isolated from uninfected people. That was even more than the corresponding indicator received in any cities participating in our survey (see above).

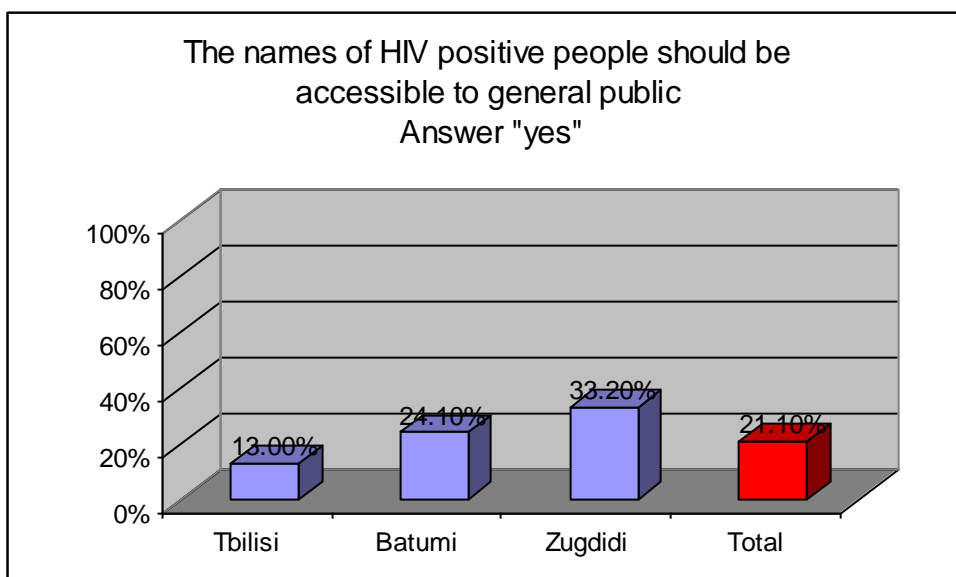
Figure 25: Percentage distribution of respondents agreeing that PLHA should be isolated from the rest of society



Question №30 - The names of HIV positive people should be accessible to general public

When asked if the names of HIV positive people should be accessible to general public, 21.1% indicated that the names of PLHA should not be kept confidential. The highest percentage was found among respondents in Zugdidi (33.2%) that was 2.5-times greater than the proportion of those participants in Tbilisi who embraced the idea of disclosing the names of PLHA. Positive answer was given by 24.1% of respondents in Batumi.

Figure 26: Percentage distribution of those respondents who think that the names of PLHA should be accessible to public

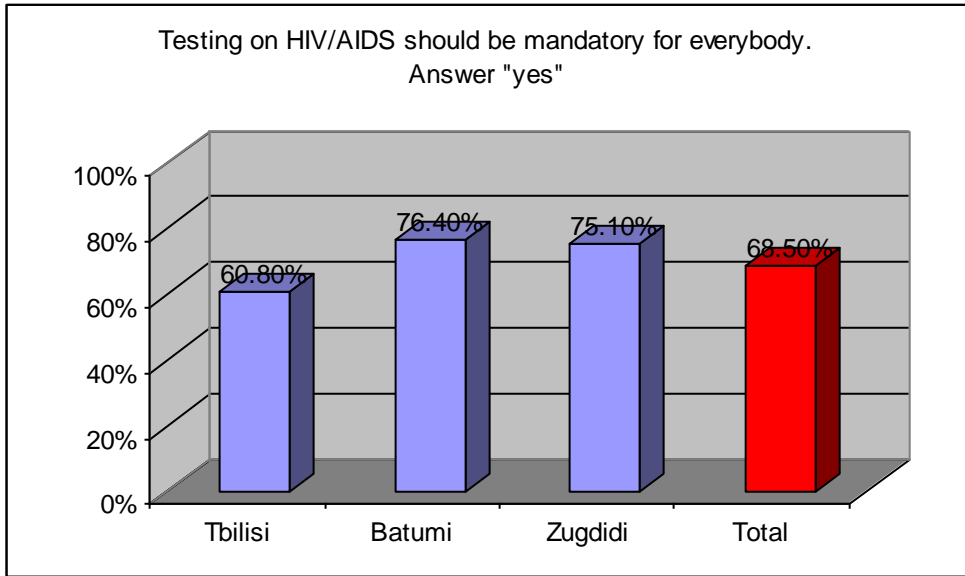


It was interesting to discover that young people interviewed during the GIP survey, were more likely to agree that the names of HIV-positive people should be open to society. These respondents accounted for 56% of all participants³.

