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Women's Knowledge and Attitudes about HIV/AIDS Prevention Policy in post-Socialist Georgia

Summary

The current paper explores factors influencing women's decisions to oppose school-based HIV prevention programs in Georgia. Examining the individual characteristics common among those opposed to reproductive and sexual health programs in schools can assist in understanding the correlates of opposition and lend insight into how best to build popular support for this important public health intervention. Using data from the CDC 1999/2000 Georgian Women RHS, I test if HIV knowledge predicts women's attitude toward school-based health education. The results show very low levels of HIV knowledge and high levels of misconceptions among educated women. The lack of HIV knowledge and misconceptions concerning HIV transmission are powerful predictors, among other socio-demographic and cultural factors, of opposition among Georgian women to school-based HIV prevention programs. This analysis finds evidence for the importance of adult education programs in the realm of reproductive and sexual health, for creating a supportive legislative environment for school-based program implementation.

Background

The development of comprehensive educational programs is recognized as a key area for public health promotion. Schools are important settings for encouraging healthy lifestyle norms among children and young adults. School-based reproductive and sexual health education programs, including components on preventing HIV, are important elements of country-level HIV/AIDS prevention plans. In addition to providing knowledge and life skills, HIV education treats sexuality as an important part of human lives, promoting positive human relationships, and gives factual information that help to reduce stigma and misconceptions about HIV and sexuality.

School based programs focusing on reproductive and sexual health are often socially divisive, and Georgia is no exception. Today, the country is going through a fundamental process of re-orientation and liberalization in norms of sexual behavior, but many traditionally conservative sexual views are still widely held (1, 2). Georgia currently has a low HIV/AIDS prevalence rate, but it is classified as a high growth region within the global AIDS pandemic (3). The risk of rapidly spreading infection is quite high due to widespread injecting drug use, commercial sex work, intensive population mobility to high-prevalence countries, risky

behaviors such as needle shearing, and unprotected sexual behaviors, the effects of which are amplified due to the low levels of HIV education, widespread sexual health misconceptions and gender inequality (4,5,6,7). As a result of more than a decade of economic crisis, the role of the family and school in education has also declined, with adolescents becoming exposed to the strong influence of street life manifesting itself in smoking, alcoholism, drug-abuse, and prostitution at ever younger ages.

According to several studies, HIV/AIDS-related knowledge among the Georgian population is considered satisfactory. At the same time, however, studies indicate high levels of co-occurrence of incorrect beliefs about HIV transmission, which is largely independent of accurate knowledge about documented modes of transmission. Co-occurring inaccurate beliefs about undocumented modes of transmission reflect cultural understandings of disease, which are often shaped by the local history of HIV transmission. Such inaccurate knowledge is largely constructed by social-cultural and structural characteristics of the society, which put individuals at risk and deepens discrimination and stigmatization. One investigation that compares HIV/AIDS knowledge in five Eastern European countries among different occupational groups show that Georgian nurses are the least aware of HIV and AIDS (8).

Comparing the data from two studies (9, 8) indicates that the level of AIDS knowledge correlates with the level of education. According to the 2002 Adolescent's Reproductive Health Survey (10) 87% of youth has a keen interest in sexuality issues but their discussions are limited to their peers. Adolescent have heard about HIV/AIDS (86%), but they have poor knowledge about transmission routes and prevention. While male adolescents have demonstrated higher knowledge due to different sexual standards and pre-marital experience, female adolescents indicate lower levels of knowledge.

The two behavioral and biomarker surveillance surveys (11, 12) conducted among injecting drug users and female sex workers demonstrated high awareness but moderate to low level of knowledge about AIDS transmission routes and prevention methods. Consistent utilization of condoms with regular partners rarely takes place (12%), even if respondents ever used previously-used needles/syringes (67%), or had sexual contacts with commercial sex workers (48%).

Despite strong protest from some religious leaders and political parties, a pilot phase school-based HIV/STI and drug prevention education program became available in October, 2005. Twenty secondary schools in the city of Tbilisi took part in the Life Skills Building

Program developed by the local experts, within the framework of the Global Fund to Fight AIDS, TB and Malaria (GFATM) project (13). After the pilot phase, the program will be evaluated by a special committee of public representatives, including religious groups, people living with HIV and adolescents, to improve the content and the language of materials. This pilot program may provide the basis for widespread program implementation across Georgia, but first the questions of community acceptance must be addressed. There remains strong opposition to the incorporation of reproductive and sexual health issues into school curricula.

