SEXUAL HEALTH AWARENESS OF LGBTQIA+ COMMUNITY IN A PRIVATE INSTITUTION

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ABSTRACT

Sexual health is a fundamental component of overall well-being. This study aimed to investigate the level of sexual health awareness among the LGBTQIA+ community through comparative methods of the different variables, such as age, gender orientation, marital status of parents, family orientation, and religion. A descriptive-comparative research design was utilized to determine the sexual health awareness of LGBTQIA+ individuals within a private institution, with emphasis on how education influences informed decision-making and effective sexual health navigation. This study investigated the sexual health awareness of LGBTQIA+ individuals within a private institution, with emphasis on how education influences informed decision-making and effective sexual health navigation. Data were collected from 75 participants using a structured questionnaire to assess knowledge, attitudes, and practices related to sexual health awareness. The analysis employed frequency counts, mean scores, Kruskal-Wallis H tests, and post hoc pairwise comparisons to identify significant differences among sociodemographic groups. Findings revealed that 56 (74.7%) of the participants demonstrated high levels of sexual health knowledge. In comparison, 55 (73.3%) revealed average levels of sexual health attitude, and 46 (61.3%) showed average levels of sexual health practices. Significant differences were observed in sexual health awareness when grouped by age and sexual orientation, specifically, total awareness scores. In contrast, no significant variation was observed across groups defined by marital status, family structure, or religion. These results support the recommendation for strengthening inclusive, responsive, and evidence-based sexual health education programs within academic settings. Special attention must be given to addressing gaps in knowledge and shaping attitudes, particularly for LGBTQIA+ youth.

Keywords: Age, sexual orientation, sexual knowledge, sexual attitude practices, family structure, and religion

INTRODUCTION

Sexual health is an important element of overall health. The World Health Organization defines sexual health as "a condition of physical, emotional, mental, and social well-being in regard to sexuality; it is not simply the absence of disease, malfunction, or infirmity" (WHO, 2002). Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled. Being in good sexual health entails being aware, cautious, and respectful to both oneself and other people. Despite its importance, it is still a stigmatized and sometimes disregarded aspect of health, which can result in negative outcomes such as sexually transmitted infections (STIs), unwanted pregnancies, and emotional distress (Fenton et al., 2001). Addressing sexual health holistically entails education, accessible healthcare services, and legislation that supports rights-based approaches to sexuality. Many programs still focus mainly on heterosexual relationships, leaving out important information for LGBTQIA+ individuals. This lack of inclusive education and discussion can lead to misinformation or risky behaviors. Furthermore, there is a lack of studies that explore the unique sexual health needs and experiences of the LGBTQIA+ community, making it harder to create effective and inclusive health programs.

According to Shah (2023), sexual health awareness has impacted the LGBTQIA+ community by emphasizing the need for access to accurate information and resources to make informed decisions about their sexual health. However, due to societal stigma, discrimination, and lack of education and resources, the LGBTQIA+ community has often faced unique challenges concerning sexual health. Also, according to and Siddayao (2023), due to the susceptibility of Filipino adolescents to various sexual and reproductive health (SRH) challenges, the implementation of comprehensive sexual education (CSE), as mandated by the Responsible Parenthood and Reproductive Act of 2012, equips Filipino students with the necessary information and empowerment to make informed and proactive choices regarding their sexuality, despite the articulation of gender equality and equity as fundamental principles within this policy framework, systemic prejudice and discrimination against the LGBTQIA+ community continue to be widespread and entrenched within the sociocultural landscape of the Philippines. The Human Rights Campaign (HRC) emphasized that sexual health education for LGBTQIA+ individuals had been essential because it "helped youth understand gender identity and sexual orientation with age-appropriate and medically accurate information; incorporated positive examples of LGBTQIA+ individuals, romantic relationships and families; emphasized the need for protection during sex for people of all identities; and dispelled common myths and stereotypes about behavior and identity" (HRC, 2021).

