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STIGMA AND HIV/AIDS: ATTITUDES OF VLORA UNIVERSITY STUDENTS TOWARDS PEOPLE LIVING WITH HIV

Rezarta Lalo*, **Gjergji Theodhosi****, **Fatjona Kamberi***, **Juljana Xhindoli***

*Faculty of Public Health, University "Ismail Qemali", Vlorë Albania

**University of Medicine Tirana

Abstract

Introduction: Stigma often is associated with misconception and insufficient knowledge for the disease itself and the transmission ways, the moral judgment and the way people may get infected.

Purpose: The main aim of this study is to establish the attitudes of Vlorë University students towards persons living with HIV/AIDS.

Methodology: This is a descriptive study where quantitative method was used for the data and information resulting from a survey structured in the form of a questionnaire. The study participants were 721 randomly selected students from the Vlorë University. For statistical analysis of the data was used statistical program SAS (Statistical Analysis System) version 9.1. A p values $\leq 0,05$ were accepted as statistically significant.

Results: The average age of the students was 20.75 ± 2.2 years, 56.45% were female and 43.55% male. Regarding attitudes towards persons living with HIV 83% of students did not agree to use the same utensils with a person infected with HIV, 75% affirm that they can not kiss a person infected with HIV, 74% can not swim or bath with a person living with HIV. Even though 65.54% of the students have a good knowledge about HIV / AIDS, 47% result that keep stigmatizing attitude towards people with HIV ($P < 0.0001 < 0.05$). There was no significant association between gender ($P = 0.1516 > 0.05$), subject of the study ($P = 0.1101 > 0.05$) and HIV related attitudes items.

Conclusions: Our findings demonstrate the benefit of furnishing Vlorë University students with accurate information about HIV/AIDS as a strategy to eliminate the stigma of AIDS.

Keywords: Attitudes, knowledge, HIV infection, person living with HIV, University of Vlorë

1. Introduction:

Stigma is one of the many reactions that HIV/AIDS epidemic has caused. These reactions come from individuals, communities and even nations. During all this time the sympathy and care is transformed into silence, avoidance, denial, fear, anger up to the violence (Malcolm, Aggleton et al., 1998). Learning about the HIV status through the lab analyses is always a traumatic experience which changes a person's life (Leserman, 2008). The difficulties relate to the discrimination and stigmatization which complicate the compliance and relate to the need to apply the holistic models of caring, which treat the psychological, spiritual and physical dimensions for HIV infected patients (Barroso & Powell-Cope, 2000). Research has shown that the fast progression of the disease is associated with the low level of social support (Leserman, Petitto et al., 2000). Stigma associated with HIV has caused the fact that many people who live with this disease do not get the proper care and social support, and they experience a *low level of emotional wellbeing* compared to overall population (Hays, Cunningham et al., 2000).

Most of the time stigma is multi dimensional. There are three types of stigma related to HIV/AIDS. Firstly, "the self stigma" which happens through "self blaming" . Secondly, " the perceived stigma" related to the fear of the individuals to show their HIV status as they might get discriminated. Thirdly, "approved stigma" which happens when the individuals get discriminated repeatedly because of their HIV status (Thomas, 2006).

Stigma towards HIV/AIDS acts like a barrier for the treatment, care and prevention of HIV, including testing and volunteer counseling (Fortenberry, McFarlane et al., 2002; Kalichman & Simbayi, 2004; Lieber, Rotheram-Borus et al.,2006).

Stigma often is associated with misconception and insufficient knowledge for the disease itself and the transmission ways, the moral judgment and the way people may get infected. People or their groups are labeled as "responsible" for the epidemic for example the sexual workers or they are responsible for the infection they have. They are excluded, bullied, isolated and are the objects of rumors and may even get thrown out of their place of living (Badahdah AM. 2005; Thomas, 2006).

Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in 2012 (UNAIDS 2013). The results from the European screening for HIV/AIDS in 2011 showed that HIV infection remains a main health problem in Europe. The younger generations are a vulnerable target group from HIV virus. Around 11% of the self reported cases with HIV in 2011 were the young group of 15-24 year old (WHO EURO Surveillance Report 2012).The increase in cases detected might be due to the reduction of information given to the general population (Tung W. et al. 2008). Healthcare professionals including nurses have significant responsibility for providing information about the transmission of HIV and for developing a strategic health programs to reduce that transmission (Christina Ouzouni et al. 2012). Nursing students as a subgroup of health care professionals exposed to an occupational risk of HIV infection due to direct contact with blood and bodily fluid during clinical practice, and have been reported to tend to have negative attitudes towards PLHIV. There are many factors related to negative PLHIV related

attitudes, such as a low knowledge level, and fear of the possibility of becoming infected and death (Christina Ouzouni et al. 2012).

Referring a study concluded from De Beers et al. in 2012 in the Polytechnic University of Namibia as one of the countries with high prevalence in young people, we can state that even though most of the students know someone who lives with HIV/AIDS, they still have negative attitude toward them. This shows that they have misunderstandings or the wrong ideas on the ways of transmission or the stigma attitude. Some students think that the ones that are infected with HIV should be isolated. They feel that they should not work with the infected people because the infected people have had immoral behavior. These negative attitudes are also predominant in the general population and contribute massively in mystification, stigmatization and continuing the inappropriate fear toward HIV/AIDS. These results are similar to other studies conducted in other parts of the world that show the existence of various misconceptions about HIV/AIDS and the pervasiveness of the stigmatization of individuals with HIV/AIDS (Badahdah A.M. et al. 2010; Edet Olaide Bamidele 2012; Kaijaleena Serlo 2008).

There are very few studies in Albania that focus on the stigmatization toward the HIV infected people (Dango & Agolli 2008; Morrison, Banushi et al., 2011). Most of the studied conducted the recent years aimed the prevention of the disease and in the assessment of the population (groups), dangerous behavior (Agolli.I 2012). There are also some other studies about the assessment of knowledge, behavior and attitude toward the STD in Albanian universities (Burazer.G et al 2003; Merkuri. L 2013; Bashllari. A et al., 2014) and the evaluation of knowledge, sexual behavior and attitude toward to the risk of HIV/AIDS in teenagers (Krasniqi.M 2014; Kicaj.E et al., 2014). According to Merkuri. L in 2013 students with better knowledge of STD/HIV/AIDS have more correct attitude and vice versa. 15.1% of the students think that HIV positive people should not go the same school as the other non infected people. Referring this study in general, negative attitudes in males are higher than in females.

2. Purpose:

The main aim of this study is to establish the attitudes of the Vlora University students towards persons living with HIV/AIDS.

3. Objectives of the study:

To determine socio-demographic data of the study participants.

To establish students' general knowledge on HIV / AIDS

To establish students' attitudes towards persons living with HIV/AIDS.

To assess stigmatizing attitudes towards people living with HIV / AIDS according to socio-demographic data of study participants.

To evaluate the association between knowledge about HIV/AIDS and attitudes towards people living with HIV.

4. Methodology of the study:

In addition to a descriptive-type-of-study, this is a quantitative method which uses the data and information resulting from a survey structured in the form of a questionnaire. The survey was conducted among 721 randomly selected UV students during May-June 2014. During the drafting of the questionnaire was consulted a range of materials and questionnaires were considered models used roughly similar studies. The format of the questions followed a Likert scaling also known as a summated rating scale. In Likert scaling each participant's rates multiple items designed to measure one construct (Christensen, et al. 2011). For the knowledge index, 12 statements were generated to assess students' general knowledge about HIV and its transmission. Students could choose from 3 options for each question: "correct", "wrong" and "don't know". The "don't know" answers were treated as wrong answers in the analysis. An index of AIDS knowledge was created that ranged from 0 to 12, with higher scores indicating greater knowledge of HIV.

AIDS-related stigma was measured by 12 items that indicated the emotional responses and behavioural reactions towards PLWHA. Participants responded to each statement on a Likert-type scale with possible responses ranging from 1 (strongly agree) to 5 (strongly disagree) included the option "don't know".