Few studies examine individual and structural characteristics in relation to school sex education policies. While the majority of adults, including parents and voters, support comprehensive sex education, some religious, community and political leaders have negative attitudes toward condom promotion and sex education (14, 15). Herek and Glunt (1993) demonstrated that for AIDS pragmatism attitudes, that include free condom distribution and AIDS education in public schools, education, religion, gender, race, casual contact beliefs and attitudes toward gay men, emerged as significant predictors in different models (16). Beliefs about the risk posed by casual contact affected the AIDS coercion attitudes that support AIDS stigmatized policy. Authors argue that people who overestimate the risks posed by casual contact simply do not believe public health authorities who say that HIV cannot be transmitted through these routes. The similar explanations in the cases of Russia and other post-Soviet republics are grounded on local history of high medical risk of getting HIV from utilization of unsterilized supplies (17, 18).

The prevailing misinformation often contributes to the negative attitudes and stigma that is usually strong among individuals who have negative attitudes toward the publicity of the subject of sex education. Given the current attempts at the implementation of family-life education and low level of AIDS knowledge with strong attitudes toward gender roles, Georgia provides unique opportunity to further explore the ways in which health knowledge affects attitudes toward comprehensive school health education.

Clearly, understanding public attitudes toward comprehensive health education is necessary to create a supportive environment for legislative purposes and to understand sexuality-related and AIDS-related attitudes specifically. In Georgia, where women are mostly in charge of the education of children within family, research evaluating individual attitudes toward politicized and sensitive issues will have wide-ranging practical implications. Examining the individual characteristics common among those opposed to reproductive and sexual health

programs in schools can assist in understanding the correlates of opposition and lend insight into how best to build popular support for this important public health intervention.

The primary goal of this paper is to provide insights into the cognitive and cultural attitudes toward school health education in Georgia. I will address the following questions. First, what is the HIV/AIDS knowledge level among women and how does this knowledge affect women's attitudes toward sex education? Second, what are the characteristics of those women who oppose versus those who favor sex education? Third, what are the main traditional beliefs and cultural attitudes that prevent women from supporting sex education? To answer these questions I hypothesize that lack of knowledge about AIDS transmission and prevention tends to increase opposition toward school sex education, after controlling for socio-demographic variables and net of other cultural attitudes that might mediate relation between AIDS knowledge and decisions on school health policy. In addition, I intend to find high support for sex education, low level of AIDS knowledge and high belief in casual and medical risk of getting HIV.

Research Methodology

Data: Information concerning comprehensive school sex education was obtained from the 1999-2000 Georgian Women Reproductive Health Survey (RHS), conducted by the National Center for Disease Control, Tbilisi, with assistance from the Division of Reproductive health, Centers for Disease Control and Prevention Atlanta (19). The survey face-to-face interviewed a nationally representative sample of 7798 women 15-44 years of age, including 5703 ever sexually experienced women. The overall sample was selected through 14495 households, yielding a response rate of 98.8%. The survey was designed to collect information from reproductive-age women throughout Georgia, primarily to assess reproductive health conditions according to demographic, socioeconomic and health related questions. Analyses in this study include the total sample of 7798 women and all procedures utilize weighted data.

Measures: Women's attitude towards school health education derived from the question: "Do you think schools should teach courses about reproductive biology, contraception and prevention of sexually transmitted diseases?", and I focus on those who are actively opposed (responding "no"). While the final report of CDC Georgian RHS 1999-2000 briefly covers this topic under the chapter of sex education, analyses in my study will refer to the attitudes toward sex education as a dependent variable.

Level of HIV/AIDS knowledge is assessed from the several questions about AIDS transmission routes including through sexual, blood/needle sharing and vertical transmission (alpha reliability 0.844). The knowledge of HIV prevention will be based on three main types of prevention strategies, abstinence, fidelity and condom use (alpha reliability 0.777).

As controls, the model employs individual predictors from socio-demographic variables. Such variables influence women's attitudes toward sex education in indirect ways as well as through their effect on the individual's social environment. Respondents provided information on their age, education, residence, working status, number of children and religious affiliation. All these variables, except age and education, are coded as dummy variables, with one category defined as a reference category.