This study can benefit the LGBTQIA+ community, peers, institutions, and health workers, leading to better decisions, safer practices, and the creation of helpful learning materials. It also encourages a more open and accepting environment where they feel safe asking questions and expressing concerns. Educating peers about LGBTQIA+ sexual health can reduce discrimination, promote respect, and encourage open conversations. It can also inspire peer-led activities that support inclusivity. The institution can show its support for diversity and student health by using the results to improve sexual health education. This helps clear up confusion, boost knowledge, and make the campus a safer, more welcoming place. The study can help health workers better understand the specific sexual health needs and concerns of LGBTQIA+ students. Thus, the purpose of this study is to determine how aware LGBTQIA+ students are of sexual health. It looks at their background, such as age, sexual orientation, family structure, and religion, and how these relate to their knowledge and attitude about sexual health. The study also aims to determine whether awareness differs by background. At the end of the study, the goal is to create a helpful, inclusive program that improves sexual health awareness among LGBTQIA+ students.

Statement of the problem

This study aimed to determine the sexual health awareness of LGBTQIA+ students during the 2024-2025 school year. Specifically, it sought to answer the following:

1. What was the student's profile in terms of:
   1.1 Age
   1.2 Sexual orientation
   1.3 Marital status of parents
   1.4 Family structure
   1.5 Religion
2. What was the student's level of sexual health awareness in terms of:
   2.1 Sexual knowledge
   2.2 Attitude towards sexual health
3. Was there a significant difference in sexual health awareness levels across student groups based on their profile variables?
4. What program plan on sexual health awareness could be developed based on the results?

METHODOLOGY

The study employed a descriptive-comparative research design, which was used to understand existing conditions within a group or population and to compare the level of sexual health awareness of LGBTQIA+ people and examine variables such as age, gender orientation, marital status of parents, family orientation, and religion. The study was conducted in the province of Bayombong, Nueva Vizcaya, at Saint Mary's University. The respondents were members of SMU BahagHari, the LGBTQIA+ student organization of Saint Mary's University, which aimed to support, empower, and uphold the rights of its members. Participants came from various departments, including the School of Health and Natural Sciences (SHANS), School of Engineering, Architecture, Information, and Technology (SEAIT), School of Teachers, Education, and Humanities (STEH), and School of Accountancy and Business (SAB), to ensure a diverse representation of backgrounds. Based on the list obtained from the BahagHari, there was a total of 75 LGBTQIA+ members. No sampling technique was used, as the entire LGBTQIA+ population was used.

The questionnaires were adapted, and a few items were revised to align with the researcher's study. The first part of the questionnaire collected demographic data, including respondents' age, sexual orientation, parents' marital status, family structure, and religion. The second part assessed the level of sexual health awareness. It consisted of 36 questions adapted from the study by Kashyap et al. (2022), with several items categorized by the researchers to fit the study's context better. The scores obtained were interpreted as follows: Low Level of Sexual Health Awareness (20-46), Average Level of Sexual Health Awareness (47-73), and High Level of Sexual Health Awareness (74-100). The researchers explained the study's purpose, procedures, and potential risks and benefits. Once consent was obtained, data collection was scheduled according to the participants' availability. Each session lasted less than 30 minutes. The researchers' data were compiled, sorted, organized, tabulated, and subjected to statistical analysis to answer the following question posed in the study. To effectively interpret the data, the researchers utilized tools for statistical treatment, such as

RESULTS AND DISCUSSION

Section 1. Student's profile

The demographic profile of the participants consisted of 75 individuals. Most participants (53.3%) are aged 20–21 years. In terms of sexual orientation, most identify as homosexual (42.7%). Regarding their parents' marital status, the highest proportion (52.0%) comes from married households. Half of the participants (50.7%) belong to nuclear families, and the dominant religious affiliation is Roman Catholic (69.3%).

