Stigmatisation, An Epidemic of HIV Infection: Students Perception of People Infected with HIV

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DOI: https://doi.org/10.47772/IJRISS.2026.100500149

Received: 26 April 2026; Accepted: 02 May 2026; Published: 25 May 2026

ABSTRACT

The gains of the fight against HIV/AIDS seems threatened by a third force, stigmatization. The focus of the study was to identify the scope and pattern of respondents' knowledge and their relationship with people living with HIV/AIDS. In a survey, 400 Junior High Students completed self-administered questionnaire, comprising of two measures, beliefs toward people living with HIV/AIDS and knowledge of HIV/AIDS. Based on factor analysis two factors of the *Belief* construct, suggest tolerance and acceptance of people infected with HIV based on factor loadings ranged between .401 and .662 on promax rotation. Positive correlation between the items and the factors were also registered. However, gaps in levels of knowledge and in misconceptions on HIV issues threaten their comfortability with the infected. There is a willingness to tolerate and accept people living with HIV without stigmatisation. However, students' comfortability to do that willingly will depend on the quality of functional knowledge and facts about HIV/AIDS. The fight against stigmatisation may continue to linger on until misconceptions are continually addressed. Heightened awareness and knowledge of health risk are important preconditions for self-directed change.

Keywords: Stigma, HIV, knowledge, beliefs, misconceptions

INTRODUCTION

People who are infected with HIV have often been stigmatized by mainstream society. Intolerant attitudes toward these people often lead to intolerant behaviours toward them. Changing such attitudes, is thus a key objective in many HIV education programmes. The HIV epidemic was categorised into three phases in any community by Jonathan Mann, the founding Director of the WHO's former Global Programme on AIDS in 1987. In the conceptualization, he distinguished between the three phases as the epidemic of HIV infection, the epidemic of AIDS itself and the third epidemic, potentially the most explosive - the epidemic of social, cultural, economic and political responses to AIDS. The third, he stressed was characterised above all, by exceptionally high levels of stigma, discrimination which are central to the global challenge as the disease itself (Mann, 1987 in Parker & Aggleton, 2003).

Stigma is defined as a mark of disgrace associated with a particular circumstance, quality, or person (English Oxford Living Dictionaries, 2019) that sets a person apart from others. When a person is labelled by their illness they are no longer seen as an individual but as part of a stereotyped group. Negative attitudes and beliefs toward this group create prejudice which leads to negative actions and discrimination (Government of Western Australia, 2019). Further, Goffman (1963) defined stigma as 'an attribute that is significantly discrediting' and argued that the stigmatised individual is thus seen to be a person who possesses 'an undesirable difference'. The society thus conceptualise on the basis of what constitutes 'difference' or 'deviance' and that it is applied by society through rules and sanctions resulting in a kind of 'spoiled identity' for the person concerned (Parker & Aggleton, 2003).

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at people living with HIV and AIDS. In 35% of countries with available data, over 50% of people report having discriminatory attitudes towards people living with HIV (AVERT, 2018). Others have tendered to understand stigma in highly emotional terms: anger and other negative feelings towards people living with HIV and AIDS with the conclusion to 'the belief that they deserve their illness, avoidance and ostracism, and support for coercive public policies that threaten their human rights' (Herek, Capitanio & Widaman, 2002).

By 2000, a renewed effort to combat 'stigma' was considered among the top list of the five most pressing items on the agenda for the world community by Peter Piot, the Executive Director of UNAIDS (Parker & Aggleton, 2003). Effectively, addressing stigma removes what still stands as a roadblock to concerted action, whether at local community, national or global level (Piot, 2000 in Parker & Aggleton, 2003). Consequently, the theme for the World AIDS Campaign, 2002-03 was HIV- and AIDS-related stigma and discrimination.

USAID (2000) indicated, that the problem is a difficult one, because underlying the apparent universality of the problem of HIV/AIDS-related stigma, discrimination and denial there appears to be a diversity and complexity that makes it difficult to grasp in a programmatically useful way.

