

HIV/AIDS Knowledge and Stigma among MAPEH Teachers of Caraga Region, Philippines

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Abstract - This study was conducted to determine the level of knowledge, enacted and internalized stigma on HIV/AIDS, to 216 teacher-respondents who are teaching Grade 8 MAPEH subject in select public secondary schools of Caraga Region, Philippines. The study, utilized the descriptive correlational design, revealed a rating of above average level on HIV knowledge and an average and below average ratings on enacted and internalized stigma respectively. Similar misconceptions and stigmatization among the respondents were noted. No significant differences were observed when the sociodemographic variables were compared to their knowledge and internalized stigma. Age has been shown to manifest a significant difference in terms of the respondents' level of enacted stigma. The study concluded that there is a need for an intensive training of teachers to reduce enacted and internalized stigma as they deal with their students and co-workers. A review on the basics of HIV/AIDS prevention protocols, diagnostics and symptomatology is necessary as teachers are in the best position to communicate appropriate information without bias to their students, colleagues and the community at large.

Keywords - *Enacted, Health, HIV, Internalized, Knowledge, Stigma, Teachers,*

I. INTRODUCTION

The World Health Organization has identified the Philippines as one of the countries with the fastest growing HIV epidemic (Rappler, 2015). Reports from the same agency and that of the Philippines' Department of Health revealed that the cases had risen to 17 cases in 2014 to 21 cases per day in 2015 (DOH, 2015). As early as 1998, the Philippine Government passed Republic Act 8524 stressing the importance of correct and appropriate information in the prevention of HIV/AIDS. It mandated the education sector to be in the forefront of HIV/AIDS prevention program in cooperation with the Department of Health.

The Philippine Government had recognized the severity that HIV/AIDS can bring to the country in the mid-1990s and passed the Republic Act 8504 otherwise known as the Philippine AIDS Prevention and Control Act. Article I Section 4 of the said Act mandated the Department of Education (DepEd), Commission on Higher Education (CHED) and the Technical Education and Skills Development Authority (TESDA) to utilize information

obtained from the Department of Health (DOH) in their instruction of HIV/AIDS education for basic, tertiary and skills education sector. The law requires that the lesson on HIV/AIDS should focus on causes, mode of transmission and the prevention of other sexually transmitted diseases aside from HIV/AIDS. Since HIV/AIDS has no known cure, the law emphasizes education and information dissemination as the primary approach in the delivery of healthcare services among healthcare professionals as well and not just those in the education sector. HIV education, according to Republic Act 8504, must be conducted in the workplace, for Filipinos going abroad, in the community level and to the tourists as well.

Local government units were likewise directed to strengthen their responses to HIV/AIDS with the directive from the Secretary of the Department of Interior and Local Government (DILG) through a Memorandum Circular No. 2013-19 released last April 3, 2013. The circular directed all local government heads to create a Local AIDS Council (LAC) or a Local AIDS Coordinating Body. The council formed is aimed to promote coordinated action between the local government units and the various stakeholders such as the non-government organizations, peoples' organizations, academe and church-based organizations. The council is likewise tasked to make sure that the rights of people living with HIV (PLHIV) are being protected. The council must make sure too that stigma and discrimination are eliminated while protecting their identity through confidentiality.

The current K-12 basic education curriculum addresses the problem by introducing the discussion of HIV/AIDS. The Health component of MAPEH (Music, Arts, Physical Education and Health) subject in Grade 8 specifically addresses HIV/AIDS Education. To be discussed in the first quarter of the academic year, it focuses on the modes of transmission and the preventive measures in acquiring HIV. The curriculum aims to help the students develop decision-making skills in managing sexuality-related issues. Teachers are given the task of helping the students understand their sexuality through the provision of age-appropriate lessons for them to come up with an informed decision. It likewise aims to mitigate if not eliminate stigma and discrimination associated with HIV/AIDS (DepEd, 2012).

This study attempted to find out the level of knowledge on HIV/AIDS as well as the enacted and internalized stigma of

teachers handling MAPEH Grade 8 in select secondary high schools of the Caraga Region.