The model also includes country specific attitudinal and belief variables such as attitudes toward gender roles, medical risk of getting HIV and misconceptions associated with mosquito bites and casual contact. Such variables might help to explain mechanisms between the relation of AIDS knowledge level and decision on teaching sex education at schools. Especially, views related to cultural taboos and gender roles might increase likelihood of opposition and mediate the direct effect of AIDS knowledge on opposition toward sex education. The most common beliefs in HIV medical risk are associated with surgical treatment, dental treatment, blood donation and use of beauty salon services. All these items are combined to construct variable that measures belief in HIV medical risk (alpha reliability 0.791). Misconception presents two independent variables. The first is belief in HIV transmission through mosquito bites and the other belief in transmission via shaking hands with an HIV infected person. All attitudinal variables are introduced in the model as dummy variables with one reference category.

Analysis: The first stage of the bivariate analysis shows the frequency distribution of the sample by looking at women's AIDS knowledge level, socio-demographic and attitudinal characteristics, and the same table indicates associations among independent variables and women's attitudes about sex education. Analyses were also conducted to show the distribution of women's characteristics by AIDS knowledge level. Chi-square significance tests and correlation coefficients were used to examine existing associations between dependent and independent variables.

Multivariate logistic analyses (20) taking into account women's socio-demographic and cultural background characteristics are used to examine the relationship between level of knowledge and attitudes towards sex education. The total sample of 7798 women is employed

and an odds ratio derived for each category of the factor that expresses the magnitude of the increased risk in relation to the reference category. From the scaled measures of AIDS knowledge I construct two dummy variables of transmission and prevention that express women's lack of knowledge, with reference categories of women with moderate/high transmission and some prevention knowledge.

A total of three models are examined. Model 1 is unadjusted to identify the total effect of AIDS knowledge level on the outcome variable. Model 2 is adjusted for socio-demographic variables and the full model 3 adds the series of attitudinal variables to identify the indirect and direct effect that might explain the association.

Results

According to the Georgian Reproductive Health Survey of 1999-2000, 85% of women aged 15-44 believe that courses about reproductive biology, contraception and prevention of STDs should be delivered in schools in Georgia. While the majority of women support sex education, a minority (11%) oppose such program at schools. The main argument for the opposition is early sexual initiation (84%), belief that family should teach the sex education (62%) and lack of teachers (47%).

General characteristics of respondents and its distribution according to the attitudes toward sex education are shown in Table 1. Overall, 37% of the women are young adults from 15 to 24 years of age. One in three women are in age 35 to 44 with higher opposition views about sex education. One fourth of women have a college or university education and half of respondents have secondary school education. The high opposition toward sex education is more common among older women with secondary education level. More than half of women are urban residents who also less likely to oppose sex education, compared to rural women. Overall, 40% of women in the sample are childless, with 33% (data not shown) never sexually experienced. Views on sex education among women with at least one child and among women without child are slightly similar. The dominant religion among the sample is Georgian Orthodox, who are less likely to oppose to sex education, compared to the second largest group, Muslims, and other religion affiliated respondents who are more in favor to refuse sex education. Women who reported that they do not work outside the home also reported increased opposition to teaching sex education at schools.

Adherence to traditional reproductive norms and gender roles for women demonstrates their disagreement toward sex education. Table 1 also shows that 85% of women hold conservative views about sexual experience prior to marriage and more than half agree that "women should have as many children as God gives them". About 13% of reproductive age women do not know that they can get pregnant at first intercourse and also disagree with sex education.

Women demonstrated low levels of AIDS knowledge, especially for AIDS prevention methods. Overall, knowledge of AIDS transmission among women varied between having no knowledge (9%) and knowing all five main routes of transmission (63%), with a mean of 4.96 known ways of transmission from six item questions. Knowledge about AIDS prevention varied between having no knowledge (43%) and knowing all three main prevention methods (9%), with a mean of 0.92 known ways of prevention from four item questions. Only half of women, even after a probing question, agreed on condom prevention. Belief in HIV medical risk among women varied between having no belief (15%) and having high belief (63%), with a mean of 2.58 from four item questions. While disagreement about teaching sex education is more common among women with low AIDS transmission and prevention knowledge, women with no belief in medical risk demonstrated the same attitude toward sex education. This fact is explained in Table 2 that shows that women's high belief in medical risk is indicator of high knowledge of AIDS transmission. While AIDS transmission and prevention knowledge is low among younger women, those with low education levels, and those women who are rural, unemployed, have no children and identify as a religion other than Orthodox, medical risk belief is more common among women who are older, with high education level, urban, employed, with children and Orthdox. Among two misconceptions mosquito bites is more common than shaking hands, but both variables demonstrate significant correlation with sex education and they are included in a final model.