According to Michel Sidibé, Executive Director of UNAIDS (2009-2019), whenever AIDS has won, stigma, shame, distrust, discrimination and apathy was on its side. Every time AIDS has been defeated, it has been because of trust, openness, dialogue between individuals and communities, family support, human solidarity, and the human perseverance to find new paths and solutions. He states, that Zero discrimination is essential to achieving universal health coverage and the Sustainable Development Goals and adds, all over the world, people are unable to live with dignity because of laws and practices that discriminate. A study (Ahsan Ullah, 2011) concludes that HIV-related stigma remains a barrier to effectively fighting this pandemic because fear of discrimination often prevents people from seeking treatment publicly. There are evidences that HIV-positive individuals were evicted from home by their families and rejected by their friends and colleagues.

HIV and AIDS-related stigma and discrimination are pervasive problems worldwide and People living with HIV (PLHIV) in Ghana, as elsewhere, face stigma and discrimination (Ghana AIDS Commission (GAC), 2016). Although Ghana's Constitution protects all citizens from discrimination in employment, education and housing and ensures their right to privacy, there is ambiguity in the way these provisions apply to people living with HIV and to key affected populations (Williamson, 2014).

A Stigma Index Study in Ghana (GAC, 2016) on the extent of HIV-related stigma and discrimination among Persons Living with HIV (PLHIV) including key populations living with HIV revealed that PLHIV respondents avoided all the forms of social exclusion and other forms of discrimination through non-disclosure of their HIV status to individuals and groups outside the health care delivery system; experiences of stigma and discrimination were observed to be more prevalent among PLHIV in rural than in urban locations; PLHIV who did not belong to the key populations sub-group, tended to inflict considerable emotional and psychological distress on PLHIV who belong to the key populations sub-group.

The fear surrounding the emerging HIV epidemic in the 1980s largely persists today, where little was known about how HIV is transmitted, leading people to be scared of the infected due to fear of contagion. This fear, coupled with other reasons, means that lots of people falsely believe: HIV and AIDS are always associated with death and with behaviours that some people disapprove of (such as homosexuality, drug use, sex work or infidelity). Also, that HIV is only transmitted through sex, a taboo subject in some cultures and HIV infection is the result of personal irresponsibility or moral fault (such as infidelity) that deserves to be punished (GAC, 2016).

Inaccurate information about how HIV is transmitted creates irrational behaviour and misperceptions of personal risk. People stigmatize others because of fear that they would be infected through casual contact (GAC, 2016). Myths and misinformation increase the stigma and discrimination surrounding HIV and AIDS. There is a cyclical relationship between stigma and HIV; people who experience stigma and discrimination are marginalised and made more vulnerable to HIV, while those living with HIV are more vulnerable to experiencing stigma and discrimination (AVERT, 2018).

The aforementioned give credence to the motivation of empirical research on stigma focusing heavily on beliefs and attitudes of those who are perceived to stigmatise others. The vast majority of the interventions that have been developed and evaluated in the research literature in order to respond to stigma related to HIV and AIDS aimed at increasing 'tolerance' of people with AIDS (Parker & Aggleton, 2003). Others have focused on 'stigmatizing attitudes' and the extent to which such attitudes are correlated with misunderstanding and misinformation concerning the modes of HIV transmission or the risk of infection through everyday social contact (Parker & Aggleton, 2003; Herek, Capitanio & Widaman, 2002).

The goal and essence of HIV education is to prevent people from becoming infected and to reduce stigma and discrimination: it is to change people's attitudes towards the disease and infected persons, and also to the adoption of lifestyles that will not predispose them to infection (Awusabo-Asare, 1995; CDC, 2008; AVERT, 2008). UNICEF recognizes the crucial role education plays in solving the most complex problems. However, preventive health is one of the most important and neglected topics in modern health care (American Medical Student Association, 2005). Even if a cure is found and becomes available, education will continue to be vital. Also, African countries, confronted with major economic crisis, poor infrastructure and other health problems are less likely to benefit, at least initially, from any technological breakthrough (Awusabo-Asare, 1995). While awareness of the HIV/AIDS epidemic among young people in Ghana is over 95%, this is yet to translate into corresponding positive behavioural change (Karim et al, 2003; Fobil & Soyiri, 2006). The youth continue to offer the best opportunities for prevention efforts (Bhana & Petersen, 2009).

The study was anchored on the integrative model (Fishben, 2000), as the theoretical framework. A given behaviour is most likely to occur if one has a strong intention to perform the behaviour, the necessary skills and abilities required to perform the behaviour, and if there are no environmental constraints to prevent the performance of that behaviour, the probability is close to one that the behaviour will be performed.

