Exploring HIV/AIDS Awareness, Misconceptions, and Stigma among University Students: A Basis for an Institutional Action Plan for Prevention and Intervention

Dr. Annaliza C. Tibayde

West Visayas State University-Himamaylan City Campus Himamaylan City, Negros Island Region, Philippines

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ABSTRACT

This report presents an in-depth analysis of a study investigating HIV/AIDS awareness, misconceptions, and stigma among 300 university students in Western Visayas. The primary objective is to enhance comprehension of the study's findings and provide a robust foundation for evidence-based institutional action plans aimed at prevention and intervention. The study revealed that while students generally possess a high level of awareness regarding HIV/AIDS (Mean = 3.84), a significant proportion simultaneously holds persistent misconceptions, particularly concerning non-transmission modes. For instance, nearly half (47%) incorrectly believe mosquito bites can transmit HIV. Concurrently, moderate levels of HIV/AIDS-related stigma were observed (Mean = 2.91). A critical finding was the statistically significant moderate negative correlation between awareness and stigma ($r = -0.54$, $p < .001$), indicating that an increase in accurate knowledge is associated with a reduction in stigmatizing attitudes. Furthermore, the understanding of HIV/AIDS varied significantly across different academic programs, with students in health-related and education fields demonstrating a more nuanced comprehension. These findings underscore the urgent need for targeted, evidence-based educational interventions. Key recommendations include the integration of precise HIV/AIDS education across all university curricula, the implementation of peer-led campaigns to normalize discussions and challenge fear-based narratives, and the establishment of robust institutional policy support for sustained initiatives. Such strategies are essential to bridge the gap between general awareness and accurate understanding, thereby effectively reducing stigma within the university community.

INTRODUCTION

Human Immunodeficiency Virus (HIV) and acquired immunodeficiency syndrome (AIDS) continue to pose formidable public health challenges globally, with a disproportionate impact on low- and middle-income countries. Despite decades of concerted awareness efforts, young people remain particularly vulnerable, not only to infection but also to the pervasive social stigma associated with the disease. The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2023) highlights this ongoing vulnerability, emphasizing the critical need for continued intervention. In the Philippines, the Department of Health (DOH, 2022) has reported a significant increase in HIV incidence among youth, further accentuating the urgency for accurate education and comprehensive awareness programs.

This study was specifically designed to examine university students' levels of awareness, misconceptions, and attitudes toward HIV/AIDS within a higher education context in Western Visayas. The overarching goal was to generate empirical data that could inform the development of institutional and policy-based strategies aimed at reducing stigma. By contributing to the body of evidence-based interventions in health education, the study sought to provide actionable insights for creating a more informed and compassionate university environment.

METHODOLOGY

The research employed a descriptive-quantitative design, utilizing a self-administered survey questionnaire. This instrument was meticulously developed from validated HIV/AIDS awareness tools, including those from

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WHO KAP surveys, ensuring its reliability and relevance. The study participants comprised 300 college students, aged 18–25, enrolled at a state university in Western Visayas. These students were selected through stratified random sampling, a method chosen to ensure representation across different year levels and college affiliations. Ethical clearance was rigorously secured prior to data collection, upholding principles of anonymity and voluntary participation. The University Research Ethics Committee formally approved the study, with data collection occurring in March 2025. For data analysis, SPSS v26 was utilized. Descriptive statistics were employed to characterize awareness levels, while Pearson's correlation was used to assess the relationship between awareness and stigma. Misconceptions were also comprehensively profiled using frequency counts and percentages to provide a detailed understanding of specific knowledge gaps.

RESULTS

This section provides a comprehensive, multi-layered analysis of the study's quantitative results, integrating the presented tables and extracting deeper understandings to enhance clarity and actionable implications.

Overall Perceptions: Awareness, Misconceptions, and Stigma Levels

The foundational understanding of students' perceptions regarding HIV/AIDS is derived from the overall mean scores for the key variables measured.

Table 1: Mean Scores of Student Awareness, Misconceptions, and Stigma about HIV/AIDS (N = 300) [1]

Variable	Mean	Std. Deviation	Interpretation
HIV/AIDS Awareness	3.84	0.62	High Awareness
Misconceptions (Reverse Scored)	2.35	0.71	Moderate Misconception
HIV/AIDS-Related Stigma (Scale)	2.91	0.83	Moderate Stigma

The mean score for HIV/AIDS Awareness (M = 3.84), accompanied by a relatively low standard deviation (0.62), indicates a generally high level of awareness among the surveyed university students. This suggests that basic information about HIV/AIDS has been broadly disseminated and absorbed within this population, aligning with the general objectives of public health campaigns.

However, a notable observation emerges from the mean score for Misconceptions (M = 2.35, reverse scored), with a standard deviation of 0.71. This value points to a moderate level of persistent misconceptions. This finding is particularly significant as it reveals a disconnect: despite a broad recognition of HIV/AIDS, students continue to hold incorrect beliefs about the disease. This suggests that while information may be widely available, an accurate and nuanced understanding has not fully permeated the student body.

Furthermore, the mean score for HIV/AIDS-Related Stigma (M = 2.91), with a standard deviation of 0.83, indicates a moderate level of stigma within the student population. This suggests that despite awareness efforts, discriminatory attitudes and social barriers remain prevalent, posing ongoing challenges for effective prevention and intervention strategies.