5. Data analysis:

An expert in statistic was used for data coding and analyses to enhance the research validity. For statistical analysis of the data was used statistical program SAS (Statistical Analysis System) version 9.1. For numerical variables it was used arithmetic average and size dispersion (standard deviation). For categorical variables were reported absolute numbers and percentages respective. To assess the links between different variables were used statistical tests in accordance with the nature of the variables that participate in a certain relation. We used mainly non-parametric test Kruskal-Wallis to compare the homogeneity of the various groups compared. To assess the associations between categorical variables was used Chi-square statistical test, the preferred test for the evaluation of associations between categorical variables. This test P-value reports, as well as scales of freedom. Cross tabs were used to assess the relationship between different variables (knowledge, behavior) in which was awarded the Pearson correlation index, which the values 0.1-0.29 shows weak correlation, for the values 0.3-0.49 shows moderate correlation, for the values 0.5-0.69 shows substantial correlation and over 0.7 strong correlation. P values $\leq 0,05$ were accepted as statistically significant.

Pilot study:

The validity and reliability of measuring instruments was tested in a pilot study in a group of 30 students of Public Health Faculty. These 30 students did not know that they were part of a pilot group. After evaluation was certified that there were not evident problems or difficulties in understanding the questions.

Ethical principles:

For the realization of this study initially assured permission from the rector of UV and the deans of various faculties and the approval to conduct this research study was obtained from the University "Ismail Qemali" Vlore Council of Ethics before the study commences. Studies which collect personal information on subjects, to be designed in an ethical manner to protect individuals participating in the study, also based in Helsinki Declaration. Informed consent was obtained from the participants after informing them about all the relevant issues of the study. There was no discomfort observed during questionnaire completion and the participants were assured of confidentiality.

6. Results of the study:

The mean age of the subjects in the study was 20.75 ± 2.2 years, with a representation of the maximum age 40 years. 56.45% of the respondents were men and 43.55% female. 82.9% of students are single, while 17.1% of students estimate their economic status as "Average". Regarding the subject of the study 40% are students of the Faculty of Public Health (nursing students) and 60% of other faculties (no nursing students).

General knowledge was assessed according to the answers of the 12 questions in the general knowledge section about HIV/AIDS infection. Each correct answer had 1 point and the total was classified in this category:

- 10-12 points - Very good knowledge
- 7-9 points - Good knowledge
- 0-6 points - Not so good knowledge

By the manner of students' response to any questions, we have constructed the following table.

	AIDS-related knowledge item	Correct response		Incorrect response	
		No	%	No	%
1.	A person with HIV can look healthy for many years	355	49.38	364	50.62
2.	HIV can be transmitted through saliva, kissing infected person	401	55.77	318	44.23
3.	HIV can be transmitted through a mosquito bite when it first bites an infected person	235	32.68	484	67.32
4.	HIV can be transmitted through shaking hands with infected people	587	81.64	132	18.36
5.	A pregnant woman can transmit the virus to her unborn child	580	81.46	132	18.54
6.	HIV is a disease of poor people	41	5.70	678	94.30
7.	Having a quick bath after unprotected sex can reduce the risk of contracting HIV	400	55.87	316	44.13
8.	ARV therapy provides treatment of AIDS	567	78.86	152	21.14
9.	A person would not contract HIV by having sexual intercourse with a newly infected person with HIV	432	60.08	287	39.92
10.	Sharing needles could increase the chances of contracting HIV	643	89.43	76	10.57
11.	Only people who look sick can spread the AIDS virus	545	75.80	174	24.20
12.	The girls can not get HIV from the boys who have had sex only a few times	502	69.92	216	30.08
Without answer 2 students					

Table 2. Correlation between general knowledge about HIV / AIDS and socio- demographic variables

Variables		Knowledges							
		Not so good		Good		Very good		Total	
		N	(%)	N	(%)	N	(%)	N	(%)
Gender	Female	112		211		83		406	
	Male	15.58		29.35		11.54		56.47	
	Total	137		149		27		313	
		19.05		20.72		3.76		43.53	
		249		360		110		719	
		34.63		50.07		15.30		100.00	
		Statistic		DF	Value	Prob			
		Chi-square		2	30.1725	<.0001			
Variables		Knowledges							
		Not so good		Very good		Good		Total	
		N	(%)	N	(%)	N	(%)	N	(%)
Subject	Public Health Faculty	73		77		139		289	
	Others Faculties	10.15		10.71		19.33		40.19	
	Total	176		33		221		430	
		24.48		4.59		30.74		59.81	
		249		110		360		719	
		34.63		15.30		50.07		100.00	
		Statistic		DF	Value	Prob			
		Chi-square		4	57.4604	<. 0.0001			

These attitudes were assessed starting from the 12 statements in the section "Attitudes toward people living with HIV" of the questionnaire. Each correct answer had 1 point and the total was classified in this category:

- 10-12 points - Very appropriate attitudes
- 7-9 points - Appropriate attitudes
- 0-6 points - Not so appropriate attitudes

By the manner of students' response to any questions, we have constructed the following table.