The model suggests that there are three primary determinants of intention (psychosocial variables): the attitude toward performing the behaviour (i.e. the person's overall feelings of favourableness or unfavourableness toward performing the behaviour), perceived norms concerning performance of the behaviour (including both perceptions of what others think one should do as well as perceptions of what others are doing), and one's self-efficacy with respect to performing the behaviour (i.e. one's belief that one can perform the behaviour even under a number of difficult circumstances).

METHODOLOGY

This study was based on the quantitative approach, involving Junior High School (JHS) students at Obuasi, a mining town in the Ashanti Region, Ghana, and a major HIV 'hotspot'. The focus of the study was to identify the scope and pattern of respondents' knowledge and their relationship with people living with HIVAIDS. In a survey, a Junior High School (JHS) within a cluster of schools was purposively selected. The educational system in Ghana stipulates a 6-year primary schooling after two years at the kindergarten level. Pupils continue to JHS for three years before they qualify for Senior High School (SHS). Normally at JHS one, children would have attained the age of 13 years and tare cognitively developed enough to participate in research in a meaningful way (Denton and Smith, 2001).

The JHS was chosen because the characteristics of the school satisfied the purpose and criteria set: it is not an unusual school and has no one particular feeding primary school with pupils coming from various primary schools, towns, suburbs and communities. Also, it is mixed, non-religious and public, in the midst of numerous schools, and has pupils with range of ages, religious and ethnic backgrounds. The study was conducted with all pupils in JHS two and three involving seven whole classes. JHS one was not included because HIV/AIDS is not a topic taught as a class lesson in that year group.

Sample Size determination, was based on Comrey and Lee (1992, 2013) recommendation that for a 'good' factor analysis solution a data set should contain at least 300 cases. Factor analysis is based on correlation coefficients, which tend to be most reliable when computed for large samples.

All pupils from second and third years numbering 400 responded to a completed self-administered questionnaire (CDC, 2002, 2003), comprising of two measures: beliefs toward people living with HIV/AIDS (8 statements) and knowledge of HIV/AIDS (15-items). Pupils responded to each statement on a 5-point "agreement" scale- to indicate their degree of agreement with each statement.

The process of developing and selecting appropriate questionnaires were guided by principles outlined by American Educational Research Association (AERA, 2006). These include:

- Making sure the questionnaire items match research objectives.
- Understanding the research participants considering their demographic and cultural characteristics to ensure they are understandable to them.
- Using natural and familiar language.
- Writing items that are clear, precise, and relatively short.
- Avoiding "leading" or "loaded" questions and double-barrelled questions.
- Determine whether an open-ended or a closed ended question is needed.
- Using multiple items to measure abstract constructs, which is required to ensure measures have high reliability and validity- for instance the use of the Likert Scale (summated rating scale) invented by the famous social psychologist Rensis Likert.
- Developing a questionnaire that is easy for the participants to use to avoid any confusion.
- Pilot testing of questionnaire.

The instruments benefited from the input of experienced health professionals at Kumasi Health Education Unit and School Health Education regional officers. The officers conducted a careful scrutiny, made suggestions to strengthen its suitability and cultural relevance, conceptual clarity, factual accuracy, and readability (Petosa and Jackson, 1991)

Prior to the main study, two pilot surveys among JHS pupils at different schools were conducted, Demonstration analysis showed the utility of the factor analysis technique distinguishing some factors

Gathering data from this age group presents ethical and parental consent issues (UNAIDS, 2004). Permission and consent were sought from authorities of Ghana Education Service and the school for the collection of data. They were informed about the purpose of the study, assured of confidentiality, and anonymity.

The knowledge instrument assessed the functional knowledge of pupils about facts on HIV/AIDS deemed necessary to reduce the risk of HIV infection with **t**he aim of assessing levels of awareness of how HIV is transmitted (CDC, 2005; AVERT, 2008). Functional knowledge is information about HIV transmission, testing, risk behaviours, myths and prevention, consequences of touching semen and vaginal fluids or blood (CDC, 2005, 2003, 1988; Quackenbush, Clark and Nelson, 1995). Factor analysis on the measures was carried out. Whilst the 'belief' generated two factors, no factors were identified on the 'knowledge' instruments therefore analysis, primarily, is based on descriptive statistics to identify patterns in the data by their characteristics and provide simple summaries about the sample and the measures. The 15-item knowledge instrument was scored based on a five-point scale (I am sure it is true, I think it is true, I don't know, I think it's false, I am sure it's false) concerning correct statements (facts) and incorrect statements (misconceptions) and totalled for all respondents.