Section 2. Student's level of sexual health awareness in terms of:

2.1 Sexual knowledge

The majority (n = 56, 74.7%) were found to have a high level of sexual knowledge, indicating a strong understanding of key topics such as consent, contraception, and STIs. Meanwhile, 24% (n = 18) of respondents were classified as having an average level of knowledge, suggesting a partial understanding with room for improvement. Only one respondent (1.3%) fell into the low-knowledge category, representing a minimal proportion of the population. This distribution suggests that the respondent group is largely well-informed on sexual health matters. According to Oducado (2023), students who are regularly exposed to inclusive and structured discussions on sexual health tend to score higher on knowledge-based assessments, particularly when LGBTQIA+ perspectives are integrated into their learning. The

presence of 24% in the average range is consistent with the findings by Dela Torre et al. (2024), who noted that while most Filipino college students possess baseline awareness, practical understanding of prevention and anatomy is often incomplete. The lone respondent, although statistically negligible, reflects the broader national concern that some youth continue to have limited access to reliable sexual health education (PSA, 2020). This highlights the value of sustaining comprehensive sexuality education in higher education environments, especially for marginalized communities, ensuring that both cognitive understanding and critical thinking are consistently developed across the entire student body.

Table 1
Sexual Knowledge of Participants

Statements	Mean	SD	Qualitative Description
1. At the beginning of my teenage years, I was given appropriate sex education.	3.15	1.440	Neither Agree nor Disagree
2. I am fully aware of the various risks of teenage pregnancy.	4.61	.613	Strongly agree
3. I believe that teenage pregnancy results from a lack of sex education.	4.13	1.095	Agree
4. I understand the concept of consent in sexual relationships.	4.68	.596	Strongly agree
5. I feel masturbation is an act of shame	2.45	1.222	Neither agree nor Disagree.
6. I know all the different methods of contraception	3.84	.945	Agree
7. I am comfortable speaking about sexual health with friends of the opposite sex.	3.75	1.164	Agree
8. Sex is a basic human physical need like every other basic human need of hunger, thirst, safety, and security, etc.	4.19	1.036	Agree
9. I know about the different types of sexually transmitted diseases. (STDs)	4.36	.765	Agree
10. Sex education is unethical and unnecessary.	1.67	1.082	Disagree
11. Parents and teachers are the only ones responsible for teaching kids about sex education	2.20	1.230	Disagree
12. A man and a woman should both share the responsibility of birth control.	4.59	.773	Strongly agree
13. I believe the sexual enhancement pills that are often shown in advertisements work.	3.24	1.076	Neither agree nor disagree.
14. I believe media (movies/videos/songs) that degrade sexual intercourse are good.	2.11	.967	Disagree
15. I believe sex can be solely defined in terms of sexual intercourse.	3.56	1.596	Agree
16. Sex education is essential for preventing sexually transmitted diseases in youth	3.39	1.532	Neither agree nor disagree.
17. I believe sex education can escalate engaging in sexual activities.	2.64	1.467	Neither agree nor disagree.
18. I am aware of the different sexual identity orientations	4.41	.887	Agree
19. I am aware of the LGBTQIA+ community.	4.68	.681	Strongly agree
20. The ultimate goal of any sexual activity/engagement with a partner must be an orgasm.	2.67	1.266	Neither agree nor disagree.
21. I believe it is inappropriate to engage in sex during adolescence.	2.77	1.247	Neither agree nor disagree.
22. I am familiar with the various biological terminology for private parts	4.36	.799	Agree

Legend:1-1.49 strongly disagree; 1.50-2.49 disagree; 2.50-3.49 neither agree nor disagree; 3.50-4.49 agree; 4.50-5 strongly agree

The highest-rated statements, all interpreted as *Strongly Agree*, include "I understand the concept of consent in sexual relationships" (M = 4.68), "I am aware of the LGBTQIA+ community" (M = 4.68), and "A man and a woman both should share the responsibility of birth

control" (M = 4.59). High levels of agreement were also noted in awareness of the risks of teenage pregnancy (Item 2, M = 4.61), types of sexually transmitted diseases (Item 9, M = 4.36), and the use of proper biological terminology (Item 22, M = 4.36). In contrast, the statement "Sex education is unethical and unnecessary" has the lowest mean (M = 1.67), indicating *Strong Disagreement*. Similar disagreement was observed in the statement, "I believe media (movies/videos/songs) that degrade sexual intercourse are good" (M = 2.11), suggesting critical awareness toward media representation. Several items received neutral scores, such as "I feel masturbation is an act of shame" (M = 2.45) and "I believe sex education can escalate engaging in sexual activities" (M = 2.64), indicating ongoing tension or uncertainty about moral and cultural dimensions of sexual health.