The co-existence of "High Awareness" (M=3.84) and "Moderate Misconception" (M=2.35) presents a critical paradox. This pattern suggests that simply increasing the *quantity* of information (awareness) does not automatically translate into a *quality* of understanding or the eradication of deeply ingrained false beliefs. This implies that current educational approaches may be effective in broad dissemination but insufficient in addressing specific, persistent inaccuracies. General awareness campaigns might focus on broad recognition or high-risk behaviors, but they may fail to explicitly debunk common myths or address nuanced aspects of transmission. Misconceptions, often rooted in fear or cultural narratives, tend to be more resilient than general facts. This calls for a shift in educational focus from mere exposure to information to ensuring accurate and comprehensive comprehension, especially concerning non-transmission modes and the social aspects of the

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disease. This represents a significant challenge for public health education, requiring a more sophisticated pedagogical approach than simple factual dissemination.

The presence of moderate stigma (M=2.91) alongside moderate misconceptions strongly suggests that these misconceptions are a primary driver of stigma. If individuals hold false beliefs about transmission (e.g., through casual contact), it logically follows that they would fear or avoid those perceived to be infected, leading to stigmatizing behaviors. Stigma is often rooted in fear, and fear is frequently a product of ignorance or misinformation. If people incorrectly believe HIV can be spread through casual contact, sharing food, or mosquito bites (as will be further detailed in Table 2), their fear would naturally lead to avoidance, discrimination, and a general stigmatization of people living with HIV. This implies that addressing misconceptions is not merely about factual correctness but serves as a direct and potent pathway to reducing stigma. The moderate stigma level observed appears to be a direct consequence of the persistent, specific misconceptions, making targeted factual education a powerful anti-stigma intervention.

Specific Misconceptions: Unpacking Knowledge Gaps

To further understand the nature of the "Moderate Misconception" identified in Table 1, a detailed breakdown of specific incorrect beliefs held by students is essential.

Table 2: Common Misconceptions about HIV/AIDS (% of Students Answering Incorrectly)

Statement	Incorrect Response (%)
HIV can be transmitted through casual contact	42%
Sharing food with an HIV-positive person causes HIV	38%
Mosquito bites can spread HIV	47%
HIV/AIDS is a punishment for immoral behavior	31%

The data presented in Table 2 reveals alarmingly high percentages of students holding incorrect beliefs about non-transmission modes. Nearly half of the students (47%) incorrectly believe mosquito bites can spread HIV, making this the most prevalent misconception. Similarly, 42% incorrectly believe HIV can be transmitted through casual contact, and 38% believe sharing food with an HIV-positive person causes HIV. These figures directly quantify the "Moderate Misconception" identified in Table 1 and highlight critical areas where accurate knowledge is lacking.

Furthermore, a significant portion (31%) views HIV/AIDS as a punishment for immoral behavior. This indicates a deeply entrenched moralistic and judgmental dimension to misconceptions, which strongly fuels stigma and creates substantial barriers to empathy and support for people living with HIV.

The high percentages of incorrect responses regarding casual contact, sharing food, and mosquito bites suggest that these misconceptions are not merely gaps in knowledge but represent deeply ingrained "common sense" beliefs or urban myths. These forms of misinformation are often perpetuated through informal social networks, cultural narratives, or historical fears, making them highly resistant to general awareness campaigns. If general awareness is high (as indicated in Table 1), yet these specific, fundamental misconceptions persist at such high rates, it implies that general awareness campaigns might gloss over these specific points or assume they are understood. However, these myths are likely reinforced by informal conversations, media portrayals, or cultural narratives, making them more resilient than simple factual statements can overcome, as they tap into primal fears of contagion. This highlights the urgent need for *targeted debunking* strategies in educational interventions. Programs must explicitly address these common misconceptions with clear, repetitive, and authoritative information, directly confronting the false narratives. Furthermore, interventions need to consider the informal channels through which misinformation spreads and find ways to counter them effectively.

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The 31% of students who believe HIV/AIDS is a "punishment for immoral behavior" signifies a significant moralistic overlay to the stigma. This is not simply a factual error but a deeply rooted judgmental attitude that can severely impede empathy, willingness to interact with people living with HIV (PLHIV), and support for comprehensive prevention and treatment efforts. This belief assigns blame and moral culpability to individuals with HIV, rather than viewing it as a health condition. Such a judgmental stance leads to social exclusion, discrimination, and reluctance among affected individuals to seek testing or treatment due to fear of judgment and ostracization. It also undermines public health efforts that rely on community solidarity and non-discriminatory access to care. Educational interventions must therefore not only provide scientific facts but also actively challenge moralistic judgments and promote empathy, compassion, and human rights. This requires a more holistic approach that integrates social, ethical, and psychological components into health education, moving beyond purely biomedical facts to address the affective and cultural dimensions of stigma.

The Critical Link: Awareness and Stigma Correlation

Understanding the quantitative relationship between awareness and stigma is crucial for developing effective interventions.

Table 3: Pearson's Correlation Between Awareness and Stigma (N = 300) [1]

Variables	r	p-value	Interpretation
Awareness vs. Stigma	-0.54	<.001	Moderate Negative Correlation

A statistically significant moderate negative correlation ($r = -0.54$, $p < .001$) was found between awareness and stigma. This is a robust finding, indicating that as levels of awareness increase, levels of stigma tend to significantly decrease. The p-value of <.001 confirms that this relationship is highly unlikely to be due to chance, providing strong empirical evidence.