RESULTS AND DISCUSSION

The knowledge instrument assessed the functional knowledge of pupils about facts on HIV/AIDS deemed necessary to reduce the risk of HIV infection with the aim of assessing levels of awareness of how HIV is transmitted (CDC, 2005; AVERT, 2008).

Tables 1 and 2 below reveal knowledge levels of respondents. An item-by-item analysis of the groups' responses was based on topical instructional targets outlined to indicate what respondents are certain about to identify those content areas that may require targeted instruction (CDC, 2005). Generally, all statements received some correct and incorrect responses concerning HIV/AIDS knowledge: Facts (statements: 2, 4, 6, 8-11) and Misinformation (statements: 1, 3, 5, 7, 12-15).

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume X Issue V May 2026

Table 1 Knowledge: Facts about HIV and AIDS

	Statements	Correct (I'm sure/think it's true)		Incorrect (I'm sure/think it's false or don't' know)	
		frequency	percentage	frequency	percentage
2.	A person can test negative but still be infected with HIV	300	67	148	33
4.	Males can pass HIV on to others through their semen	270	60	178	40
6.	Abstinence from sex and drugs is the best way for teenagers to avoid getting HIV	350	78	98	22
8.	HIV can be found in vaginal fluids and blood	358	80	90	20
9.	A person can get HIV by sharing drug needles with a drug abuser who has the disease	343	77	105	23
10.	HIV can be found in breast milk	238	53	210	47
11.	Once you are infected with HIV, you are infected for life	328	73	120	27

Table 2 Knowledge: Misinformation about HIV and AIDS

	Statements	Correct (I'm sure/think it's false)		Incorrect (I'm sure/think it's true or don't' know)	
		frequency	percentage	frequency	percentage
1.	You can't get AIDS if you have sex only once or twice without a condom	188	42	260	58
3.	Condoms are 100% effective in HIV prevention	224	50	224	50
5.	You can get HIV by sitting on the seat of a toilet that a person with AIDS has used	299	66.7	149	33.3
7.	You can get HIV from drinking from the same glass that a person with AIDS drank from	318	71	130	29
12.	People infected with HIV are usually very thin and sickly	90	20	358	80
13.	You can get HIV from being in a swimming pool	300	67	148	33
14.	You can get HIV from a mosquito bite	298	66.5	150	33.5
15.	If you want to keep from getting HIV, using any other condom is just as good as using latex condoms	198	44	250	56

Mode of HIV transmission (statements 4, 8, 9, 10*):* sought responses about consequences of touching semen, vaginal fluids or blood, mother to child transmission and risks behaviours associated with drug use. Statements eight received the highest correct responses: 80% (358): "HIV can be found in vaginal fluids and blood". Whilst 62% were sure, 13% did not know and 7%, false. Similarly, statement four is about source of transmission of HIV: "Males can pass HIV on to others through their semen", had 60% correct responses (40% sure), 26% "don't know" and 14%, false. "A person can get HIV by sharing drug needles with a drug abuser who has the disease" (statement 9) had 77% correct responses, 8% did not know and 15%, false. Another source of HIV transmission, mother to child transmission through breastfeeding (statement 10) rather received fewer correct responses of 53% (35% sure), don't know, 16% and false, 31% (16% sure).

Prevention (statement 6): "Abstinence from sex and drugs is the best way for teenagers to avoid getting HIV" received 78% (350) correct responses (66% confident), 8% "don't know" and 14% false responses (6% sure).

Testing (statement 2): "A person can test negative but still be infected with HIV" had 67% (300) correct responses (38% sure) and 26% false responses (15% sure).

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume X Issue V May 2026

Cure (statement 11): "Once you are infected with HIV, you are infected for life", had 73% (328) correct responses (53% sure), 9% don't know and 18% false responses.

Misconceptions or myths about protection (statement 1, 3 15): "You can't get AIDS if you have sex only once or twice without a condom", "Condoms are 100% effective in HIV prevention" and "If you want to keep from getting HIV using any other condom is just as good as using latex condoms" are all misconceptions about condom use for protection against HIV transmission for statements one, three and 15 respectively. Correct responses ranged between 42% and 50%: 42% (188) responded correctly (38% sure) for statement one; 50% (224) for statement three and 44% (198) for statement 15, showing a 50% or below correct rate. 58% and 56% either did not know or got it wrong for statements one and three respectively. For 38% of respondents to be confident that "You can't get AIDS if you have sex only once or twice without a condom" is worrying.