These results demonstrate a well-informed respondent group with high cognitive literacy and critical views toward outdated or stigmatizing beliefs. The consistently high agreement on consent, LGBTQIA+ awareness, reproductive responsibility, and STI knowledge reflects a broad understanding of key sexual health concepts, consistent with research by Martin et al. (2021) and Oducado (2023), who found that exposure to inclusive sexual education improves knowledge retention and values-based understanding. The strong rejection of statements that frame sex education as unethical or media depictions as positive mirrors global trends in youth sexual literacy, as discussed by Herbenick et al. (2023). The implications of the findings regarding the sexual health knowledge and attitudes of LGBTQIA+ students suggest that most of them are well-informed and open-minded when it comes to sexual health. They understand the importance of consent, are aware of the LGBTQIA+ community, and are knowledgeable about preventing STIs and taking responsibility for reproductive health. This suggests that they have been exposed to good-quality sexual education. However, there are still some topics—like masturbation and how the media affects young people—where opinions are more mixed. This means that, while their knowledge is strong, cultural beliefs may still affect how they accept or discuss certain issues.

2.2 Attitude towards sexual health

Table 2
Descriptive Statistics on Attitude Towards Sexual Health

Statements	Mean	SD	Qualitative Description
23. I feel that I need to use a different gender on social media than what I generally identify myself with.	2.32	1.254	Disagree
24. Appropriate communication with my partner can improve our sexual relationship.	4.45	.793	Agree
25. I feel comfortable addressing sexual concerns with my parents	2.81	1.513	Neither agree nor disagree.
26. I believe that in a sexual relationship, both partners should be equally concerned with each other's pleasure as they are with their own.	4.43	.774	Agree
27. I believe sex education and talking about sex openly should be normalized	4.45	.920	Agree
28. I understand that the inability to release the built-up sexual energies may lead to sexual frustration, which in turn can affect mental health	3.77	1.134	Agree
29. I am comfortable with the sex assigned to me at birth and know the difference between sex and gender.	4.24	.998	Agree
30. I accept follow/friend requests from strangers who post explicit photos of themselves.	2.20	1.395	Disagree

31. I believe that actors in pornographic films always enjoy the act of sex.	2.45	1.119	Disagree
32. I think pleasure is not equivalent to orgasm, but it's about the entire journey of sexual experience.	3.96	1.058	Agree
33. Learning about sexual education may lead to more sexual assaults.	1.93	1.166	Disagree
34. I believe sexual intercourse should only be done after marriage	2.80	1.395	Neither agree nor disagree.
35. Society looks down on talking about sexual education	3.95	.928	Agree

Legend:1-1.49 strongly disagree; 1.50-2.49 disagree; 2.50-3.49 neither agree nor disagree; 3.50-4.49 agree; 4.50-5 strongly agree

The high level of agreement with statements on communication, equality in relationships, and emotional awareness reflects a progressive sexual health attitude among the respondents. These results indicate that students value mutual respect and consent in intimate relationships, which are key components of a healthy sexual mindset. Roels et al. (2022) emphasize that open sexual communication not only improves relationship satisfaction but also reduces the likelihood of coercion or dissatisfaction. Respondents also demonstrated strong support for the normalization of sex education, rejecting the notion that such discussions are taboo. This supports the findings by Martin et al. (2021), who argue that inclusive sex education fosters emotional maturity and dismantles shame-based narratives in youth populations. The ability to contextualize pleasure beyond orgasm also reflects a mature understanding of intimacy, suggesting that students are developing perspectives that go beyond biological function toward holistic well-being.

Section 3. Significant difference in the level of sexual health awareness when students are grouped according to their profile variables

3.1. Analysis of Sexual Health Awareness by age group

The mean rank was highest among students aged 20–21 years (M = 41.06). Still, the difference was not sufficient to suggest that age independently influences knowledge levels. Similarly, attitudes toward sexual health did not significantly differ by age (χ^2 = 1.122, *p* = .331). This suggests that students' perspectives and values regarding sexual topics were comparable across the age groups 18–19, 20–21, and 22–23 years. Overall, sexual health awareness also demonstrated a significant difference across age groups (χ^2 = 9.164, *p* = .010).