Question #31 - Testing on HIV should be obligatory for every person

Data analysis demonstrated that majority of study participants (68.5%) favored the idea of mandatory testing on HIV. In general, this indicator was quite high in all cities and was similar by gender. Percentage distribution by cities was as follows: 60.8% in Tbilisi, 76.4% in Batumi and 75.1% in Zugdidi.

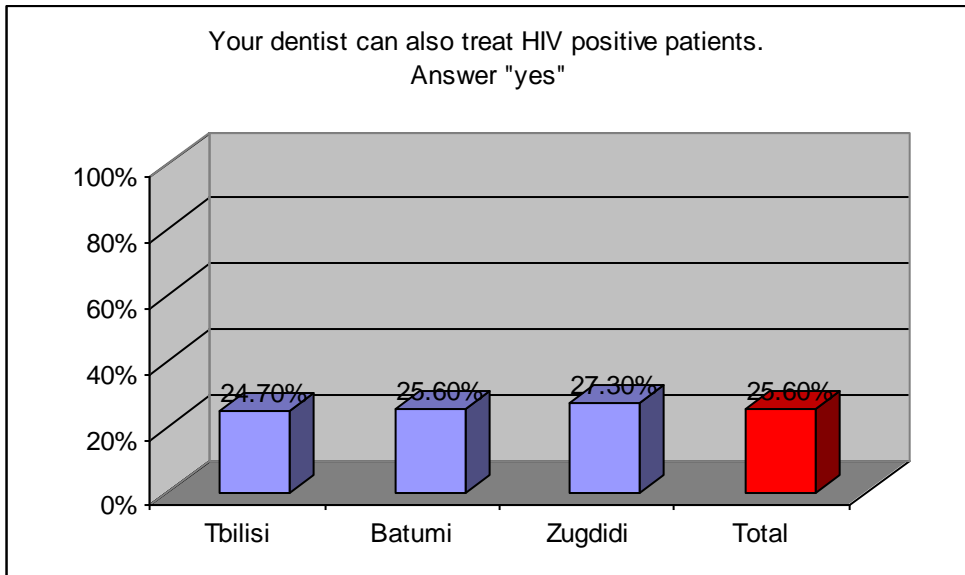
Figure # 27: Percentage distribution of those respondents who favored the idea of mandatory testing



Question #32 – Your dentist can also treat HIV positive patients

On average 74% of survey participants would not like it if their dentist provided medical services to HIV positive patients. Proportion of those respondents believing that a dentist can treat any person regardless a patient's HIV status comprised 24.7% in Tbilisi, 25.6% in Batumi and 27.3% in Zugdidi.

Figure 28

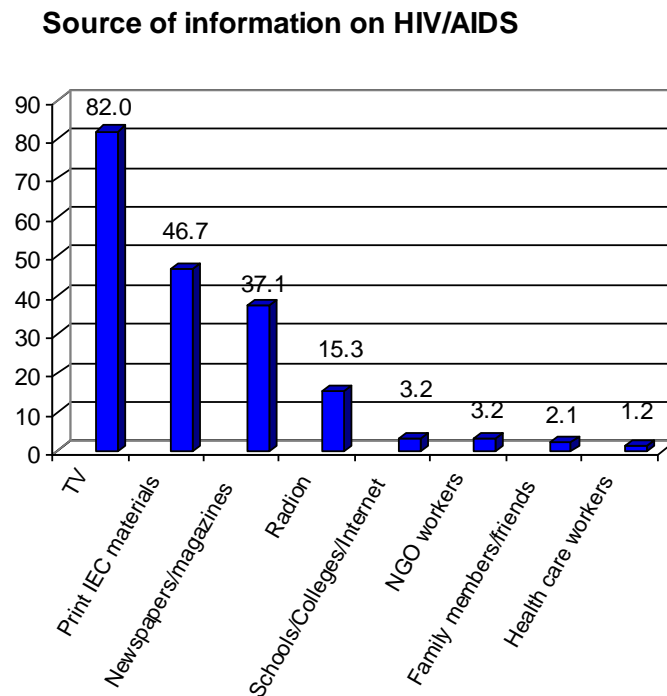


Question #33

International experiences have proved that the magnitude of HIV related stigma and discrimination is in negative correlation with the level of knowledge about HIV/AIDS. Findings of the study conducted in Georgia were consistent with the conclusions of many similar researches carried out worldwide.