Women with strong traditional views on gender role and sexuality demonstrated low levels of AIDS transmission and prevention knowledge. Women with more conservative views about virginity, motherhood to have as many children as GOD gives her and women with lack of knowledge about pregnancy occurrence show low levels of AIDS transmission and prevention knowledge, compared to women who have no such attitudes toward virginity, motherhood and pregnancy occurrence.

Multivariate analysis: All variables that were significantly associated and correlated with the dependent variable entered into the multivariate analysis. The three models of the logistic regression approach are employed to test the magnitude of the likelihood that women will oppose sex education at schools in Georgia. The first model estimates association of AIDS transmission and prevention knowledge with the opposing view on sex education. The second model includes the socio-demographic variables and the third model adds the attitudinal variables to the second model to test the effect of traditional beliefs on the opposition toward sex education, as an additional specific predictors. The results of odds ratios on the total sample (N=7798) of women presented in Table 3.

Model 1 of the analysis, which includes AIDS transmission and prevention variables, yields results similar to those of the bivariate analysis. Women with no/low transmission and no prevention knowledge demonstrated significantly higher odds of opposing sex education than the women who have moderate/high level of transmission and some level of prevention knowledge.

In Model 2, with adjustment of socio-demographic variables, AIDS transmission and prevention variables are still significantly associated with oppose view of sex education. Among personal predictors older women in age 34 to 44 significantly are more likely to oppose sex education than the women in 15 to 24 age groups. Women with university education, from urban areas, employed and of the Orthodox religion are significantly less likely to oppose sex education than women with secondary education, from rural areas, unemployed and of a religion other than Orthodox.

In Model 3, which controls for attitudinal and belief variables, the significant association for transmission knowledge and prevention are still strong on high conventional level. Women with no/low transmission knowledge (49%) and women with no prevention knowledge (23%) are more likely to oppose sex education than the women with moderate/high transmission and some prevention knowledge, respectively. Among socio-demographic variables Orthodox religion, urban and working status still predict lower odds for oppose view on sex education than the women with other/no religion and not working status. This result implies that Orthodox religion among reproductive age women in Georgia is not a factor that opposes sex education at schools, compared to Muslim or other religions. The age and having children effect holds significant, demonstrating older women's strong attitude toward sex education in schools.

The most controlling variables that include attitudes on sexuality, gender roles and misconception on casual transmission demonstrate significantly increased risk to oppose sex

education, than the women who do not have traditional attitudes and misconception about casual transmission. High belief in medical risk of getting HIV and the misconception that HIV is associated with mosquito bites indicate lower odds to oppose sex education, compare to women who do not belief that HIV can transmitted through health service utilization or who do not have misconceptions about mosquito bites. While misconceptions about mosquito bites is associated with HIV transmission though blood, as HIV medical risk, both these variables are negatively correlated with opposition to sex education and demonstrate simultaneous occurrence of misconceptions and medical risk among women who also have high transmission and prevention knowledge.

Including the attitudinal variables, through which AIDS knowledge and socio-demographic variables may be expected to operate indirectly, does reduce the effect of AIDS transmission and prevention knowledge on the likelihood to oppose sex education. In fact, in all models the direct effect of AIDS transmission and prevention status decreases the likelihood of opposition to sex education, but it remains significant in all models. This tells us that the AIDS knowledge effect is strong predictor for opposing sex education among women in Georgia.

Finally, low knowledge of AIDS transmission and prevention demonstrate increased likelihood to oppose sex education that supports the main hypothesis. On the other hand, potential influence of misconceptions relevant to AIDS transmission depends significantly on their contextual structure, as it is a case with the opposite influence of mosquito bites and shaking hands on an attitude of sex education.