II. METHODOLOGY

The study utilized correlational research design to determine the relationship of sociodemographic factors (age, sex, undergraduate degree, highest educational attainment and years of teaching experience) to the levels of knowledge on HIV/AIDS, enacted and internalized stigma. The respondents were MAPEH Grade 8 teachers from the main public secondary high school of every municipality that comprises the provinces of Caraga Region. Total number of respondents summed up to 216. There were two research survey questionnaires utilized in the study. To determine the knowledge level of the respondents on HIV/AIDS, the "HIV/AIDS Knowledge Questionnaire" developed by Carey, Morrison-Beedy and Johnson (1999 and 2002) was utilized with added inputs from Centers for Disease Control (CDC) and the World Health Organization (WHO) national surveys. The tool is composed of 40 – item true or false questions. A considerable number of items are stated negatively and are reversely coded. The tool developed by Carey and company was cited by the AIDS Education and Federation Journal (2002) to have been subjected to repeated reliability tests and found out to have high internal consistency across samples ($\alpha = .75$ to $.89$) and test – retest stability across several intervals ($r = .76$ to $.94$). The tool survey tool is used more often in similar studies.

The World Health Organization (WHO), The United States Agency for International Development (USAID) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) developed the HIV Stigma Index culled from dozens of researches dealing with behavioral dimensions relative to people living with HIV/AIDS (Nyblade and MacQuarie, 2006). The compiled indicators formed the basis in determining the extent of stigma. From these indicators the second tool is developed and crafted. The tool is divided into two distinct parts. The first part is composed of 28 – item true or false questions dealing with internalized stigma. Just like the first tool, some indicators are negatively stated and reverse – coded to discourage tail - gaiting. The second part measures the extent of external or enacted stigma. Similar to the other tools, it is composed of true or false items with some stated negatively and reverse – coded. The indicators for enacted stigma are composed of 28 items.

The mean of the correct responses from the survey tool were obtained to determine the levels of knowledge on HIV/AIDS, enacted and internalized stigma. One way ANOVA and Kruskal – Wallis test for independent sample were used to determine if significant difference existed in the level of knowledge, internalized and enacted stigma to the identified sociodemographic data. The descriptive labels for the range of the knowledge and stigma levels are as follows: 81.0 to 100.0 (high); 61.00 to 80.00 (above average); 41.00 to 60.00 (average); 21.00 to 40.00 (below average) and 0 to 20.00 (poor).

III. RESULTS

Respondents' Profile. Most of the respondents (77%) are aged 40 years old and below with those aged 21 – 30 years old comprised almost half (42%) of the respondents. Female respondents (73%) outnumbered the males. Respondents who were graduate of BS in Physical Education or Secondary Education major in MAPEH (Music, Arts, Physical Education and Health) constituted 46% of the respondents. The majority of the respondents were from varied disciplines teaching MAPEH. They were graduates of languages, mathematical sciences, pure sciences, and other courses. More than two-thirds of the respondents (71%) did not have advanced degrees beside their undergraduate education. They all have teaching experience of under 10 years (72%).

On HIV/AIDS Knowledge. The respondents' level of knowledge on HIV/AIDS was generally rated as above average (74%). The same result was likewise manifested when the respondents were grouped according to the identified sociodemographic variables. No significant differences in the level of knowledge were observed when grouped according to the above-stated sociodemographic profile variables.

Common misconceptions of the respondents were observed. Almost half of the respondents (46%) believed that someone will get HIV/AIDS by deep kissing. Half of the respondents agreed that taking a test for HIV one week after having sex would tell if a person has HIV (52%) and that HIV and AIDS were the same (55%). More than half of the respondents thought that one could get HIV if they have sex with gays (57%) or with women (63%). More than two-thirds (68%) of the respondents believed that all sexually-transmitted infections including HIV/AIDS can be prevented by using condoms.

On Enacted Stigma. Respondents recorded an average (44.3%) level of enacted stigma. The same level was observed when the respondents were grouped according to age (48.2%), sex (43.75%), undergraduate degree (43.9%) and years of teaching experience (45.4%). When they were categorized based on their highest educational attainment, the enacted stigma was rated as below average (36.3%). Age was found out to be a significant factor on the enacted stigma among the sociodemographic variables.

Less than half of the respondents believed that persons with HIV/AIDS should be sent away from the rest (40.3%), excluded from social gathering (44.9%), will not allow their children or any child to play with a child with HIV/AIDS (45.8%) or to be near with an HIV-infected person (46.8%). Of the same proportion (46.8%) replied that they cannot work effectively in the workplace if they have an HIV-positive co-employee.