Researchers looked at the major information sources on HIV/AIDS and tried to measure which source was the most popular among general population. In total 760 respondents answered questions regarding the sources of information; of them 365 respondents were from Tbilisi, 197 from Batumi and 198 from Zugdidi. Overwhelming majority of respondents (82%) reported that TV was the major source for receiving information about HIV/AIDS; almost half of participants (46.7%) reported having read informational booklets and educational print materials. More than one-third of people surveyed mentioned that they have received information about the AIDS epidemic through the press - news media, magazines and journals. Relatively rarely was reported receiving information through the following channels: radio (15.3%); schools or other educational institutions, Internet; NGOs or other HIV programs (around 3%); very few respondents told they have received information from their friends or family members (2.1%); most interestingly the role of health institutions in disseminating information about the virus was minimal; only 1.2% of surveyed people reported receiving information about HIV/AIDS from health care providers.

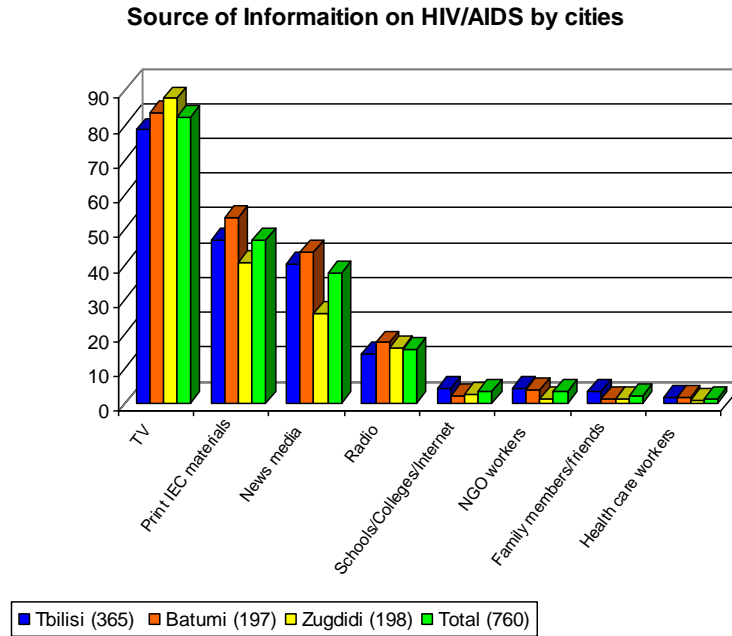
Figure 29: Major sources for receiving information about HIV/AIDS



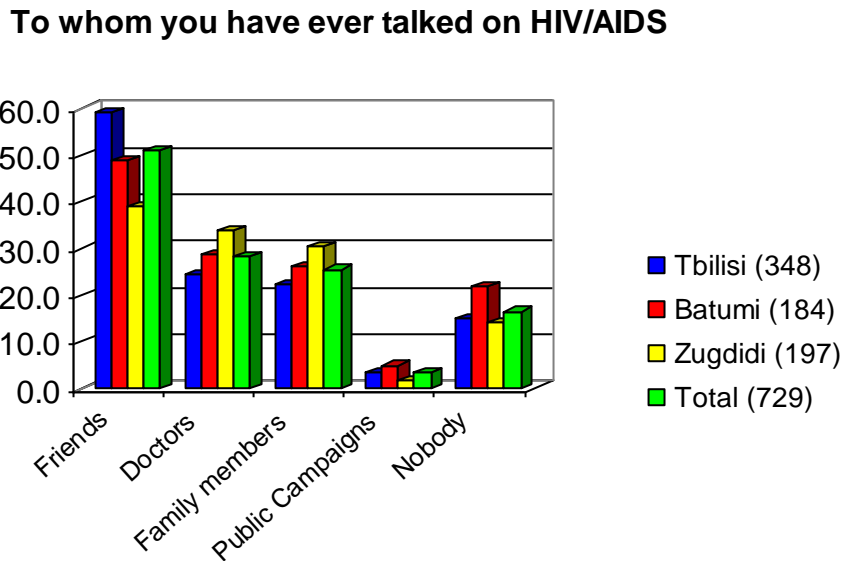
The Figure above visibly demonstrates the popularity of various information sources among respondents in terms of HIV/AIDS. The Figure #30 below represents the percentage by

