IPPF International Planned Parenthood Federation

East & South East Asia and Oceania Region

From choice, a world of possibilities

Photo by UNFPA

Overprotected and Underserved

The Influence of Law on Young People's Access to Sexual and Reproductive Health in Philippines

Who We Are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals in more than 170 countries.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Our Vision

All people are free to make choices about their sexuality and well-being, in a world without discrimination.

Our Mission

To lead a locally-owned, globally connected civil society movement that provides and enables services and champions sexual and reproductive health and rights for all, especially the underserved.

Overprotected and Underserved:
The Influence of Law on Young People's Access to Sexual & Reproductive Health in Philippines

Across the world, laws create significant barriers to sexual and reproductive health services (SRH) for youth yet little research exists about the role of law in influencing and shaping access. In 2012, International Planned Parenthood Federation (IPPF) commissioned "Over-protected and under-served: A multi-country study on legal barriers to young people's access to sexual and reproductive health services". Three countries, El Salvador, Senegal, and the UK, that represent different legal systems and contrasting social, cultural, religious and political traditions, were chosen for the pilot study. Youth were the main respondents, with their views, opinions and perceptions on the role of the law remaining central to the findings and recommendations. Research conducted in these three countries, helped raise awareness about the direct and indirect impact laws can have on youth.

IPPF East, South East Asia and Oceania Region (ESEAOR) recognized the urgent need for a similar study in our region. Despite the overall progress on sexual and reproductive health and rights (SRHR), youth's SRHR remains a problem. For example, teen pregnancy, child bride and female genital mutilation continue to

exist in ESEAOR region. IPPF ESEAOR and our Member Associations will use the evidence generated to inform our SRHR advocacy efforts. The analysis will be used with policymakers to advocate for changes to the legal system, to expand instead of restricting access, to all youth. The research will also guide the content of our youth programming, to address misunderstandings about SRHR and the law, and empower youth to advocate for a youth-friendly SRHR environment. UNFPA Asia Pacific Regional Office's Reaching out to Young People Project, which is committed to addressing the legal and policy barriers to young people's SRHR, made it possible for IPPF ESEAOR and Coram Children's Legal Centre to carry out the study in Philippines.

It took the Philippines thirteen years and four months for the Reproductive Health Law to be enacted. The law mandates the national government to make reproductive health services accessible and available to poor families through information, sexuality education in school, and the provision of free contraceptives. This has been a positive move for the country which now has a growing population that has reached the rate of 103,511,899. This study will identify and address the barriers for youth to access sexual and reproductive services in the country. The research shows that there are significant direct and indirect legal barriers to young people's SRHR and existence of facilitative laws, which have the potential to empower youth. IPPF ESEAOR has previously conducted the same study in Indonesia and plans to conduct a similar research in Malaysia.

A special thanks to Kirsten Anderson, the researcher of this report and ESEAOR Program Team especially Gessen Rocas, Brayant Gonzales and Davina Isaac.

Best Wishes
Nora Murat
Regional Director
IPPF East & South East Asia and Oceania Region

IPPF International Planned Parenthood Federation
East & South East Asia and Oceania Region

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The methodology for this research draws and expands upon a pilot multi-country study conducted by Coram International and the International Planned Parenthood Federation in El Salvador, Senegal and the United Kingdom in 2012 - 2013.

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Executive Summary

The overall objective of this study was to determine the impact of the law on young people's access to sexual and reproductive health services (SRH) in the Philippines. Whilst existing research has begun to explore the social, cultural and economic barriers to young people's access to SRH, much less is known about the influence of law, as well as knowledge and perceptions of law, on access to services. The research project explored young people's and health service providers' knowledge, perceptions and understanding of various areas of law; and how these affect young people's access to sexual and reproductive health services in the Philippines.

In order to achieve these objectives, researchers employed a number of methodological approaches, including a desk-based review of existing laws, regulations and policies on SRH in the Philippines, as well as qualitative and quantitative methods of in-country primary data collection and analysis across locations in two regions: Metro Manila and Pampanga.

Law on Comprehensive Sexuality Education

The 2012 Reproductive Health Act (RHA) mandates the provision of comprehensive sexuality education (CSE) in schools. A recent Executive Order issued by the Office of the President also instructs the Department of Education to implement comprehensive sexuality education in the school curriculum. While the Department of Education has taken first steps towards implementation (e.g. it has commissioned a study on gaps in health service provision in schools), it is yet to fully implement CSE in the school curriculum, as of April 2017. Further, the law allows private educational institutions (e.g. religious schools) to develop their own curriculum on CSE. The current access to CSE, according to young people involved in the research, appears to vary by school and teacher, and appears to exclude important topics, such as 'healthy relationships'. It also appears to be hampered by a lack of skills and training on the part of teachers, and compounded by socio-cultural norms that stigmatise pre-marital sex and sex under the legal age of marriage. Myths and misperceptions about sex and sexuality appear to be widespread amongst young people, and this seems to negatively impact on their SRH-related service-seeking behaviour.