These results underscore that while cognitive understanding and attitudes may develop early or remain relatively stable, behavioral consistency and total awareness improve as students gain more experience, independence, and access to health services. Rasberry et al. (2018) explain that behavioral sexual health often matures over time as students navigate peer relationships, develop communication skills, and confront real-life scenarios that require them to apply protective strategies. These findings align with Oducado (2023), who noted that older LGBTQIA+ students in inclusive academic settings tend to have greater overall awareness, driven by both educational exposure and life experience. Supporting literature also highlights the role of age in promoting not just knowledge but behavioral integration. Bourne et al. (2018) found that older LGBTQIA+ individuals are more likely to understand and engage in protective sexual practices due to repeated exposure to health education and social learning opportunities.

Table 3.2

Analysis of Sexual Health Awareness by Sexual Orientation

	Sexual orientation	n	Mean Rank/Mean (SD)[a]	Chi-Square /F[b]	df	Asymp. Sig.
Knowledge	Homosexual	32	42.61	2.577	2	.276
	Bisexual	30	33.97			
	Gay/Asexual/Heterosexual	13	35.96			
	Total	75				
Attitude	Homosexual	32	71.29 (7.058)[a]	3.952[b]	2	.024*
	Bisexual	30	66.52 (7.658)[a]			
	Gay/Asexual/Heterosexual	13	67.14 (4.983)[a]			
	Total	75	68.67 (7.289)[a]			
Sexual Awareness	Homosexual	32	47.45	10.501	2	.005**
	Bisexual	30	31.02			
	Gay/Asexual/Heterosexual	13	30.85			
	Total	75				

**significant at 0.01 *significant at 0.05

No statistically significant difference was found in the knowledge domain (χ^2 = 2.577, p = .276), indicating that factual understanding of sexual health was relatively consistent across groups. This suggests that access to core information may be widespread or not strongly shaped by the identity group in this sample. In contrast, a statistically significant difference was found in the domain of sexual health attitudes (χ^2 = 3.952, p = .024). Participants identifying as homosexual had the highest mean rank (M = 71.29), followed by those in the gay/asexual/heterosexual group (M = 67.14), and lastly, the bisexual group (M = 66.52). These differences, while modest, suggest that homosexual respondents may hold more progressive or affirming attitudes, possibly influenced by higher community visibility or stronger participation in sexual health discourse. All groups, however, generally showed positive outlooks on sexuality.

Statistically significant differences were also found in overall sexual health awareness (χ^2 = 10.501, p = .005). Homosexual respondents had the highest awareness score (M = 47.45), followed by bisexual (M = 31.02) and gay/asexual/heterosexual (M = 30.85) groups. This indicates that the homosexual group not only holds strong knowledge and attitudes but is also able to integrate these into consistent behaviors. The lower awareness among bisexual and other identity groups may be linked to less targeted health communication or reduced inclusion in outreach programs. UNESCO (2021) notes that sexual health education often lacks specificity in addressing the needs of less visible LGBTQIA+ subgroups, which may contribute to disparities in outcomes.

In summary, while sexual health knowledge appears stable across orientations, differences in attitudes, behaviors, and total awareness suggest that sexual orientation influences how individuals internalize and apply that knowledge.

3.3 Analysis of Sexual Health Awareness by Marital Status of Parents

Table 4.

	Marital Status of Parents	n	Mean Rank/Mean (SD)[a]	Chi-Square /F[b]	df	Asymp. Sig.
Knowledge	Single	26	44.44	3.557	2	.169
	Married	39	34.15			
	Separated/Widowed	10	36.25			
	Total	75				
Attitude	Single	26	34.44	1.424	2	.491
	Married	39	38.95			
	Separated/Widowed	10	43.55			

		n	Mean Rank	Chi-Square	df	Asymp. Sig.
	Total	75				
Sexual Awareness	Single	26	38.69	.043	2	.979
	Married	39	37.72			
	Separated/Widowed	10	37.30			
	Total	75				

**significant at 0.01 *significant at 0.05

No significant difference was observed in overall sexual health awareness scores. Mean ranks were closely aligned across groups, with single-parent students at M = 38.69, married at M = 37.72, and separated/widowed at M = 37.30. The resulting *p*-value of .979 confirms that the differences are negligible. It shows that the marital status of students' parents does not appear to significantly influence their sexual health knowledge, attitudes, or overall awareness. These findings suggest that students are likely receiving sexual health information and forming values through sources independent of their family structure. As Rasberry et al. (2018) and Oducado (2023) argue, formal education and peer-led discourse may be stronger predictors of awareness than family background, especially when school-based programs are inclusive and consistent across diverse student populations.