research sites. It is obvious that general tendencies and patterns are quite similar for all three cities – Tbilisi, Batumi and Zugdidi.

Figure 30: Major sources of information by respondents in Tbilisi, Batumi and Zugdidi



Question #34 – To whom have you ever talked about HIV/AIDS?
Figure 31



Respondents were asked to name those to whom they have ever talked about HIV/AIDS. As demonstrated in the Figure above, more than half (51.2%) respondents reported that they have talked to their friends about HIV/AIDS. The percentage indicator was highest for respondents

in Tbilisi (59.2%); it slightly decreased for Batumi participants (48.9%) and did not exceed 39.1% for people surveyed in Zugdidi.

When asked about the major sources of information on HIV/AIDS, only 1.2% (9/763) of respondents reported receiving information on HIV from health care workers. However, analyzing responses given to the Question # 34 revealed that much more respondents have talked to health care workers about HIV/AIDS. Those who reported having discussed HIV related matters with medical doctors comprised 28% (205/729). The highest percentage indicator was found among respondents in Zugdidi (34%); it slightly decreased for Batumi participants (28.8%) and was lowest among respondents in Tbilisi (24.4%).

Approximately one-fourth of respondents (25.5%) reported that they have talked about HIV/AIDS with family members. Slightly more participants in Zugdidi have had a conversation about HIV with their family (30.5%) compared with those in Batumi and Tbilisi (26.1%, and 22.4% respectively).

It was interesting to find that almost 15% of respondents in Tbilisi, 22% in Batumi and 14% in Zugdidi told that they have never talked about HIV with anybody. The majority of such responses were reported by the respondents of reproductive age. No significant difference among participants by cities was observed.

Conclusions and recommendations

The survey proved that high level of stigmatizing and judgmental attitudes towards PLHA are still prevailing in Georgia. Even though that over the last years, wide-range public awareness campaigns have been organized in Georgia, the level of HIV awareness among community members is not adequate. The knowledge on HIV varies among the populations in different cities. Population in the capital city is relatively well aware of HIV/AIDS compared with the people living in Batumi and Zugdidi. The difference in HIV awareness by gender is also observed in all three cities. Male respondents were more likely to give correct answers about HIV transmission than female participants. The difference in the level of HIV awareness by gender is most obvious in Zugdidi, less in Batumi and the least in Tbilisi. Taking these findings into consideration, special emphases should be placed to investigate what are the main reasons for inequalities by gender and cities and address unmet needs of women as well as populations in regions.

Preventive activities and awareness raising public campaigns should be expanded to other cities and regions as well to reach out to communities not only in urban cities but also in remote areas. Serious efforts should be undertaken for widening educational activities targeting women. It is well-recognized that women are especially vulnerable to HIV due to biological, socio-cultural, economic and other reasons. Gender-specific national strategies for HIV prevention and education should be elaborated in the country. All gender specific issues should be reflected and adequately addressed in the national strategies.

The survey proved that the knowledge about HIV plays a key role in the formation of either positive or negative attitude toward PLHA. The level of knowledge is in reciprocal relation with the level of judgmental and stigmatizing attitudes. Better informed respondents have demonstrated higher level of empathy toward PLHA than less-informed groups; survey participants who were more knowledgeable about HIV/AIDS generally have shown less aggression and disgust toward the people affected by HIV. These findings stress the need for increasing public awareness of HIV/AIDS.