AIDS-related attitudes item	Correct response		Incorrect response	
	No	%	No	%
1. I can still be a friend with a person living with HIV	439	62.00	269	38.00
2. A person with HIV should be treated as equal as a person without HIV	538	75.99	170	24.01
3. I can work with a person living with HIV	473	66.71	236	33.29
4. I can stay in the same desk with a person living with HIV	452	63.75	257	36.25
5. I can kiss a person living with HIV	174	24.54	535	75.46
6. I can hold and shake hands with a person living with HIV	469	66.15	240	33.85
7. I can swim or bath with a person living with HIV	185	26.13	523	73.87
8. I can sleep in the same bed with a person living with HIV	190	26.80	519	73.20
9. I can play with a person living with HIV	501	70.76	207	29.24
10. I can share kitchen utensils with a person living with HIV	120	16.95	588	83.05
11. Employee living with HIV should still work as long as he/she is fit for work	398	56.22	310	43.78
12. I will care for a relative living with HIV	533	75.28	175	24.72

Without answer for statements (3,4,5,6,8) 12 students and for statements (1,2,7,9,10,11,12) 13 students

Table 4. Correlation between attitudes towards persons living with HIV / AIDS and socio- demographic variables

<i>Variables</i>		Not appropriate attitudes		Appropriate attitudes		Very appropriate attitudes		Total	
		N	(%)	N	(%)	N	(%)	N	(%)
Gender	Female	175	24.68	154	21.72	71	10.01	400	56.41
	Male	157	22.14	100	14.11	52	7.34	309	43.59
	Total	332	46.82	254	35.83	123	17.34	709	100.00

Statistic	DF	Value	Prob
Chi-square	2	3.7735	0.1516
Likelihood Ratio Chi-square	2	3.7794	0.1511
Mantel-Haenszel Chi square	1	1.9983	0.1575

<i>Variables</i>		<i>Attitudes</i>							
		Not appropriate attitudes		Appropriate attitudes		Very appropriate attitudes		Total	
		N	(%)	N	(%)	N	(%)	N	(%)
Subject	Public Health Faculty	124	17.49	112	15.80	48	6.77	284	40.06
	Others Faculties	208	29.34	142	20.02	75	10.58	425	59.94
	Total	332	46.83	254	35.82	123	17.35	709	100.00

Statistic	DF	Value	Prob
Chi-square	4	7.5363	0.1101

Table 5. Evaluation of association between general knowledge about HIV/AIDS and attitudes towards persons living with HIV / AIDS

General knowledge about HIV/AIDS								
AIDS-related attitudes item								
The scale of measuring	Not appropriate attitudes		Appropriate attitudes		Very appropriate attitudes		Total	
	N	(%)	N	(%)	N	(%)	N	(%)
Not very good	155	(21.89)	74	(10.45)	15	(2.12)	244	(34.46)
Very good	23	(3.25)	45	(6.36)	39	(5.51)	107	(15.12)
Good	153	(21.61)	135	(19.07)	69	(9.75)	357	(50.42)
Total	331	(46.75)	254	(35.88)	123	(17.37)	708	(100.00)
Without answer		13						
Statistic		DF		Value		Prob		
Chi-square		4		74.9418		<.0001		

Table 5.1. Evaluation of association between general knowledge about HIV/AIDS and attitudes towards persons living with HIV / AIDS

Knowledge	Attitude											
	<i>I can share kitchen utensils with a person living with HIV</i>											
<i>HIV can be transmitted through saliva</i>	Strongly disagree		Agree		Don't know		Disagree		Strongly agree		Total	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
Strongly disagree	72	10.18	47	6.65	44	6.23	68	9.62	30	4.24	261	36.92
Agree	61	8.63	9	1.27	19	2.69	43	6.08	3	0.43	135	19.10
Don't know	41	5.80	5	0.71	12	1.70	26	3.67	1	0.14	85	12.02
Disagree	46	6.51	15	2.12	22	3.11	43	6.08	8	1.13	134	18.95
Strongly agree	58	8.20	1	0.14	5	0.71	27	3.82	1	0.14	92	13.01
Total	278	39.32	77	10.89	102	14.44	207	29.27	43	6.08	707	100.00
Pearson Correlation $r=-0.12$												