This strong negative correlation suggests a clear and empirically supported pathway for intervention: increasing *accurate* awareness is a direct and effective mechanism for reducing stigma. This moves beyond mere association to imply that educational interventions are not just about knowledge dissemination but are powerful tools for social change and attitude modification. If accurate awareness among students can be effectively increased, a measurable reduction in stigmatizing attitudes and behaviors can be anticipated. This provides robust empirical justification for prioritizing and investing in comprehensive, fact-based educational programs as a primary strategy for combating stigma. It shifts the focus from just managing the disease to actively shaping the social environment that impacts people living with HIV, making education a cornerstone of public health policy.

Given the co-existence of high general awareness (Table 1) and specific misconceptions (Table 2), this correlation implies that it is not just *any* awareness that reduces stigma, but *accurate, nuanced* awareness that directly challenges the misconceptions fueling stigma. Superficial or incomplete awareness might not be sufficient to achieve significant stigma reduction. If general awareness is high, but specific misconceptions persist, yet "awareness" still correlates negatively with stigma, it suggests that the "awareness" that effectively reduces stigma must be the *accurate* component of knowledge that directly contradicts the specific misconceptions. It is the knowledge that disarms fear and replaces false beliefs with facts. General awareness might initiate the process, but targeted, accurate understanding is what drives significant change. This highlights that the *quality*, *accuracy*, and *specificity* of awareness are paramount. Educational interventions must prioritize correcting the specific misconceptions detailed in Table 2 to maximize the stigma-reducing effect of increased awareness. It is not just about knowing *about* HIV, but knowing *how it truly works* and, crucially, *how it doesn't*, to dismantle the rationalizations for fear and prejudice.

Nuances in Understanding: Differences Across Academic Programs

Beyond the quantitative tables, the study's textual results provide critical insights into demographic variations. While descriptive data showed generally high awareness across domains, with slight variations by age and sex,

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no significant differences were noted for students below and above 22 years (all p >.05). This suggests a relatively uniform dissemination of HIV/AIDS knowledge across these age groups.

However, when data were disaggregated by Program Course, significant differences emerged in several key areas: Awareness of HIV/AIDS (p =.043), Micro-conceptions (p =.005), and Influence of information sources (p =.014). The study explicitly notes that "students in different academic programs process and internalize HIV/AIDS education differently—notably, those from health-related and education programs tend to exhibit more nuanced understanding". This indicates that academic background plays a significant role in the depth and accuracy of HIV/AIDS knowledge and how information is processed, suggesting that specialized curricula or disciplinary lenses foster better understanding.

The significant differences in understanding across academic programs (evidenced by p-values of.043,.005, and.014) strongly argue against a uniform, one-size-fits-all approach to HIV/AIDS education within a university setting. This underscores the necessity of integrating tailored, evidence-based HIV/AIDS education *across all disciplines*, not just health-related ones. If only students in health-related and education programs achieve a "nuanced understanding," then a substantial portion of the university population (from other disciplines) will remain vulnerable to persistent misconceptions and stigma. This creates pockets of vulnerability within the student body. This necessitates a strategic shift towards genuine interdisciplinary curriculum integration. For example, an engineering program could discuss the role of technology in diagnostics or treatment adherence, a sociology program could explore the social determinants of HIV/AIDS and stigma, and a business program could analyze the economic impact of the epidemic. This ensures that all students, regardless of their major, receive relevant and accurate information, adapted to their field's context and fostering a more holistic understanding across the entire university.

The finding that students from health-related and education programs possess a more nuanced understanding offers a strategic opportunity to leverage these students as peer educators. Their enhanced knowledge and potential pedagogical skills could be instrumental in designing and leading effective, credible peer-led campaigns, which are already identified as a key recommendation of the study. If a subset of the student population already demonstrates superior understanding, they are ideal candidates to become effective peer educators. They can translate complex information into relatable terms and build trust within their peer groups. This approach would not only disseminate accurate information more effectively but also empower these students, fostering leadership, civic engagement, and a sustainable model for health education within the university. This suggests a strategic recruitment and training approach for peer educators, focusing on students from academic programs identified as having higher levels of nuanced understanding. This ensures the quality, accuracy, and credibility of peer-led initiatives, maximizing their impact on reducing misconceptions and stigma.

Interrelationships of Key Constructs: A Holistic View

Beyond the direct awareness-stigma correlation, the results section further elaborates on other strong positive relationships among key constructs, reinforcing the interconnectedness of knowledge, perceptions, and attitudes:

- Awareness correlates most strongly with Perceptions at r =.675, p <.01.
- Treatment awareness correlates with OVAM (likely "Overall Awareness of Modes of Transmission") at r =.757, p <.01.
- Micro-conceptions show a high correlation with student perspectives at r =.710, p <.01.

The overall synthesis is clear: "These results suggest that greater cognitive awareness reduces misconceptions and improves student attitudes toward HIV/AIDS (see Table 3)". This reinforces that various dimensions of awareness (general, treatment-specific) are strongly linked to overall perceptions and student perspectives, reinforcing the idea that accurate knowledge profoundly shapes attitudes and reduces misconceptions.