Half of the respondents said that HIV/AIDS is a punishment for bad behavior (53.7%) hence it is their own fault that they got HIV (50.9%). These respondents would not allow any person living with HIV/AIDS to use the cooking nor eating utensils of others (56.5%). The study also noted that more than half of the

teacher-respondents considered persons with HIV as promiscuous (67%) and are either gay men or prostitutes (64%). The promiscuity of men (68%) and the presence of women prostitutes (72%) are responsible for the spread of HIV/AIDS in the community, the respondents opined. Many respondents too are hesitant to share toilet or bathroom (79.2%), linens or beddings (57%) to persons with HIV/AIDS. They are likely to feel uncomfortable working with a co-teacher with HIV/AIDS (57.9%), dine or buy in a restaurant if one of the food servers has HIV (59.7) or when a dining facility is being managed or owned by a person living with HIV/AIDS (57.9%).

On Internalized Stigma. The internalized stigma of the respondents was generally rated as below average (39.9%). The respondents were rated below average when grouped according to sex (38.3%), undergraduate degree (33.8%), highest educational attainment (32.4%) while rated as average when grouped according to years of teaching experience (41%) and age (44%). The sociodemographic variables and the levels of internalized stigma did not show any significant differences.

More than a third of the respondents think that if they will get infected with HIV, they will place their friends in danger

(45.8%). As such, they will separate themselves (36.5%), will dine in a separate table (33.3%), bring their own eating utensils (67.6%) or transfer to another place (35%). If ever they will get infected with HIV, they will consider themselves as unproductive citizens (35%). Almost all of them will refrain from having any form of sexual relationships if they have HIV infection (93%). Majority of the teachers asked in the study would feel dirty (65.7%), low self-esteem (76.8%) and guilty (83.3%) once infected. These feelings are related to their religious affiliation (49.5%) and believe that God has something to do with their HIV status (67%).

The mixed feelings of guilt, shame and dirt will drive the respondents not to reveal their HIV status to anyone (40.7%) if they get infected. They are more likely to isolate themselves from their own family (53%) or from their co-workers (60%). Respondents are more likely to be ashamed of themselves if infected (70%) than feel the shame if a family member (50.4%) will contract HIV.

Table 3. Means ^(a), ^(b) and p-values ^(c), ^(d) of means difference on the level of knowledge, enacted stigma, and internalized stigma on HIV/AIDS and spirituality when grouped by profile variables

Profile variables	knowledge level (K) on HIV/AIDS ($\bar{x}_K = 73.2$)	level enacted stigma (ES) on HIV/AIDS ($\bar{x}_{ES} = 43.9$)	level of internal stigma on (IS) HIV/AIDS ($\bar{x}_{IS} = 39.5$)
Age			
21-30 yrs old	72.7	46.7	40.5
31-40 yrs old	73.9	40.2	37.0
41-50 yrs old	74.8	41.2	39.3
above 50 yrs old	68.7	51.3	46.9
<i>p-value</i>	0.218 ^(d)	0.035* ^(c)	0.384 ^(d)
Sex			
female	74.8	42.9	36.2
Male	72.6	44.2	40.8
<i>p-value</i>	0.330 ^(d)	0.632 ^(c)	0.081 ^(c)
Undergraduate degree			
AB lang/socsci	75.0	42.5	40.4
AB/BS engg/sci	73.6	41.9	38.2
BS/BSEd tech	71.9	44.7	41.3
BS/BSEd MAPEH	72.8	45.0	39.2
<i>p-value</i>	0.761 ^(d)	0.761 ^(c)	0.852 ^(c)

Highest educational attainment			
BS	73.0	44.6	40.4
MA/MS units	73.6	44.9	38.5
at least MA/MS	73.6	38.8	36.1
<i>p-value</i>	0.976 ^(d)	0.291 ^(c)	0.447 ^(c)
Number of years in teaching experience			
> 10 yrs	73.0	43.7	38.3
11 to 20 yrs	74.7	44.0	43.2
more than 20 yrs	71.1	45.2	41.6
<i>p-value</i>	0.558 ^(d)	0.950 ^(c)	0.212 ^(c)

Legend: \bar{x}_i = overall mean for variable i

(a) 0.0-20.0 : poor , 21.0-40.0 : below average, 41.0-60.0 : average, 61.0-80.0 : above average, 81.0-100.0 : excellent

(b) 0.0-20.0 : poor , 21.0-40.0 : below average, 41.0-60.0 : average, 61.0-80.0 : above average, 81.0-100.0 : high

(c) one-way ANOVA

(d) Kruskal-Wallis test for k-independent samples; due to non-normality of K and/or inequality of variance of IS with age

* Means difference is significant at 5%.