Table 5.2. Evaluation of association between general knowledge about HIV/AIDS and attitudes towards persons living with HIV / AIDS

Knowledge <i>HIV can be transmitted through shaking hands with infected people</i>	Attitude											
	<i>I can still be a friend with a person living with HIV</i>											
	Strongly disagree		Agree		Don't know		Disagree		Strongly agree		Total	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
Strongly disagree	41	5.80	266	37.63	84	11.88	58	8.20	100	14.14	549	77.65
Agree	1	0.14	4	0.57	2	0.28	3	0.43	0	0.00	10	1.42
Don't know	9	1.27	9	1.27	9	1.27	0	0.00	0	0.00	27	3.81
Disagree	14	1.98	53	7.50	26	3.68	16	2.26	6	0.85	115	16.27
Strongly agree	1	0.14	0	0.00	3	0.43	1	0.14	1	0.14	6	0.85
Total	66	9.33	332	46.97	124	17.54	78	11.03	107	15.13	707	100.00

Pearson Correlation $r=-0.11$

7. Discussion

This study evaluated the knowledge of students of Vlore University on HIV/AIDS and their stigmatizing attitudes toward HIV people by analyzing in the same time the impact that the knowledge level had on their attitude toward PLWHA. We found specific deficiencies in Vlora University students' knowledge about HIV. **Table 1** shows that 94% of the students answer wrong or do not know that HIV is a disease of the poor people, so that it has a higher prevalence in the countries with low socio-economic status (Knowledge 6); 67% state that HIV is transmitted through the mosquito bites which is still wrong (K3); about 49% of the students think that a person with HIV may seem healthy for many years (K1), while 51% are wrong, showing that they do not have knowledge on this infection incubation time period; 44% state mistakenly that HIV can be transmitted through the saliva and/or kissing (K2) answers these in contrast with the study conducted from Twahafifwa Ndahekeleka Tupavali Nghaamwa 2013 where most of the students answer these statements correct. When we compared the level of knowledge in different genders and the field of study we noticed that females (41% very good and good knowledge) had better knowledge than males (25% very good and good knowledge). This is statistically significant with $P<0.0001<0.05$ (**table 2**). These results are in contrary with other studies where males had better knowledge than females (Paraniala S. C. Lui et al.,2014; A.M. Badahdah et al.,2010; Wondemagegn Mulu et al.,2014). On the other hand some other studies did not show statistical significance related to gender (Majelantle et al., 2014; Josephine.O 2014). There is statistical significance in the results as for the field of study especially in the nursing students and non nursing students (N=430) from them 254 (53%) had very good and good knowledge, to the nursing students (N=289) from them 216 (47%) had very good and good knowledge $P<0.0001<0.05$. This was conformed by Kruskal-Wallis Test (Chi-Square 19.0053, DF 2, $Pr>Chi$ square<.0001. These results are similar to other studies' results

which show that medical students had better knowledge than non-medical students (Namaitijiang Maimaiti et al., China 2010).

As for the attitudes toward the people who live with HIV status, our study found that even though most of the students have positive attitude (53%) there was a considerable percentage of 47% who keep a stigmatizing attitude. This result (53%) was higher than that found in a study by A.M. Badahdah et al., 2010 in which 33.8% had positive attitude, but compared to (Edet Olaide Bamidele et al., 2012) where 64% of the students had positive attitude, our result is lower. In this study we found (**table 3**) an emphasized stigma related to the statement number 10 (I can share kitchen utensils with a person that has HIV), around 83% stated that there did not agree. Also in the statement number 5 (I can kiss somebody with HIV) 75% of the students do not agree. The statement number 7 (I can swim or bath with a person living with HIV) 74% of the students did not agree, and also for the statement number 8 (I can sleep in the same bed with a person living with HIV) 73% do not agree. For the same statements as above, if we compare the results with the study conducted by Twahafifwa 2013, we notice lower stigma (39.7%; 28%;8.6%;7%) respectively.