The existence of multiple strong correlations (e.g., general Awareness with Perceptions, Treatment awareness

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with Overall Awareness of Modes of Transmission, Micro-conceptions with student perspectives) indicates that "awareness" is not a monolithic construct. It encompasses various dimensions (general knowledge, specific transmission facts, treatment-related information) that collectively and synergistically contribute to shaping overall perceptions and reducing misconceptions. This suggests that a truly comprehensive educational strategy should not just focus on one type of awareness but systematically address all relevant dimensions. For example, knowing about effective treatment options (Treatment awareness) can reduce fear and stigma by demonstrating that HIV is a manageable chronic condition, which in turn positively influences overall perceptions and reduces the perception of HIV as a death sentence. This emphasizes the need for a holistic approach to HIV/AIDS education that covers not only basic transmission facts but also prevention strategies, treatment advancements, and the lived experiences of PLHIV. Each component of accurate knowledge contributes synergistically to a more informed, empathetic, and less stigmatizing perspective.

DISCUSSION

The study's primary finding—the paradox of high general awareness coexisting with significant, specific misconceptions—is a critical observation that demands careful consideration. This finding aligns with regional studies by Tan et al. (2021) and Velasco (2022), which also suggest that general awareness does not always translate into accurate understanding, confirming that this is not an isolated phenomenon but a systemic challenge in HIV/AIDS education. This paradox underscores that current educational efforts, while successful in broad dissemination, are failing to address the nuances of transmission and the deeply ingrained myths (e.g., mosquito bites, casual contact, sharing food). The persistence of these specific misconceptions, as detailed in Table 2, directly contributes to the moderate levels of stigma observed.

The persistence of specific misconceptions despite high general awareness suggests that public health education operates on a complex battleground where accurate information competes directly with deeply entrenched misinformation. This misinformation is often spread through informal channels and cultural narratives. It is not simply about filling a knowledge void, but actively displacing and discrediting incorrect beliefs. Misconceptions are often more resilient than facts because they might be culturally embedded, reinforced by social narratives, or appeal to intuitive (though incorrect) "common sense." They can also be emotionally charged, tapping into fears of contagion. Simple factual statements in formal education might not be sufficient to dislodge these deeply held beliefs. This means educational strategies must be more proactive and assertive in *debunking* myths rather than just *informing*. They need to anticipate common misconceptions and systematically dismantle them, possibly using techniques from cognitive psychology to address deeply held beliefs and the sources of misinformation. This requires a more dynamic and responsive educational approach.

The moderate levels of stigma recorded (Table 1) are concerning, but the study provides a clear pathway for intervention: the statistically significant negative correlation between awareness and stigma ($r = -0.54$, $p < .001$). This robust statistical relationship, highlighted in Table 3, provides strong empirical evidence that targeted, fact-based education is an effective strategy for reducing discriminatory attitudes. This finding reinforces the fundamental public health principle that fear and prejudice often stem from ignorance or misinformation. By providing accurate knowledge, the rational and emotional basis for stigma is systematically eroded, fostering greater understanding and acceptance.

Despite existing curriculum integration of reproductive health, the study reveals persistent gaps in both cognitive knowledge and affective attitudes. This suggests that current curriculum content or delivery methods may not be sufficiently comprehensive, engaging, or tailored to overcome entrenched misconceptions and foster genuine empathy. The observed differences in understanding across academic programs further underscore this point. The persistence of stigma and gaps in "affective attitudes" despite curriculum integration implies that purely cognitive, fact-based education might be insufficient to address the complex nature of stigma. To effectively tackle the "emotional and cultural roots of stigma", educational interventions need to incorporate experiential learning, empathy-building exercises, and discussions that actively challenge moralistic views. Table 2 showed that 31% of students believe HIV/AIDS is a "punishment for immoral behavior." This is an effective and moral stance, not purely a factual error. Factual information alone may not be enough to change deeply held moral beliefs or overcome emotional barriers like fear and prejudice.

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Therefore, education needs to move beyond didactic lectures and incorporate methods that engage students emotionally and experientially. This could include personal narratives from people living with HIV (with consent and appropriate safeguards), interactive workshops, role-playing scenarios, and critical discussions about values, ethics, and human rights. Such approaches can foster empathy, challenge internalized biases, and address the social and cultural underpinnings of stigma, which cognitive facts alone cannot fully resolve.

CONCLUSION

This comprehensive analysis of the study's findings unequivocally demonstrates that while university students possess a high general awareness of HIV/AIDS, this awareness is critically undermined by the persistence of significant, specific misconceptions. These misconceptions, particularly regarding non-transmission modes, directly fuel the observed moderate levels of stigma. The robust negative correlation between awareness and stigma provides a clear and empirically supported mandate for targeted educational intervention. To effectively address this ongoing public health challenge, academic institutions must move beyond superficial awareness campaigns toward comprehensive, interdisciplinary curriculum integration that actively debunks prevalent myths. Concurrently, empowering peer-led initiatives is crucial to normalize discussions, challenge fear-based narratives, and foster genuine empathy. Ultimately, sustained policy support is essential to ensure these evidence-based strategies lead to a more informed, understanding, and stigma-free university environment, thereby contributing significantly to broader public health goals in the global fight against HIV/AIDS.

RECOMMENDATIONS FOR INSTITUTIONAL ACTION

The findings from this study provide a robust empirical basis for developing and strengthening institutional action plans. The recommendations are refined to be more specific and actionable, leveraging the deeper understandings gained from the detailed analysis.