IV. DISCUSSION

The knowledge of the respondents is one of the key areas being sought in the study. Items being asked regarding HIV/AIDS Knowledge cover questions dealing with modes of transmission, diagnostics, preventive measures and symptomatology. In general, the respondents were rated as above average with 7 to 8 questions out of 10 answered correctly regardless of sociodemographic grouping. This is supported by the lack of significant difference in the level of knowledge among the respondents with the sociodemographic variables mentioned in the study. While the presence of misconceptions is generally low, there is a need to correct them as these are basic facts concerning HIV prevention, transmission and diagnosis.

The findings of the study is compatible with the results of a study conducted by Dawson and company (2001) among teachers' knowledge on HIV/AIDS. They found out that no significant difference existed among the gender of the teachers regarding their general knowledge on HIV/AIDS transmission. Three years later, a study among South African teachers reveal the same results (Peltzer et al, 2003) Other studies done in Asia contradicted the findings of Dawson and Peltzer. Li and colleagues (2004) noted that among students in China showed that female respondents perceived themselves as less knowledgeable than their male counterparts. The same result was observed in Iraq among college students' knowledge on HIV/AIDS was asked (Othman, 2014). Other studies conducted in China validated the study of Li as more males tend to demonstrate a higher level of knowledge on HIV/AIDS than females (Tung, 2013).

Teachers teaching Music, Arts, Physical Education and Health (MAPEH) are not exclusively Education graduates with Physical Education (PE) or MAPEH as their specialization. Due

to lack of teachers who are graduates on this area of specialization, teachers from other academic discipline were assigned to handle MAPEH in the secondary level. The current study investigated to determine the presence of association between the academic disciplines of the teacher – respondents' academic discipline to the knowledge on HIV/AIDS.

While the current study did not find significant difference on the level of knowledge on HIV/AIDS to their academic preparation (such as baccalaureate degree and years of teaching experience) such is not the case in other settings. Argawal and associates (1999) found out that science teachers are better informed compared to their peers. Dawson and colleagues (2001) on the other hand reported that teachers of allied health degrees have significantly greater knowledge on the likelihood of HIV transmission and general information on HIV/AIDS compared to other teachers of different academic discipline in Central Massachusetts secondary schools. While Peltzer (2003) on the other hand found out that teachers with longer teaching experience and HIV teaching experience tend to be equipped with better knowledge on HIV/AIDS compared with the rest. It was likewise found out that life – skills teachers (equivalent to Technology and Livelihood Education or TLE in the Philippine secondary education system) were better well – informed than the other teachers of different academic discipline.

Aside from the provision knowledge, mitigating stigma is an essential part in the fight against HIV/AIDS. While education plays an important role in mitigating the impact of HIV among vulnerable groups, the provision of accurate information is not enough. As Aggleton and company (2010) pointed out, education is a double-edged sword in HIV/AIDS prevention programs. HIV/AIDS programs in school become counter-productive when it cultivates or reinforces myth and failed to

address stigmatization issues. Due to fear and uncertainty, HIV infection had created a wide array of problems such as stigma and discrimination.

As a matter of national policy, the Philippine's Department of Health (2012) approach to HIV/AIDS epidemic is not limited to the provision of accurate information regarding transmission and prevention of harbouring the virus but likewise stipulating a policy of zero – tolerance to stigmatization and discrimination among persons living with HIV/AIDS. The Civil Service Commission and the Department of Interior and Local Government issued a circular detailing the eradication of stigma and discrimination among persons living with HIV/AIDS in the workplace specifically the government sector.

While the level of knowledge among secondary school MAPEH/PE teachers is above average, it failed to reduce the levels of internalized and enacted stigma. Stigmatization extends to include even their co-workers inspite of the fact that they know casual contact do not transfer the virus. Even in the presence of accurate and adequate information regarding HIV/AIDS, Clarke (2008) is precise in reporting that stigma creeps into the educational systems “pervasively”. This is exactly what happened to the respondents. The study revealed that regardless of sociodemographic grouping of the respondents, no significant difference between them were observed. Aside from ignorance, fear and moral judgments intensifies these thwarted beliefs of any persons living with HIV/AIDS. The prevalence of stigmatization among the respondents that dwells on moral and religious contexts mirrors the observation of Clarke with the results of the study. Those individuals perceived to be commercial sex workers, homosexuals and drug addicts are labelled to be the cause and carriers of HIV in the country. It can be observed too that if ever they catch HIV, they will view themselves adversely with connotations of being unclean, unproductive and unwanted members of the society citing religion to be a relevant influence.