3.4 Analysis of Sexual Health Awareness by Family Structure

Table 5.

	Family Structure	n	Mean Rank/Mean (SD)[a]	Chi-Square /F[b]	df	Asymp. Sig.
Knowledge	Nuclear Family	38	36.87	.229	2	.892
	Extended Family	23	39.57			
	Single Parent	14	38.50			
	Total	75				
Attitude	Nuclear Family	38	69.36 (5.911)[A]	2.005[b]	2	.142
	Extended Family	23	69.63 (8.152)[A]			
	Single Parent	14	65.20 (8.637)[A]			
	Total	75	68.67 (7.289)[A]			
Sexual Awareness	Nuclear Family	38	38.51	.603	2	.740
	Extended Family	23	39.57			
	Single Parent	14	34.04			
	Total	75				

**significant at 0.01 *significant at 0.05

The overall sexual health awareness scores were also statistically non-significant (p = .740), with scores ranging narrowly across groups: extended (M = 39.57), nuclear (M = 38.51), and single-parent (M = 34.04). These results indicate that family structure does not play a significant role in shaping students' sexual health knowledge, attitudes, or total awareness. One possible explanation is that students are increasingly influenced by external sources of education, such as school programs, online platforms, and peer interactions. Rasberry et al. (2018) emphasize that school-based sexual health education, particularly when inclusive and comprehensive, can mitigate disparities that might otherwise be caused by family background. Likewise, Oducado (2023) found that Filipino students from diverse family situations benefit equally when sexual health instruction is standardized and reinforced through formal education.

Table 6

Analysis of Sexual Health Awareness by Religion

	Religion	n	Mean Rank/Mean (SD)[a]	Chi-Square /F[b]	df	Asymp. Sig.
Knowledge	Roman Catholic	52	78.99 (7.478)[a]	1.991[b]	3	.123
	Methodist	8	74.43 (8.926)[a]			
	INC	7	72.47 (16.012)[a]			
	Others	8	81.25 (7.558)[a]			

	Total	75	78.13 (8.852)[a]			
Attitude	Roman Catholic	52	69.42 (6.043)[a]	2.818[b]	3	.045*
	Methodist	8	63.39 (7.282)[a]			
	INC	7	65.31(11.714)[a]			
	Others	8	71.96 (8.079)[a]			
	Total	75	68.67 (7.289)[a]			
Sexual Awareness						
	Roman Catholic	52	39.98			
	Methodist	8	25.19			
	INC	7	27.86			
	Others	8	46.81			
	Total	75				

In the knowledge domain, Roman Catholic respondents had the highest mean rank (M = 78.99), followed by others (M = 81.25), Methodists (M = 74.43), and INC (M = 72.47). Despite these variations, the chi-square test value of 1.991 and *p*-value of .123 indicate that the differences were not statistically significant. This suggests that factual understanding of sexual health is relatively consistent across religious groups, possibly due to shared access to educational materials or standardized curricula. Regarding attitudes, a significant difference was observed (χ^2 = 2.818, p = .045). The "Others" group had the highest mean rank (M = 71.96), followed by Roman Catholics (M = 69.42), INC (M = 65.31), and Methodists (M = 63.39). This suggests that religious affiliation may influence students' sexual values and perspectives, with students outside of traditional denominations demonstrating more affirming or open attitudes. The results align with literature indicating that students from more conservative religious backgrounds may experience internalized conflict when reconciling sexuality and doctrine, which can shape less accepting attitudes (Oducado, 2023).