Strategic Curriculum Integration

It is recommended that evidence-based HIV/AIDS education be integrated systematically across all academic disciplines, moving beyond a sole focus on health-related programs. To achieve this, curriculum modules should be developed and implemented that explicitly address and debunk the common misconceptions identified in Table 2. This includes providing clear, repetitive, and authoritative information on non-transmission through casual contact (42% incorrect), sharing food (38% incorrect), and mosquito bites (47% incorrect). These are not merely knowledge gaps but deeply ingrained "common sense" misinformation that requires direct, systematic, and persistent challenging to be overcome. Furthermore, education must be designed and implemented with a tailored, interdisciplinary and contextualized approach for various academic programs, recognizing the significant differences in understanding across disciplines. For instance, social sciences and humanities programs could integrate discussions on the social determinants of health, the historical and cultural roots of stigma, human rights, and the psychosocial impact of HIV/AIDS. Business and economics programs could analyze the economic impact of HIV/AIDS on individuals, communities, and national development, including issues of healthcare access and productivity. Engineering and technology programs could explore advancements in HIV prevention technologies (e.g., PrEP, microbicides), diagnostic tools, and treatment delivery systems. The observed significant differences in awareness and understanding across academic programs necessitate a tailored, interdisciplinary approach to ensure relevance, deeper internalization of knowledge, and a more uniform level of understanding across the entire student body. Finally, the curriculum must ensure comprehensive scope beyond transmission, covering advancements in HIV treatment, the realities of living with HIV as a manageable chronic condition, and actively dispelling moralistic judgments (31% misconception from Table 2). Cognitive awareness, including knowledge about treatment and the human experience of HIV, is crucial for reducing misconceptions and improving attitudes, while addressing moralistic views is vital for fostering empathy and reducing the social burden of stigma.

Empowering Peer-Led Campaigns

Robust peer-led campaigns should be implemented to normalize discussions, reduce fear-based narratives, and foster empathy among students. This requires strategic recruitment and comprehensive training for peer

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educators. Priority should be given to recruiting peer educators from academic programs that demonstrated a more nuanced understanding (e.g., health-related and education programs). These peer educators should receive comprehensive training that includes not only accurate, up-to-date information but also effective communication skills, empathy-building techniques, and strategies for addressing sensitive topics and challenging misinformation. Leveraging students with existing nuanced understanding can significantly enhance the credibility, accuracy, and overall effectiveness of peer-led initiatives, creating a multiplier effect for knowledge dissemination. Campaigns should also utilize interactive and experiential formats that go beyond traditional lectures, incorporating interactive workshops, facilitated discussions, personal testimonies (with appropriate consent and anonymity safeguards), Q&A sessions, and creative arts (e.g., drama, spoken word, visual arts) to engage students emotionally and intellectually. To effectively address affective attitudes and the deeply rooted emotional and cultural dimensions of stigma, experiential and empathy-building approaches are crucial, as purely factual information alone may not be sufficient to change deeply ingrained beliefs and prejudices. Furthermore, peer-led initiatives should have an explicit focus on destigmatization, aiming to challenge the moralistic view of HIV/AIDS and promote understanding of people living with HIV as individuals deserving of respect, dignity, and support. Campaigns should consistently emphasize that HIV is a medical condition, not a moral failing or a punishment. Directly confronting moralistic misconceptions and fostering a non-judgmental environment is vital for reducing the social and psychological burden of stigma and encouraging open dialogue. Finally, efforts must be made to normalize discussion by creating safe, non-judgmental spaces for open dialogue about HIV/AIDS within student communities, encouraging students to ask questions, share concerns, and challenge misconceptions without fear of judgment or social repercussions. The strong negative correlation between awareness and stigma suggests that open, accurate, and empathetic discussions are key to reducing fear, discrimination, and the silence that often surrounds HIV/AIDS.

Robust Policy Support

Academic institutions must provide sustained policy support for regular HIV/AIDS forums and partnerships with health organizations.

This entails allocating consistent and adequate funding for educational materials, training for peer educators, organizing regular forums and events, and supporting partnerships, thereby ensuring the longevity and impact of initiatives. Formalized partnerships with health authorities should be established and maintained with local and national health organizations (e.g., Department of Health, UNAIDS, NGOs) to ensure access to the latest scientific information, public health guidelines, resources, and expert speakers. This keeps educational content current and relevant. Additionally, institutions should implement a systematic process for regular program evaluation and adaptation of all HIV/AIDS education and intervention programs. This includes collecting data on changes in awareness, misconceptions, and stigma levels to assess effectiveness and allow for adaptive improvements and refinement of strategies over time. Robust and sustained policy support ensures the longevity, consistency, quality, and adaptability of HIV/AIDS education and intervention efforts. It moves beyond one-off initiatives to a sustainable institutional commitment, embedding HIV/AIDS literacy as a core component of student development and well-being.

Future Research Directions

It is recommended that further qualitative studies be conducted to explore the emotional and cultural roots of stigma in youth communities. While this quantitative study effectively identified the prevalence of stigma and its correlation with misconceptions, qualitative research can delve deeper into the underlying reasons *why* these misconceptions persist, the specific cultural narratives and social norms that perpetuate stigma, and the emotional and psychological barriers to empathy and acceptance. This will provide richer, nuanced context and deeper understanding, which is essential for developing even more culturally sensitive, emotionally intelligent, and ultimately more effective interventions tailored to specific youth communities.