Misconceptions about mode of HIV transmission (statements 5, 7, 12, 13, 14): The following statements signify misconceptions about how one can be infected with HIV, respectively for statements 5,7,12,13 and 14: "You can get HIV by sitting on the seat of a toilet that a person with AIDS has used", "You can get HIV from drinking from the same glass that a person with AIDS drank from", "People infected with HIV are usually very thin and sickly", "You can get HIV from being in a swimming pool" and "You can get HIV from a mosquito bite".

The percentage of respondents who incorrectly indicated "You can get HIV by sitting on the seat of a toilet that a person with AIDS has used" were 33.3% (6%" don't know") but a lower percentage of 29% incorrectly answered for "You can get HIV from drinking from the same glass that a person with AIDS drank from". Whereas 66.7% (299) had correct responses for the former (statement 5), the latter (statement 7) was 71% (318). Statement 12 received the lowest of all correct responses. With a percentage score of 20% (90) correct, majority (80%) incorrectly indicated that "People infected with HIV are usually very thin and sickly"; only 8% indicated "don't know" whilst 58% wrongly, were confident of their choice. "You can get HIV from being in a swimming pool" received 67% (300) correct responses, 16% don't know, only 9% confident. "You can get HIV from a mosquito bite" had 66.5% (298) correct responses, 10% "don't know" and 15% confident.

Analysis of Beliefs: The 'belief' factor was analysed to determine underlying factors. Principal component analysis suggests three components could be extracted as shown in the bar plot. The first three components account for 50.7% of the cumulative variance (22.6% for the first, 15.3%, the second and 12.8, the third). However, all the components had variances (eigenvalue) greater than 1.0 (Table 3).

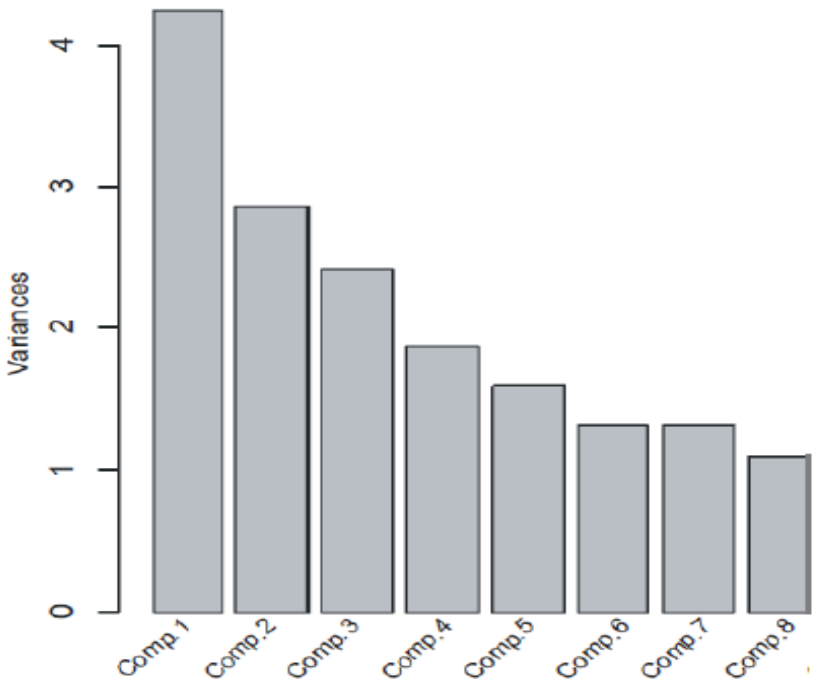

Fig 1 Bar (Scree) plot of the variances explained by the principal components (Beliefs)

Table 3 Summary of Principal Components: Importance of components (Beliefs)

Component	Standard Deviation (Eigenvalue)	Variance	
		Proportion of variance	Cumulative Proportion
1	2.060	0.226	0.226
2	1.692	0.153	0.379
3	1.551	0.128	0.507
4	1.369	0.100	0.607
5	1.262	0.085	0.692
6	1.148	0.070	0.762
7	1.146	0.070	0.832
8	1.011	0.054	1.000