Discussion

This article explores questions about attitudes toward teaching comprehensive family-life education in public schools and defines categories of reproductive age women among the general population who might oppose such education in Georgia. The article describes characteristics of women and predicts attitude toward teaching sex education at schools. The main explanatory variables in the study are the knowledge of HIV transmission routes and knowledge of HIV prevention strategies. Using data from Georgian RHS 1999/2000, I test that HIV knowledge predicts women's attitude toward school sex education and if so, then lack of transmission and lack of prevention knowledge would increase the opposition to comprehensive sex education controlling for socio-demographic and attitudinal variables.

Results from a multivariate analysis of a nationally representative sample of women aged 15-44 reveal that the likelihood of opposition of sex education varies by AIDS knowledge and certain control variables. This study has documented significant relationships between the level of HIV knowledge and the likelihood of sex education, supporting the first part of the hypothesis. Yet, direct effects of both AIDS knowledge variables remain significant. In the full model, a significant contextual effect remains for both transmission and prevention variables, which implies that effect of HIV knowledge is a strong predictor for attitudes about sex education. The lack of AIDS transmission and prevention knowledge demonstrated strong significant association with increased likelihood to oppose sex education which is also supported by the hypothesis.

The overall low level of HIV/AIDS knowledge suggests that majority of women in the reproductive ages lack information about disease transmission routes and preventive mechanisms. The current level of health knowledge and prevailing misconceptions are largely a result of inaccessible health services. Comprehensive health education is not available publicly, and many young and unemployed women are not aware about the structure and regulations of health facilities providing free information. Another consideration is the nature of common medical risk and misconceptions, which are linked to the poor quality and sanitation of health services such as use of needles, use of dental and surgical services (Georgian news 2005). Lack of knowledge prevents women from making pragmatic choice on school health education, suggesting that providing HIV/AIDS information would help women to make the right decision in favor of school health education.

Lack of HIV/AIDS knowledge is well demonstrated among traditional housewife women, a fact that reinforces the view that the older generation and women with kids still are not open to the debate of sex education. Women from Muslim religious backgrounds are especially poorly informed, which is partly due to language barriers and lack of communication in less developed border regions where ethnic minorities are mostly resettled.

The great effect of women's traditional attitudes and beliefs suggest that providing information would benefit school health education. Those reproductive age young sexually not experienced women who are misinformed about pregnancy occurrence can particularly benefit from school based health education. Those half of respondent women who belief in fatalistic and conservative attitudes need more preventive knowledge in order to make positive decisions regarding school health education. Cultural stigma that prevents society from discussing

sexuality will be overcome through the public discussion of HIV/STI and drug prevention programs that will be a part of school health education. Schools can provide wider access not only to young people but to their parents, through encouraging communication skills between parents and children.

Finally, this study demonstrates that the lack of health knowledge is the main factor that must be stressed before starting any debate about public sex education. While some traditional attitudes show strong influence on the AIDS knowledge and attitude toward sex education it is important to engage society in an open discussion about HIV/AIDS and provide resources for prevention health services. It is necessary to correct misconceptions and attitudes about health care utilization and to accentuate the usefulness of the health care system in preventing and teaching healthy behaviors.

Openness in public discussion of sexuality issues will crucially help to promote comprehensive sex education at all societal levels. It can balance and correct the information that has maintained mistrust and misinformation.

In the near future Georgian society is expected to engage in a public evaluation and high debate on the current pilot Life Skills Building Program that will be discussed at the national level. I do hope that society with its school system, public authorities, and various organizations will do a lot to support such educational program for school children. The large part of education and health promotion occurs through the media and it is a time for Georgian mass media to disseminate the information, to determine peoples' views of the meanings of sex education and to provide positive societal standards for effective school programs.

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Table 1. Characteristics of the Sample and Women's Attitudes about Sex Education, RHS Georgia 1999/2000.