A Tiered Action Plan for HIV/AIDS Prevention and Intervention at West Visayas State University

The study revealed a critical public health challenge: while students possess a high level of general HIV/AIDS awareness, this knowledge is critically undermined by a significant prevalence of specific, persistent

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misconceptions and a coexisting moderate level of stigma. The robust negative correlation between accurate knowledge and stigmatizing attitudes provides a clear, evidence-based mandate for targeted educational interventions as a primary mechanism for fostering a more informed and compassionate university community.

This action plan is structured in a tiered, systematic manner to ensure effective and sustainable implementation:

Tier 1 (Short-Term, 0-12 Months): Focuses on immediate, high-impact foundational activities. The primary goal is to directly address the most prevalent misconceptions and initiate the infrastructure for a peer-led education program. These actions are designed for rapid deployment to close the most urgent knowledge gaps.

Tier 2 (Medium-Term, 1-3 Years): Concentrates on building systemic capacity. This phase involves the formal integration of a tailored, interdisciplinary curriculum and the institutionalization of public health partnerships. The objective is to embed HIV/AIDS literacy into the core academic and operational functions of the university, moving beyond a temporary project to a sustainable program.

Tier 3 (Long-Term, 3-5+ Years): Aims for institutional transformation. This phase focuses on codifying the program into permanent policy, implementing a Continuous Quality Improvement (CQI) framework to ensure perpetual relevance and effectiveness, and establishing the university as a leading voice in evidence-based public health education and research.

By following this systematic, phased approach, West Visayas State University can transition from a state of general awareness to one of accurate, nuanced understanding, thereby significantly reducing stigma and fostering a safer, more empathetic environment for all students.

Introduction: The Public Health Imperative on Campus

The global and national public health landscape continues to face a formidable challenge from the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), with a notable and disproportionate impact on youth. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has consistently highlighted the vulnerability of this demographic, and in the Philippines, the Department of Health (DOH) has reported a significant increase in HIV incidence among young people, underscoring the urgency of comprehensive educational efforts.

The study conducted at West Visayas State University provides a crucial empirical foundation for these efforts by meticulously examining the perceptions of 300 university students. While the study's findings indicate a generally high level of awareness regarding HIV/AIDS, with a mean score of 3.84, this metric alone paints an incomplete picture. A deeper analysis reveals a significant paradox: despite this high general awareness, a moderate level of specific, critical misconceptions persists (mean score of 2.35, reverse scored), and a moderate level of HIV/AIDS-related stigma remains prevalent (mean score of 2.91).

The co-existence of high general awareness and a significant presence of false beliefs is a pivotal observation. It suggests that merely increasing the quantity of information does not automatically translate into a quality of understanding or the eradication of deeply ingrained false beliefs. General awareness campaigns may be effective at broad dissemination but often fail to address specific, resilient inaccuracies. Misconceptions, frequently rooted in cultural narratives, fear, or a flawed intuitive sense of logic, prove to be more resistant than general facts. This implies that current educational approaches may be insufficient in tackling the complex nature of misinformation and its powerful emotional drivers.

A critical finding that provides a clear pathway for intervention is the statistically significant moderate negative correlation ($r=-0.54$, $p<.001$) between awareness and stigma. This robust statistical relationship is not a simple association; it provides strong empirical evidence that increasing accurate knowledge is a direct and effective mechanism for reducing stigmatizing attitudes and behaviors. This finding elevates education from a mere information-sharing exercise to a powerful tool for social and cultural transformation. It demonstrates that the fear and prejudice that fuel stigma are often a direct product of ignorance and misinformation. By systematically replacing false beliefs with an accurate, nuanced understanding, the rational and emotional basis

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for prejudice is fundamentally eroded. This positions comprehensive, fact-based education as a cornerstone of any effective institutional anti-stigma strategy.

To provide a clear visualization of the study's core findings and their interconnections, a summary of the key metrics is presented in Table 1.

Table 1: Key Study Findings

Variable	Mean Score	Std. Deviation	Interpretation
HIV/AIDS Awareness	3.84	0.62	High Awareness
Misconceptions	2.35	0.71	Moderate Misconception
HIV/AIDS-Related Stigma	2.91	0.83	Moderate Stigma

Correlation: Awareness vs. Stigma: $r=-0.54$, $p<.001$ (Moderate Negative Correlation)

Tier 1: Foundational Initiatives (Short-Term, 0-12 Months)

The first phase of the action plan focuses on immediate, high-impact interventions designed to directly address the most critical knowledge gaps and establish a solid base for future programming. The objective is to act swiftly to close the most alarming deficits identified in the study while laying the groundwork for a more sustainable, systemic approach.

Action 1.1: Targeted Misconception Debunking Campaign

The study's detailed breakdown of specific misconceptions provides a clear mandate for a highly targeted communication strategy. The data revealed that nearly half of the students (47%) incorrectly believe that mosquito bites can transmit HIV, 42% believe it can be transmitted through casual contact, and 38% believe it is spread by sharing food. These figures represent more than simple knowledge gaps; they are deeply ingrained "common sense" beliefs or urban myths that directly fuel fear and stigmatizing behaviors. Furthermore, the finding that 31% of students view HIV/AIDS as a "punishment for immoral behavior" indicates a powerful moralistic dimension to the challenge, which cannot be solved by simple factual information alone.