Table 4 shows that there is no statistical significance between the various socio demographic factors and the attitude toward the people with HIV. This attitude does not change according to age ($P=0.4027>0.05$ chi-square), nor the gender ($P=0.1516>0.05$), or the residence ($P=0.1590>0.05$), or field of study ($P=0.1101>0.05$) etc. meanwhile for the others studies conducted previously in Albania from Merkuri. L male attitude is higher than female attitude. The results of others studies from (Edet Olaide Bamidele et al., 2012; Oliha Josephine 2014) showed that there was no significant association between gender and HIV related, results similar to our results; while referring the study from (A.M. Badahdah et al., 2010) female students overall expressed more positive attitudes towards PLWHA than did male students; according to Namaitijiang Maimaiti et al., China 2010 which compares the attitudes between medical student and non medical students there was no significant association between subject of the study and HIV related attitudes.

The studies show that although students had good knowledge regarding HIV/AIDS, they still harbor negative attitude towards people living with the virus (Oliha Josephine 2014; Twahafifwa 2013; Edet Olaide Bamidele et al., 2012; Namaitijiang Maimaiti et al., China 2010; Serlo.K 2008). In our study according to **table 5**, even though 65.54% of the students have good knowledge on HIV/AIDS, 47% have negative stigma toward HIV people. This is clearly shown in the results presented in **table 5.1** and **5.2**. In the same time if we analyze the impact that knowledge has on the attitude of students toward HIV status people we noticed that there are statistically important results of the variables knowledge/ attitude ($P<0.0001 <0.05$ chi-square). From 107 students with very good knowledge 84 of them have very appropriate and appropriate attitude so the better attitude comes from students with very good knowledge (78.50%) and good knowledge (57.15%). As a final result, we conclude that the students with good knowledge have better attitude toward HIV people, which is similar to other studies' results (A.M. Badahdah et al., 2010; Edet Olaide Bamidele et al., 2012).

Table 5.1 shows that Pearson correlation coefficient $p=-0.12$ between the variables of knowledge on HIV/AIDS transmission through saliva and the attitude toward HIV people of sharing or not the kitchen utensils shows a weak correlation. So the students who answered right the question that HIV can be transmitted through the saliva have lower chances of sharing kitchen utensils with the persons living with HIV than the ones who answered wrong the question. From 56% of the students (395) who answered right the question on saliva transmission, around 14 % (100 students) stated that can share the kitchen utensils with HIV infected people.

Table 5.2 shows that Pearson correlation coefficient $p=-0.11$ between the variables of knowledge on HIV/AIDS transmission through hand shaking and the attitude toward HIV people through their friendship, shows a weak correlation. So, the students that answered right the question that HIV can be transmitted shaking hands with infected people have lower chances of being friends with HIV people than the ones who answered it wrong. From 94 % of the students (664) that answered right the question, only 18% (120) stated that they might be friends with HIV infected people.

Limitations of the study:

Despite the valuable contribution of this study, several limitations should be mentioned. The findings cannot be generalized to all college students in Vlora city. A bigger sample would be appropriate, including students from another private university in Vlora. In studies where information is gathered by self reporting, it is known that the answers are subject to an over or under reporting. Given that the survey data derive precisely from self-report guess it could be subject to this limitation (Brenner ND et al. J Adolescent Health 2003;33:436–57). However, to minimize this, I explained at the outset participants in the study about the importance of reporting the most realistic, accurate and rigorous. Despite these limitations, I think the study provides useful data about students' knowledge and attitudes towards people living with HIV/AIDS infection.

8. Conclusions:

Vlora University students have a good knowledge about HIV / AIDS, but limited information and misunderstandings of some possible routes of transmission of HIV. Nursing students had better knowledge than students of other faculties; female students also resulted in better knowledge. Regarding attitudes towards people living with HIV, our study found a considerable percentage that hold stigmatizing attitude towards them, but there wasn't a significant relationship with socio-demographic factors such as gender or subject of study. According to association between knowledge-stigma our study found that students with better knowledge have positive attitudes with them. Our findings demonstrate the benefit of furnishing Vlora University students with accurate information about HIV/AIDS as a strategy to eliminate the stigma of AIDS. It is necessary to perform periodical studies in this area in order to evaluate the trends and to assess the progress.

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