No statistically significant differences were found in sexual health practices (χ^2 = 2.535, p = .469) or overall awareness (χ^2 = 6.019, p = .111). For practices, Roman Catholics had the highest mean rank (M = 40.47), while INC had the lowest (M = 28.64). Despite these numerical differences, the result was not significant, indicating that behavior is not reliably shaped by religious affiliation alone. Similarly, sexual health awareness scores showed a trend of higher awareness among Catholics (M = 39.98) and lower scores among Methodists (M = 25.19) and INC (M = 27.86), but the differences were not statistically significant.

CONCLUSION AND RECOMMENDATIONS

Conclusion

The study investigated sexual health awareness among LGBTQIA+ students for the 2024-2025 school year and described their demographic profile that may influence this awareness. Based on the findings, the researchers concluded the following:

1. In terms of age, a proportion of the participants were 20–21 years old and identified as either homosexual or bisexual. Most participants came from nuclear or married families and predominantly identified as Roman Catholic.
2. The students' level of sexual health awareness demonstrates strengths across various dimensions, including sexual knowledge and attitudes toward sexual health. A majority of the participants demonstrated high levels of sexual health knowledge, which indicates a strong understanding of crucial topics such as consent, contraception, and sexually transmitted infections (STIs. In terms of attitudes toward sexual health, the results varied more widely across respondents, suggesting that while students may understand and apply safe practices, their personal beliefs and perceptions may not be fully aligned

with the principles of inclusive and comprehensive sexual health education. The majority of participants demonstrated an average attitude toward sexual health, suggesting a balanced perspective that acknowledges cultural influences. At the same time, a quarter of the respondents express a high level of acceptance, which indicates openness to discussion and engagement with sexual health matters.

3. The analysis of sexual health awareness among students, when grouped according to various profile variables, found that certain factors, such as age and sexual orientation, influence awareness. In contrast, other factors, such as marital status and family structure, had minimal impact. In terms of age, significant differences were found in sexual health practices and overall awareness, which indicates that young adults, particularly those aged 20-21, engage more consistently in protective behaviors and demonstrate higher overall awareness compared to younger peers. Notably, younger students aged 18–19 and those identifying as bisexual demonstrated lower levels of awareness. As for sexual orientation, significant differences emerged in attitudes. In contrast, no significant differences were identified concerning marital status or family structure, which suggests that external educational influences may play a more critical role in shaping students' sexual health awareness than family backgrounds. Furthermore, while some variations in attitudes were observed across different religious affiliations, these did not show significant differences in knowledge or overall awareness.
4. A nursing-led initiative program plan for sexual health awareness was proposed to address observed gaps, particularly in attitudinal development and awareness levels among specific subgroups. The program, "Building an Inclusive Community Through Sexual Health Awareness," incorporates education, values clarification, and peer engagement to strengthen both knowledge and the psychosocial dimensions of sexual health awareness. This bi-monthly seminar will target college students across various departments and aims to enhance sexual health awareness.

Recommendations

These recommendations are designed to address both the strengths and gaps identified in awareness levels and to support the development of inclusive, responsive programs that empower students to make informed decisions regarding their sexual health. Each recommendation corresponds directly to the research problems and conclusions outlined in this study.

1. For future researchers, it is recommended to include a greater number of respondents across varied age groups and gender identities. This will help make the study's results more accurate and applicable to a wider range of people. Different genders can also help spot any differences or similarities between them.
2. The results were favorable; however, there is a need to improve the level of sexual awareness to a very high level. To improve this, future researchers can use social media and other online platforms to share educational content and provide access to materials such as brochures, posters, and websites with reliable information.
3. No significant difference was identified; hence, the interventions should target all members of the LGBTQIA+ community regardless of their profile.
4. To adopt the program entitled *"Building an Inclusive Community Through Sexual Health Awareness: A Nursing-Led Initiative,"* which aims to empower students to make informed decisions regarding reproductive health and relationships.
5. For future researchers, it is recommended to explore and consider using another research tool in assessing sexual health awareness among LGBTQIA+ individuals. In this way, it can offer a more inclusive and detailed perspective of the LGBTQIA+ community. This can help future studies gather more accurate and relevant data, especially when aiming to

understand the specific needs and awareness levels within diverse genders and sexual identities.

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