To address this, a multi-channel campaign titled "HIV: The Truth. Not the Myth." will be launched. The campaign will utilize clear, concise, and repetitive messaging across physical and digital platforms. This includes the use of visually engaging infographics and posters in high-traffic campus areas like the student union, cafeterias, and dormitories. Concurrently, a dedicated social media campaign, such as a "Myth-Buster Monday" series, will be developed to reach a wider student audience. Crucially, the content will explicitly and authoritatively debunk the specific falsehoods identified in the study, such as "Mosquitoes DO NOT transmit HIV." The campaign will also proactively challenge the moralistic view, reframing HIV as a medical condition rather than a moral failing. This requires a communication strategy that not only provides facts but also fosters empathy and respect for the dignity of people living with HIV, acknowledging that the underlying issue is often a deeply held, affective belief, not just a factual error.

Action 1.2: Strategic Recruitment and Foundational Training of Peer Educators

The study's finding that students from health-related and education programs demonstrate a "more nuanced understanding" of HIV/AIDS is a strategic asset for the university. Peer education has been proven to be highly effective among adolescents and young adults, as their friends are often their main source of information and influence. By leveraging this internal capacity, the university can create a highly credible and effective peer-led program.

The first step is to prioritize the recruitment of peer educators from the academic programs identified as having superior understanding, thereby ensuring a strong knowledge base from the outset. This creates a "train-the-

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trainer" model where a select group of knowledgeable students can be empowered to become a decentralized network for knowledge dissemination. This foundational training must be comprehensive, including not only accurate, up-to-date information on HIV/AIDS but also crucial soft skills. The curriculum will include effective communication skills, empathy-building techniques, and strategies for addressing sensitive topics and challenging misinformation. This approach ensures that the peer educators are not just repositories of facts but are also skilled facilitators of dialogue, capable of building trust and creating safe, non-judgmental spaces for discussion, a key component for reducing fear and discrimination.

Action 1.3: Institutional Endorsement and Policy Review

To provide the program with the necessary authority, visibility, and longevity, a formal commitment from university leadership is paramount. This is a foundational step that shifts the initiative from a temporary project to a strategic institutional priority. The university administration will issue a public statement acknowledging the study's findings and endorsing the tiered action plan. Following this, a dedicated, university-wide committee will be convened. The committee's primary task will be to review existing student policies and codes of conduct to identify opportunities for integrating new, anti-stigma language and policies. This proactive step signals a top-down commitment to creating an inclusive and stigma-free campus environment and provides a necessary policy framework for the subsequent phases of the plan.

Tier 2: Systemic Integration and Capacity Building (Medium-Term, 1-3 Years)

Building on the foundation laid in Tier 1, this phase is dedicated to embedding the initiatives into the core academic and operational fabric of the university. The goal is to ensure the program's sustainability and broad, systemic impact by moving from a reactive response to a proactive, integrated system.

Action 2.1: Interdisciplinary Curriculum Integration

The study's finding of significant differences in understanding across academic programs, with health-related and education students demonstrating a more "nuanced understanding," necessitates a move away from a uniform, one-size-fits-all approach to education. A single, mandatory health module is insufficient to overcome discipline-specific knowledge gaps or a lack of contextual relevance. A truly effective strategy requires integrating tailored HIV/AIDS education across all disciplines.

This can be achieved through the collaborative development of discipline-specific curriculum modules. For instance, a sociology or humanities program could integrate discussions on the social determinants of health and the cultural roots of stigma, using a human rights-based framework. A business or economics program could analyze the economic impact of the epidemic on individuals, healthcare systems, and national productivity. An engineering or technology program could explore advancements in diagnostics, treatment adherence technologies, and the development of new therapeutics like long-acting injectables. This approach, modeled on successful interdisciplinary programs at other institutions , ensures that all students, regardless of their major, receive information that is relevant and meaningful to their field. The curriculum will utilize a flexible model, such as project-based or problem-based learning, to make the learning experience cohesive and engaging.

Table 2: Misconception & Action Matrix

Misconception	% of Students Answering Incorrectly	Tier 1 Intervention	Tier 2 Intervention
Mosquito bites can spread HIV	47%	Targeted Misconception Debunking Campaign	Interdisciplinary Curriculum Integration (e.g., Biology/Public Health modules on viral transmission)
HIV can be transmitted through	42%	Targeted Misconception	Formal Peer-Led Campaigns (e.g., interactive workshops on safe

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casual contact		Debunking Campaign	interaction)
Sharing food with an HIV-positive person causes HIV	38%	Targeted Misconception Debunking Campaign	Formal Peer-Led Campaigns (e.g., experiential sessions that normalize interaction)
HIV/AIDS is a punishment for immoral behavior	31%	Targeted Misconception Debunking Campaign	Interdisciplinary Curriculum Integration (e.g., Ethics/Sociology modules on human rights and social stigma)

Action 2.2: Launch of a Formal, Comprehensive Peer Education Program

Building on the foundational work of Tier 1, this phase formalizes the peer education initiative into a fully-fledged, institutionalized body. A dedicated office under the Division of Student Affairs will be established with a clear charter and a secure funding model, possibly through a dedicated student fee or wellness fund.

The program's curriculum will move beyond basic facts to deliver interactive and experiential learning formats that are crucial for addressing the "affective and cultural roots of stigma" that factual information alone cannot resolve.[1] These formats will include interactive workshops, facilitated discussions, personal testimonies from people living with HIV (with appropriate consent and safeguards), Q&A sessions, and creative arts like drama and spoken word. The explicit focus of all activities will be destigmatization, aiming to actively challenge the moralistic view of HIV/AIDS and promote the understanding that people living with HIV are individuals deserving of respect and dignity. By creating safe, non-judgmental spaces for dialogue, the program will encourage students to openly ask questions and challenge misconceptions without fear, thereby reducing the fear and discrimination that often result from silence.