Laws that regulate access to services

Access to contraceptives

Several provisions of the RHA restrict the right of adolescents to seek independent access to contraceptive services or information, and limit the availability of contraceptives. In addition, a legal challenge to the RHA's constitutionality led to eight provisions of the law being struck out by the Supreme Court in 2014, further restricting access of adolescents to services, information and referrals for reproductive health services. Most significantly, the RHA articulates a parental or guardian consent requirement for minors (under 18) to access modern methods of family planning. Parental consent requirements appear to function as a direct legal barrier to young people independently accessing contraceptives; this barrier is compounded by restrictive religious and social norms that result in the stigmatization of pre-marital sex and sex under the legal age of marriage. These dynamics impact on SRH service-seeking behaviours of

young people by preventing them from attempting to access contraception in the first place, and also through denial of services by health professionals. The stigma against pre-marital sex and sex under the legal age of marriage is heightened among certain groups of young people; in particular, girls face more stringent social expectations around pre-marital sex, and this may compound feelings of embarrassment, acting as a strong deterrent to accessing contraceptives (and getting parental consent to do so).

In addition, restrictions on the availability of contraceptives is a significant barrier to access: only contraceptives classified as 'non-abortifacient' by the Food and Drug Administration are permitted in the Philippines. This has resulted in the prohibition on several types of contraceptives, including emergency contraception (which has not been legally available in the Philippines since 2001), and two implant contraceptives. A temporary restraining order also put on hold the issuing and renewing of licenses for the distribution and sale of all family planning commodities. The temporary restraining order on the purchase of contraceptive implants was found to directly restrict young people's access to this type of contraction, and its potential impact in the coming years is likely to be felt in public and private health facilities, drying up supply of these essential contraceptive products. Furthermore, the study found that the absolute nature of the prohibition on emergency contraception creates insurmountable barriers for young people in need of emergency contraception, even in cases of particular need, including for victims of rape.

Access to STI and HIV testing and treatment

The RHA's parental or guardian consent requirement for minors (i.e. under-18s) who want to access 'modern methods of family planning' in the Philippines, also likely applies to STI and HIV testing and treatment. Young people's access to HIV testing is also regulated by a specific law – the 1998 HIV/AIDS Act – according to which 'minors' can access HIV testing only with parental consent. Service providers tended to identify that persons aged under 18 years require parental consent before they are able to carry out HIV or STI testing and treatment. This was the case across public, private and NGO-run clinics; however, NGO-run clinics appear to be more flexible in their application of the law.

Access to confidentiality

Individuals in the Philippines have a constitutional right to privacy, the country has one of the most stringent Data Privacy Acts in the region and numerous guidelines regulating health and industry bodies contain privacy and confidentiality provisions. However, confidentiality within the context of access to health care is not explicitly mandated in primary legislation (with the exception of the HIV/AIDS Act), which may create uncertainty for young people seeking confidential access to contraceptive services, as they cannot trust that service providers will keep their interactions confidential. Young people involved in the study were found to have limited understandings of the law relating to confidentiality. Uncertainty about whether their information will be kept confidential can act as a significant barrier for young people trying to access SRH services. In particular, given the stigma associated pre-marital sex and sex under the legal age of marriage, young people may be 'put off' from accessing SRH services where they fear that service providers will not be able to guarantee their confidentiality.

Child protection laws and obligations are also relevant to privacy and confidentiality, as they may require service providers to disclose to the authorities cases in which they believe children to be at risk (e.g. of sexual abuse or exploitation). Certain professionals in the Philippines (including health professionals) have

mandatory reporting obligations where they have a belief that a child has suffered abuse. While child protection reporting is crucial for ensuring that children are protected from abuse, adolescents may be discouraged from seeking SRH services if they fear that they may be reported to the authorities. In particular, the study found that young people who sell sex face significant barriers in accessing services, due to the requirement of service providers to make a child protection referral in relation to any person under the age of 18 years who sells sex.

Access to abortion

Abortion has been criminalized in the Philippines for over a century, and there are no legal exceptions to the prohibition of abortion (though it may be argued that the criminal law defence of 'necessity' applies, which would allow abortion to save the life of a pregnant person). The qualitative and quantitative evidence collected for this study suggests that the blanket ban on abortion creates (nearly) insurmountable barriers for young women who want to access safe and legal abortions. The dominance of conservative social and religious norms creates further barriers to access, as most service providers and young people agree that abortions should be illegal in all circumstances. As a result of these legal and socio-religious barriers, young women in need of abortion services are pushed into accessing 'underground' abortion services. Those women that are well-connected or wealthy may be able to access a trained health professional who will conduct the abortion 'under the table'; but those women from poor and disadvantaged backgrounds often need to resort to a variety of potentially life-threatening methods (including the use of herbs, drugs, and punching their stomachs). Estimates suggest that over half a million women in the Philippines try to terminate pregnancies in an unsafe manner every year.