The survey demonstrated that people are most likely to give correct answers to questions on how HIV is transmitted (questions regarding monogamous relations, condom use, etc.). More attention should be focused on how HIV cannot be transmitted in order to correct prevailing myths and misconceptions about HIV. Special emphasis should be placed to convince people that HIV cannot be transmitted through mosquito bites, through saliva or casual contacts. Some respondents still believe that a child can catch the virus through playing with HIV-infected children, or the virus can be transmitted from infected persons to their caregivers. Therefore, to enhance population's knowledge about HIV by providing correct information and reinforcing messages on a regular basis is of utmost importance.

The survey findings point out that majority of surveyed people experience fear toward PLHA. It should be emphasized that some respondents have dual feelings – while empathizing HIV infected people they also have a feeling of apprehension. Most participants think that if they were HIV-positive, they would be abandoned by friends, relatives and beloved ones. The feeling of shame was cited by many respondents as one of the main reasons for not disclosing

HIV positive status to others. It is known that while answering hypothetical questions, some people may tend to extrapolate their own feelings and attitudes and project their own expected behaviors to the general population. Therefore, it is possible that those respondents, who told that they would be abandoned by friends if they were infected, themselves would react in a similar way.

It is essential to conduct more FGDs and in-depth interviews that would shed more lights on those underlying factors that induce negative attitudes and breed stigma and judgmental relations with PLHA. Based on the findings more tailored and targeted IEC materials should be developed. To ensure that desired impact is achieved all these materials, as a rule, should be pre-tested among target groups.

Wide-scale public awareness raising campaigns dedicated to HIV/AIDS should not be occurring occasionally as it is happening in most countries including Georgia. Public information campaigns help counter denial and lead to reduced levels of AIDS epidemics and HIV related stigma. Due to the fact that Georgia is categorized as having a low-prevalence HIV epidemic with the estimated HIV prevalence rate 0.1% among adults¹⁰, most state-funded or donor supported programs in the country are focused on most-at-risk populations, and educational campaigns targeting general public as well as interventions aimed at combating stigma and discrimination of PLHA are mostly planned only twice a year – on December 1, World AIDS Day, and on the third Sunday of May when international communities worldwide commemorate AIDS Memorial Day. It is obvious, that HIV public awareness raising campaigns should be implemented on a more regular basis and should be utilizing all potential media outlets and other means of communication.

The media have a pivotal role to play in the fight against HIV related stigma and discrimination as it has tremendous reach and influence. According to the survey in Tbilisi, Batumi and Zugdidi, vast majority of respondents identify television, radio and newspapers as their primary source of information about HIV/AIDS, more than doctors, friends, and family. Similar statistics have been reported in the US, UK, India, and elsewhere in the world¹¹. Therefore, ensuring greater and positive involvement of mass media in HIV prevention is a key to success.

It is necessary to develop media standards for reporting on HIV/AIDS in a non-judgmental and non-stigmatizing manner. Trainings for sensitizing media representatives will be crucial to ensure that the journalists' ethical guidelines coined as RESPECT (Responsible, Ethical, Sensitive, Participative, Empowering, Compassion and Trust)¹² are well-understood and followed.

The survey conducted among the population in three cities of Georgia once again confirmed that TV is the major source for receiving information about HIV/AIDS (more than 80% of all respondents reported receiving information from TV). Therefore, one of the most essential ways to increase awareness and decrease stigmatizing attitudes among general public can be broadcasting HIV educational video-clips, talk-shows, social ads, etc. However, recognizing

¹¹ Global Media AIDS Initiative: The Media and HIV/AIDS: Making a difference; UNAIDS, Kaiser Family

¹² Putting HIV on the front page; UNAIDS

that the utilization of TV commercials may require solid financial resources, that is not always affordable and feasible, other information sources, such as print media and/or printed IEC materials should be used more aggressively.

Given that HIV/AIDS is a multidimensional and multisectoral issue, the role of other sectors in public education should be strengthened. Meaningful partnership should be established among government, health professionals, non-governmental organizations and local communities. To outreach to wider population with HIV prevention and education, involvement of various sectors should be encouraged. With the aim to fight AIDS and reduce its impact at individual, community or national level public, private and business sectors should be involved in the implementation of HIV national strategies. Extensive advocacy work should be undertaken to sensitize business communities and private sectors on the issues of HIV/AIDS and convince them that investing in HIV prevention today will avoid far heavier financial and human costs in the future. Further steps should be taken to encourage employers and management teams to ensure enhanced access to HIV information, counseling and testing services. IEC materials on HIV prevention should be available at workplaces. Community mobilization should lead to enhanced participation of community and religious leaders and celebrities in HIV preventions strategies.