Factor Analysis*:* On the factor analysis, out of a number of solutions, two factors were considered to give the best description of the data. These were subjectively labelled as *Tolerance and Acceptance.* Factor loadings ranged between .401 (item 3) and .66a2 (item 5) on promax rotation (Table 4). The two factors suggest similar ideas, relates to the tendency to tolerate or accept people who are either infected or affected by HIV. Whilst "Acceptance" indicates the readiness of respondents to associate with people with HIV in certain conditions, "Tolerance", is about the propensity to endure their presence. Higher scores in both factors show positive attitude towards infected persons and therefore such people may not be stigmatised or discriminated. Higher scores in both factors show positive attitude towards persons with HIV and therefore such people will not be stigmatised or discriminated against.

Table 4 Factor Analysis

Item #	Statements	Uniqueness	Factor Loading	
Factor 1: Tolerance			Promax	Varimax
7.	I would avoid a classmate who I heard had HIV.	0.642	0.592	0.580
8.	I would avoid a classmate whose family member had HIV.	0.699	0.572	0.548
6.	A person who has HIV should stay away from public places.	0.652	0.536	0.537
2.	A person who has HIV shouldn't be allowed to eat lunch in the school cafeteria	0.742	0.498	0.489
Factor 2: Acceptance				
5.	I wouldn't mind playing sports with someone who has HIV.	0.547	0.662	0.666
4.	I wouldn't mind swimming in the same pool as someone who has HIV.	0.721	0.543	0.528
1.	I wouldn't mind being in the same classroom with someone who has HIV	0.753	0.499	0.496
3.	I would feel comfortable hugging a close friend who has HIV.	0.820	0.401	0.412

There is positive correlation between the items and the factor. A high score on the factor means the person believes that classmates who have HIV should be tolerated and not be avoided. However, the majority of the responses indicated they will not avoid or reject persons with HIV. The higher the score, the greater the likelihood, that the infected will not be rejected.

Table 5 Correlation*:* Tolerance and Acceptance Levels

Statements		Correlation
7.	I would avoid a classmate who I heard had HIV.	0.7216966
8.	I would avoid a classmate whose family member had HIV.	0.6980153
6.	A person who has HIV should stay away from public places.	0.6539925
2.	A person who has HIV shouldn't be allowed to eat lunch in the school cafeteria	0.6071260
5.	I wouldn't mind playing sports with someone who has HIV.	0.8129296
4.	I wouldn't mind swimming in the same pool as someone who has HIV.	0.6667882

1.	I wouldn't mind being in the same classroom with someone who has HIV	0.6125374
3.	I would feel comfortable hugging a close friend who has HIV.	0.4916898

The Correlation table (4) shows positive relationships between the views and the factors. In spite of the positive correlation between all statements and the factors, there were variations ranging between 'playing sport with HIV infected person' (r = 0.813) and 'hugging a close friend infected with HIV' (r = 0.492). This indicates, that the higher the score the stronger the agreement to a statement. A. high score on the factor indicates the level of readiness or acceptance to get closer to an infected individual, for instance, playing sports with persons who have HIV. The Acceptance factor indicates the readiness of respondents to associate with people with HIV in certain conditions.

The feeling of comfortability hugging a close friend has the least agreement suggesting a limit to how far an individual can get closer to an infected person. Earlier study (Amoako-Agyeman, 2012) found out that in general, tolerance level increases as knowledge in HIV/AIDS increases; confidence in HIV knowledge was the best predictor of tolerance. Therefore, students with higher confidence in their HIV knowledge are more likely to tolerate people infected with HIV.

A study (Ahsan Ullah, 2011) on physicians and nurses attached to different hospitals revealed that the spouses of respondents in charge of the HIV-positive individuals put pressure to stop serving the patient or even quit the job. They had the notion that HIV is only transmitted through sexual activities and that is prevalent among them. Although the physicians know well about the routes of transmission, they do not believe it by heart. Therefore, their fear of being infected makes them discriminate against the HIV-positive individuals.

The stigma attached to HIV/AIDS can extend into the next generation, placing an emotional burden on them (Ahsan Ullah, 2011). In a study (Amoako-Agyeman, 2016), an implicit meaning of doing of what is "bad" in the context of HIV and relationships was expressed strongly: that if students are able to avoid "bad life, bad association, bad practices, bad influence, they could avoid HIV". They associated *"*bad" to immorality or infidelity, anything detestable, in contrast to their values and societal norms.