Characteristics	Oppose sex education		χ^2	Total	
	%	N		%	N
Socio-Demographic Variables					
Age: 15-24	11.2	239	24.77*	36.8	2388
25-34	9.0	227		31.4	2731
35-44	12.9	298		31.8	2679
Education: Incomplete/Complete Secondary	13.5	441	73.39*	50.1	3655
College	10.1	191		23.8	2058
University	7.1	132		26.1	2085
Residence: Rural	14.2	389	80.14*	44.0	3039
Urban	8.6	375		54.0	4759
Children: 0	10.1	231	5.44∓	39.6	2599
1+	11.6	533		60.4	5199
Religion: Other religion/no religion	18.5	212	141.91*	19.8	1237
Orthodox	9.2	552		80.2	6561
Work Status: Working	7.7	105	29.50*	20.7	1606
Not working	11.9	659		79.3	6192
Attitude and Belief Variables					
Women should be virgin when she marries	11.8	693	33.50*	85.0	6689
God decides how many children women must have	13.5	480	64.19*	51.1	3901
Women can not get pregnant on the first intercourse	16.1	123	40.67*	13.4	885
Medical risk of HIV infection	7.1	159	67.23*	30.3	2436
Mosquito bites transmits HIV	9.6	323	17.62*	44.5	3598
Shaking hands transmits HIV	16.9	110	34.70*	8.9	706
AIDS Knowledge					
Transmission: No knowledge	24.8	136	250.76*	9.3	598
Low knowledge	17.0	60		5.4	389
Moderate knowledge	11.8	180		22.3	1734
High knowledge	8.2	388		63.0	5077
Prevention: No knowledge	14.6	407	98.64*	42.7	3184
Low knowledge	9.1	224		33.8	2741
Moderate knowledge	7.7	85		15.1	1225
High knowledge	7.0	48		8.5	648
Total	11.0	764		100	7798

Note: ∓ $p \leq .05$, * $p \leq .001$.

Table 2. Characteristics of the Sample by AIDS Knowledge, RHS Georgia 1999/2000.

Characteristics	No/Low Transmission Knowledge	No Prevention Knowledge
Socio-Demographic Variables		
Age: 15-24	20.9	51.5
25-34	10.1	36.2
35-44	12.1	38.8
Education: Primary/Secondary school	24.9	52.2
College	6.8	37.1
University	2.4	29.5
Residence: Rural	25.1	52.9
Urban	6.5	34.7
Children: 0	17.2	48.9
1+	13.0	38.6
Religion: Other religion/no religion	41.4	61.5
Orthodox	8.1	38.0
Work Status: Working	4.3	32.1
Not working	17.4	45.5
Attitude and Belief Variables		
Women should be virgin when she marries	16.4	44.7
God decides how many children women must have	19.0	46.5
Women can not get pregnant on the first intercourse	28.1	64.7
Medical risk of HIV infection	1.0	31.0
Mosquito bites transmits HIV	1.1	37.7
Shaking hands transmits HIV	1.6	54.1
Total	**14.7**	**42.7**

Table 3. Odds Ratios from Logistic Regression Estimates Predicting Women's Opposite View on Sex Education in Georgia, RHS 1999/2000

Variables	Oppose Sex Education		
	Model 1	Model 2	Model 3
AIDS Knowledge			
Transmission [Moderate/high knowledge]			
No/low knowledge	2.34***	1.75***	1.49***
Prevention [Some knowledge]			
No knowledge	1.46***	1.37***	1.23**
Socio-Demographic Variables			
Age [15-24]			
25-34		0.92	0.95
35-44		1.36**	1.39**
Education [Primary/Secondary school]			
College		0.96	0.99
University		0.79*	0.86
Residence [Rural]			
Urban		0.81**	0.86*
Children [0]			
1+		1.12	1.28**
Religion [Other religion/no religion]			
Orthodox		0.69***	0.71***
Work Status [Not Working]			
Working		0.79*	0.82*
Attitude and Belief Variables			
Women should be virgin when she marries			1.17
[Disagree women should be virgin when she marries]			
God decides how many children women must have			1.55***
[Disagree God decides how many children have]			
Women can't get pregnant on the first intercourse			1.62***
[Disagree women can't get pregnant on 1st intercourse]			
Medical risk of HIV infection			0.69***
[Disagree in medical risk of HIV transmission]			
Mosquito bites transmits HIV			0.81*
[Disagree that mosquito bites transmits HIV]			
Shaking hands transmits HIV			1.70***
[Disagree that shaking hands transmits HIV]			
R^2 Cox & Shnell	0.020	0.029	0.040
Intercept	-2.440	-2.007	-2.459

Note: Brackets [] indicates reference group; * $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$.