Special emphasis should be placed on strategies targeting youth and young people at risk. Educational sessions, as well as outreach to students should be carried out on a regular basis. International experiences have shown that youth-focused and age-specific behavioral change and communication (BCC) strategies should involve not only discussions, lectures, sessions at schools and/or universities, but also exhibitions, essay contests, sport-competitions. Educational activities for youth can be effectively combined with entertainment (music, drama). Considerable attention should be given to the factors that stimulate negative attitude toward PLHA.

Survey findings revealed that very few respondents reported receiving HIV information from health institutions. Health care system is expected to have more significant role in HIV education and prevention. Trainings should be provided to medical staff on HIV/AIDS. Advocacy work should be undertaken with health officials and policy makers to ensure that HIV prevention, education as well as counseling and testing services are incorporated into health care system at all levels, especially into the primary health care settings. IEC materials should be easily available for all clients visiting health care centers; posters can be displayed at visible places, especially in waiting rooms or so called educational corners. IEC materials should be user-friendly; messages should stimulate discussions and encourage readers to get tested on HIV. To help people generate more sensitive, compassionate, non-discriminatory attitude toward PLHA, messages should be designed in a way that avoids negativity and inspires readers with the spirit and courage to empathize and support the people affected by the virus. Content of positive messages could be as follows: “HIV cannot be transmitted through friendship” (Poster, Local NGO – Georgia Positive Group), or “Do not be negative about being positive” (Anti-Stigma Public Campaign, Zimbabwe, 2005).

Individual in-depth interviews or group discussions should be organized with HIV infected people and their family members. That will allow researchers to unveil real facts about

discrimination in different settings. Discrimination based on individual's HIV seropositivity takes many forms: delay or denial of medical procedures, dismissing workers regardless of their capacity for work, denial of employment, being unwelcome or shunned by the community members, etc. Based on these findings, specific tailored materials should be elaborated and disseminated at targeted facilities and audiences.

Based on the survey results 46.8% of respondents would disclose their HIV status to regular sexual partners if they were infected. More work will be needed in this direction among community members, including people living with HIV, to inform them about the need for the adoption of preventive measures. Every infected person should be equipped psychologically to notify his/her regular partner (partners) of the potential HIV exposure and of the necessity of having an HIV test. Partner notification is particularly important to protect sexual partners of infected people and contain further spread of HIV to general public.

One of the most effective ways to elaborate effective HIV prevention is to promote evidence-based programming through researches. Therefore, it is very important to strengthen research capacities of local health care professionals and social researchers in Georgia. Findings generated through this survey may serve as a baseline for future national surveys. Follow up studies should be conducted that will enable researchers and policy makers to track the behavior change and evaluate efficacy of strategies and interventions being carried out.

Therefore, one of the significant recommendations is to advocate for mobilizing adequate resources (financial as well as human) to ensure that follow-up researches, surveys and studies are carried out at a certain periodicity. The data produced will be used to monitor the level of knowledge among general public, to evaluate population's attitude towards PLHA and guide future planning and development decisions in the area of HIV/AIDS.

And at last but not at least, planning, implementation and evaluation of HIV national strategies should be carried out in partnership with PLHA. There is strong evidence that HIV epidemics can be prevented or at least contained through targeting PLHA. The idea of ensuring a Greater Involvement of PLHA (known as GIPA principle endorsed by UN member countries as part of the Declaration of Commitment on HIV/AIDS)¹³ has been embraced by many communities worldwide. Incremental steps should be taken by skilled professionals to encourage people living with HIV in Georgia to become involved in awareness raising campaigns and serve as volunteers in public speaking and communications. There are have been many effective examples worldwide that sharing of real-life stories and testimonials from individuals who are willing to identify themselves and who have dealt with HIV with courage and dignity can help more than anything else to build positive atmosphere in which people are inspired to move from *passive support to supportive action*.