Tolerance and Acceptance represent the readiness of respondents to associate with people with HIV; the belief that classmates who have HIV should not be avoided but be tolerated and accepted. In spite of what seems to be a readiness to associate with infected people, there was a sense of stigmatization. One-third of the statements (6, 7, 8, 9 and 11) recorded the highest level of correct responses ranging from 70% to 80%. These are mostly about the mode of transmission and prevention by abstinence. Another one-third of the statements (2, 4, 5, 13, and 14) mostly illustrating misconceptions (and some conceptions) about how one can be infected with HIV and testing had scores between 60% and 67%. The rest however received correct responses 50% or below. Those between 40% and 50% were mainly about misconceptions about condoms and protection (1, 3, 10 and 15). In this instance, almost half of respondents could not indicate the truth about what a sexual act without protection could lead to. For instance, 58% in statement 'one' indicated wrongly that *you can't get AIDS if you have sex only once or twice without a condom* raises major concern. The statement (12) with the lowest of correct scores (20%) is about "People infected with HIV are usually very thin and sickly" could lead to targeting even the wrong people in situations where stigmatisation is high. Whilst 80% are sure that *HIV can be found in vaginal fluids and blood,* 26% "don't know" if *males can pass HIV on to others through their semen.* The results show that levels of knowledge are not yet universal. Accurate knowledge of how HIV is transmitted and appropriate behaviour change remains one of the most important prerequisites for reducing the rate of HIV infection (AVERT, 2008).

Maticka-Tyndale et al. (2010) in a Kenyan study observed, that students are regularly examined on their knowledge of HIV/AIDS through the national examination system as part of monitoring the on-going delivery. Ability to distinguish between facts and misinformation is crucial; education needs to be an on-going process, because each generation of young people need to be informed about how they can protect themselves from HIV as they grow up (AVERT, 2008). Knowledge creates the precondition for change (Bandura, 1998) and heightened awareness and knowledge of health risk are important preconditions for self-directed change (Bandura, 1994). Therefore, distinguishing between facts and misinformation, and assessing levels of awareness of how HIV is transmitted (AVERT, 2008) is crucial in HIV education. Du Plessis et al. (1993) draw distinction between knowledge and simple awareness: creating awareness and acquiring knowledge are influenced by

different intermediate variables such as "selective perception, the interpretation of messages and selective access to sources of information" (p.4).

CONCLUSION AND RECOMMENDATION

Findings show that many young people still hold serious misconceptions about HIV/AIDS. Though conclusions suggest a strong sense of HIV awareness, gaps still exist in knowledge levels, therefore, not yet universal. A comprehensive and systematic education is important to address signs suggesting stigmatisation or discrimination of infected people especially in societies where beliefs exist that infection of HIV and AIDS could also be the result of witchcraft, punishment from gods, ancestral spirits, or visitation of God(s) wrath on sexually promiscuous and sinners. Students may have a strong sense of tolerating and accepting people infected with HIV; their comfortability to do that willingly may depend on the quality of knowledge and facts about HIV and AIDS. Without a corresponding increasing quality or accuracy of the knowledge, winning the fight against stigmatisation, an explosive epidemic of HIV infection, may continue to linger on.

A study by Dessie and Zewotir (2024), found that factors such as older age, social support, greater education, higher socioeconomic status, good knowledge of HIV, and longer years of living with HIV significantly lowered the likelihood of HIV-related stigma.

This study aligns with the conclusion of Dessie and Zewotir (2024) to combat systemic HIV-associated stigma, that it is crucial to develop wholesome and comprehensive social methods by raising community-level HIV awareness. In addition to activism, local economic development is also crucial for creating thriving communities with a strong social fabric.

Given these high levels of misconceptions, it is not difficult to see why increased policy attention and resource mobilization to HIV/AIDS prevention among young people in Ghana may yield limited positive behaviour change and progress towards reducing infections. Giving of functional knowledge should continue in schools about HIV transmission, testing, risk behaviours, myths and prevention, consequences of touching semen and vaginal fluids or blood (CDC, 2005, 2003b, 1988; Quackenbush, Clark and Nelson, 1995) and the activity should be a continuous activity. HIV/AIDS prevention programmes must refocus on the quality of information and knowledge imparted, taking cognizance of local contexts (Ganle, Tagoe-Darko & Mensah, 2012).

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