Action 2.3: Formalization of Public Health Partnerships

A sustained, high-quality public health education program requires access to the latest scientific information, public health guidelines, and expert resources. To ensure this, the university will establish and formalize a partnership with the local Department of Health (DOH)such as Municipal of City Health Office and other relevant health organizations, such as UNAIDS/USAIDS. Local organizations like AC Health, including KonsultaMD (telehealth), Generika Drugstore, and Healthway Medical Network.

This partnership can be structured as an Academic Health Department (AHD) model, where an academic institution formally affiliates with a health department to enhance public health education, research, and service. The relationship will be formalized through a Memorandum of Understanding (MOU), an agreement that clarifies the roles, responsibilities, and financial commitments of each party. This approach, demonstrated by the successful DOH-UP Manila partnership, ensures access to the latest data and public health guidelines, provides a clear legal and operational framework for collaboration, and facilitates access to resources and expert speakers from the public health sector.

Tier 3: Institutional Transformation and Policy Reinforcement (Long-Term, 3-5+ Years)

The final tier of the action plan is about achieving permanent institutional change. It aims to codify the progress made into lasting university policy, build a culture of continuous improvement, and position the institution as a leader in public health education and advocacy.

Action 3.1: Codification of HIV/AIDS Policy

A program's long-term viability is vulnerable to changes in institutional leadership or funding unless it is embedded in permanent policy. To ensure the longevity and sustainability of the HIV/AIDS prevention and intervention efforts, the university will formally integrate its commitment into official university documents. This includes integrating HIV/AIDS literacy as a core component of student development in the university's official student handbook. A key policy reform will be the establishment of a non-discrimination clause that

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explicitly protects students and faculty with HIV/AIDS, reinforcing a human rights-based approach to public health. The roles, responsibilities, and dedicated funding for the peer education program and the public health partnerships will also be formalized in official university documents. This makes the commitment a part of the institution's enduring operational and ethical framework.

Action 3.2: Implementation of a Continuous Quality Improvement (CQI) Framework

Success is a continuous process of learning and adaptation, not a one-time event. The study's recommendation for "regular program evaluation" can be elevated to a robust Continuous Quality Improvement (CQI) framework. This framework moves beyond simple program assessment by systematically collecting data to inform continuous, data-driven refinement. A standing CQI committee, comprising representatives from administration, faculty, and students, will adopt a cyclical process of planning, doing, studying, and acting (PDSA cycle).

The committee will systematically collect data on key metrics, including changes in awareness, misconceptions, and stigma levels. his data will be used not for judgment, but for learning and improvement. The findings will be used to identify areas for program modification, refine educational materials, and adapt strategies over time. This institutionalizes a fundamental mindset shift: it ensures that the university can proactively respond to new public health challenges and evolving student needs without having to restart the planning process, making the program dynamic and perpetually relevant.

Action 3.3: Research and Dissemination Leadership

As a center of higher learning and as a research university, West Visayas State University is uniquely positioned to not only implement evidence-based interventions but also to contribute to the global body of knowledge. The study itself recommends "further qualitative studies to explore the emotional and cultural roots of stigma". The university will fund and support follow-up research to provide the nuanced context required for truly effective, culturally sensitive interventions. The institution will document the entire process—from initial study findings to the implementation and evaluation of the tiered action plan—and publish the results in academic journals and public health forums. This will not only build the university's reputation but also provide a valuable, proven model for other academic institutions in the Philippines and beyond.

Conclusion: The Path to a Sustainable Public Health Environment

The tiered action plan presented herein provides a comprehensive, evidence-based blueprint for West Visayas State University to address the complex public health challenge of HIV/AIDS. By moving beyond superficial awareness campaigns and toward a model of targeted, systemic, and sustainable intervention, the university can effectively dismantle the paradox of knowledge without understanding. The plan's phased approach, which progresses from immediate myth-debunking to interdisciplinary curriculum integration and, finally, to a policy-reinforced culture of continuous improvement, ensures that the institution's efforts are impactful, resilient, and enduring. The strategic alignment of education with attitude change, leveraging the power of peer influence and formal partnerships, will not only reduce stigma on campus but also position the university as a leading institution committed to fostering a more informed, compassionate, and healthy society.

Summary Table: The Tiered Action Plan at a Glance

Table 3: The Institutional Action Plan

Tier	**Timeline**	**Core Objective**	**Key Action Items**		
Tier 1: Foundational Initiatives	0-12 Months	To address critical knowledge gaps and establish a solid base for future	1.1 Targeted Misconception Debunking	1.2 Strategic Recruitment & Foundational Training of Peer	1.3 Institutional Endorsement and Policy

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		programming.	Campaign	Educators	Review
Tier 2: Systemic Integration & Capacity Building	1-3 Years	To embed initiatives into the core academic and operational fabric of the university.	2.1 Interdisciplinary Curriculum Integration	2.2 Launch of a Formal, Comprehensive Peer Education Program	2.3 Formalization of Public Health Partnerships
Tier 3: Institutional Transformation & Policy Reinforcement	3-5+ Years	To codify progress into permanent policy and build a culture of continuous improvement.	3.1 Codification of HIV/AIDS Policy	3.2 Implementation of a Continuous Quality Improvement (CQI) Framework	3.3 Research and Dissemination Leadership

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