¹³ The Greater Involvement of People Living with HIV (GIPA); UNAIDS

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Appendix #A

Questionnaire

City

Sex

Age

Profession

Hello, my name is ----

We are conducting a study to assess the situation on HIV/AIDS in Georgia. We would appreciate if you could participate in the study. Please, read questions and mark the responses you agree with.

Please, be advised that the survey is anonymous and you will not be asked to provide your name. Your participation is very important to the study. We thank you in advance.

1	Can the risk of HIV transmission be reduced by having sex with only one uninfected, faithful partner?	1. Yes 2. No 3. Do not Know
2	Can a person reduce the risk of getting HIV by using a condom every time they have sex?	1. Yes 2. No 3. Do not Know
3	Can a healthy-looking person have HIV (without having any symptoms)?	1. Yes 2. No 3. Do not Know
4	Can a person become infected through kissing an HIV positive person?	1. Yes 2. No 3. Do not Know
5	Can a person become infected by shaking hand of an HIV positive person?	1. Yes 2. No 3. Do not Know
6	Can one get HIV by sharing food/cutlery with someone who is infected?	1. Yes 2. No 3. Do not Know
7	Can a person get HIV from mosquito bites?	1. Yes 2. No 3. Do not Know
8	Can treatment prolong and improve the quality of life of HIV positive person?	1. Yes 2. No 3. Do not Know
9	Can a person get HIV infection through taking care of AIDS patient?	1. Yes 2. No 3. Do not Know
10	Can a child get HIV through playing with an HIV positive child?	1. Yes 2. No 3. Do not Know

11	Would you buy some fruits and vegetables or some other products if a salesperson is HIV infected?	1. Yes 2. No 3. Do not Know
12	If a teacher is HIV positive, should she/he be allowed to teach?	1. Yes 2. No 3. Do not Know
13	If a student/pupil is HIV positive, should she/he be allowed to study with others?	1. Yes 2. No 3. Do not Know
14	Would you continue working in the office where one of your colleagues turns to be HIV positive?	1. Yes 2. No 3. Do not Know
15	Would you have a dinner at the house of a person who is HIV positive?	1. Yes 2. No 3. Do not Know
16	Would you go to an HIV positive doctor for treatment?	1. Yes 2. No 3. Do not Know
17	If you or one member of your family were HIV infected, would you keep it a secret?	1. Yes 2. No 3. Do not Know
18	If you were HIV positive, to whom would you disclose your status? (Mark all responses that apply)	Friend Relative Sexual partner Physician Nobody I do not think, I have to keep it secret others (please specify) _____
19	If you would not disclose your HIV status to anybody, what would be the reasons? (Mark all responses that apply)	Shame Fear of being abandoned My rights will be violated Other (please specify) _____
20	If your friend tells you that he/she is HIV positive, would you disclose this information to anybody?	1. Yes 2. No 3. Do not Know
21	HIV infected people are dangerous to society	1. Yes 2. No 3. Do not Know
22	Government shall provide free treatment to AIDS patients	1. Yes 2. No 3. Do not Know
23	Is HIV/AIDS a punishment from God?	1. Yes 2. No

		3. Do not Know
24	People with AIDS have gotten what they deserve because of their behaviors.	1. Yes 2. No 3. Do not Know
25	HIV is mostly spread to general public by: (Mark all responses that apply)	MSM Female Sex workers IDUs Others (please specify)
26	My feelings towards HIV positive people can be described as: (Mark all responses that apply)	Fear Anger Compassion Disgust Other (please specify) _____
27	If you find out that your friend is HIV positive, would you continue friendship with him/her?	1. Yes 2. No 3. Do not Know
28	A physician has a right to refuse to treat an HIV positive person.	1. Yes 2. No 3. Do not Know
29	HIV positive people should be isolated	1. Yes 2. No 3. Do not Know
30	The names of HIV positive people should be accessible to general public	1. Yes 2. No 3. Do not Know
31	Testing on HIV should be obligatory for every person	1. Yes 2. No 3. Do not Know
32	Your dentist can also treat HIV positive patients	1. Yes 2. No 3. Do not Know
33	From where you have received information on HIV/AIDS? (Mark all responses that apply)	TV Radio Booklets The press Other sources -----
34	To whom you have talked about HIV/AIDS? (Mark all responses that apply)	Friends Physician Family member Others (please, specify) -----

Thank you for your support and help