Clarke particularly mentioned teachers as one of these groups that were stigmatized if ever they contracted the virus aside from those who were socio – economically handicapped and children. By association with students or co – employees who are HIV – positive, a form of stigma by association happens. The teachers desire to maintain distance with a co –employee or not to be around with anybody who has HIV clearly depict Clarke's observation.

In a study conducted in Malawi, Kachingue and company (2005) learned that teachers are all aware of the negative impact HIV does to the community and identified themselves as the pivotal point in the fight against HIV/AIDS. While teachers may have sufficient knowledge base, some misconceptions persist even on the basic information and proper use of technical terms. For example in this study, majority of the teachers cannot differentiate HIV from AIDS. The study also reported the presence of stigma brought about by social constraints and religious reasons. The teachers' heightened display of stigma to

individuals living with HIV/AIDS especially students in school is reflected in the study conducted by Kelly (2008).

The attitudes of and beliefs towards other people with HIV and of the self if ever one gets infected revolve around the issue surrounding stigma. Table 1 describes the relationship of the teacher – respondents' knowledge, enacted and internalized stigma on HIV/AIDS when compared to the identified sociodemographic variables in the study. Logis and Gadalla (2009) reviewed twenty-four peer – reviewed studies and publications in America for a period of seven years (from 2000 to 2007) found out that significant association between high level of stigma and age of respondents existed aside from poor health. It further describes the presence of moderate correlation between stigmatizing behavior and age. This finding is similar to a study conducted earlier by Zagummy and company (2000) among teachers in Southeastern United States. The study revealed that older teacher – respondents tend to be more stigmatizing than their younger colleagues. These teachers tend to manifest more blaming attitudes to people living with HIV/AIDS. Older teachers too have the tendency to manifest unwillingness for social contact with their students who are HIV – positive that those younger teachers.

Sorsdahl and company (2011) investigated which predictors are significant to the prevalence of stigma among people living with HIV in Cape Town, South Africa. Male and younger respondents tend to experience less internalized stigma while those who are more educated respondents reported to have more internalized stigma than those with lower educational level. No sociodemographic variables were found out to be a significant predictor for the development of enacted stigma. These findings are reflective of the results of the current study. The researchers likewise opined that reasons such as access to HIV treatment and non – disclosure of HIV status contributed to the low reports of HIV – related stigma among the respondents.

Across the globe, Wagner and associates (2010) sought to determine the variables linked to stigma attached to women who were HIV – positive in Canada. Multiple regression analyses revealed that women with lower educational level and higher anxiety level are associated with higher HIV – related stigma. The role that gender plays in the development of stigma varies in some researches. While this current study found no significant association between gender and stigma, other studies done outside the country do not share the same observation. In Kenya, Yebey's group (2008) found out that women tend to exhibit lower levels of internalized stigma compared to men. Dawson (2001) on the other hand found no significant difference for gender when compared to attitudes towards HIV/AIDS in a study conducted in the United States.

V. CONCLUSION

The study revealed that the respondents displayed an above average level of knowledge on HIV/AIDS. Enacted stigma was recorded at average level while the internalized stigma was rated

as below average. No significant differences in knowledge and internalized stigma were observed when grouped according to the sociodemographic factors identified in the study.

Age is a significant factor in the development of enacted stigma among the sociodemographic variables investigated.

RECOMMENDATIONS

An intensive training workshop is needed to address stigmatization among the teachers as they deal with their colleagues and school clients. There is a need to review HIV/AIDS basics as to diagnostics, transmission, symptomatology and treatment protocols. Teachers being at

constant contact with students and vulnerable groups are in the best position to provide appropriate health teachings that are based on scientific facts and conveys communication modes that are nondiscriminating and sensitive to individual vulnerabilities. A more in-depth study investigating likewise the levels of knowledge on HIV/AIDS and HIV-related stigma among students must be sought who are recipient of the health education of the teachers. This will assess the effectiveness of these teachings afforded to them.

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