Non-discrimination

Generally, the Philippines' non-discrimination laws and regulations are comprehensive, and protect against discrimination on the ground of a number of characteristics, including age, marital status, sexual orientation and gender identity. However, in practice, gaps in the law mean that particular groups of persons such as LGBTQI persons and persons who experience gender-based violence face additional barriers to accessing SRH services.

Gender and sexual violence

In the Philippines, comprehensive laws criminalise a wide range of sexual offences; rape is criminalised, including within marriage. However, certain legal exceptions to rape and other sexual offences apply in the context of marriage or pre-marriage. In particular, a conviction of rape may be pardoned if the offender and victim marry subsequent to the act or, if the rape occurs within marriage, the wife forgives her husband. This has the effect of legitimising violence in these contexts, and limiting understandings of what amounts to violence; particularly where family law promotes the 'sanctity' of marriage and limits a woman's ability to separate from an abusive husband. This can create a culture of acceptance of sexual violence within the context of marriage and limit access to services for survivors of sexual and gender-based violence. Where the violence takes place within a context in which it is tolerated or normalised, either by law or socio-cultural norms, survivors of violence feel shame and blame for the violence, and may be deterred from seeking support and services.

LGBTQI young people

While anti-discrimination laws are reasonably comprehensive, Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) persons are not offered the same legal recognition as heterosexual persons. Same-sex marriage is not legally recognized. Also, it is not lawful for an individual to legally change their gender in the Philippines, and it is not possible to legally identify outside the gender binary (e.g. as third gender). This lack of legal recognition of LGBTQI persons serves to reinforce the idea that LGBTQI relationships and identities lack legitimacy, which can entrench stigmatization. The research found that limited legal categories and social norms that constrain LGBTQI identities and sexual expression mean that LGBTQI young people experience additional barriers accessing SRH services. Service providers appear to lack knowledge of the needs of LGBTQI young people and young people appear to be subjected to stereotypes that reduce and humiliate them, which in turn negatively influence their service-seeking behaviours. In addition, lack of legal (and social) recognition of LGBTQI persons has led to an absence of policy and services targeted to their needs.

Law and the sale of sex

The criminalisation of sex work in the Philippines was found to reinforce the deep shame and stigma associated with such activities. Whilst non-coercive provisions included in local ordinances exist in the study's research locations to safeguard the health of sex workers and communities in which they work, the study found that there is still a widespread denial of the profession in law as well as stigma, discrimination and violence. The criminalisation of sex work and stigmatisation of sex workers was also found to create barriers to reporting violence and accessing services following violence. The qualitative data collected for this study also revealed that young people who sell sex may not necessarily recognise their experiences of sexual violence as such, given the widespread stigmatisation of sex work. Persons below the age of 18 years are legally considered to be children who are sexually exploited, and are therefore unable to be registered as sex workers. While it is, of course, important to ensure that the law protects children from sexual exploitation, this law may be functioning as a barrier, preventing under-18s who sell sex from accessing services. It also drives their activities 'underground', placing them at greater risk.

1 Introduction

This report presents findings of a study exploring the influence of law on young people's access to sexual and reproductive health in the Philippines. Whilst there is a wealth of global research on the social, cultural and economic dimensions of sexual and reproductive health, much less is known about the influence of law on access to rights and services. This is despite the fact that every state around the world, without exception, has developed legislation that is in some manner designed to regulate, enable, restrict and control sexual and reproductive health, for different groups of people, and in different situations and circumstances.

In recent years there has been a growing interest amongst advocates for sexual and reproductive rights in the interplay between legal frameworks and access to protections and services. This research project contributes to efforts to build evidence and knowledge in this area, to guide future advocacy and programming work, with the ultimate aim of promoting and protecting young people's sexual and reproductive rights.

2 Definition of Key Terms and Concepts

For the purposes of this study, a **young person** is defined as anyone between the ages of 10 and 24 years inclusive; meanwhile, a **child** is defined as anyone between the ages of 0-17 years inclusive, in accordance with Article 1 of the UN Convention on the Rights of the Child (UNCRC). The word 'child' is used in the report as this is a legal term, with clear and defined implications under the law. Sometimes in the text the word '**adolescent**' is used to connote the social and biological stage of development that occurs between pre-pubescent childhood and adulthood; an adolescent may refer to anyone between the ages of 10-19 years.

Sexual and reproductive health (SRH) encompasses two related but distinct elements: health related to sexuality, and health related to reproduction. **Sexual health** implies that an individual has the freedom to have a pleasurable and safe sexual life, 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.[1] **Reproductive health** implies that an individual has the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".[2]

Sexual and reproductive rights refers to an individual's rights to have control over and make informed and free decisions on matters related to sexual and reproductive health, as well as their sexuality and sexual and reproductive life, free of coercion, discrimination and violence.[3]

Sexual and reproductive health services: in line with the above definitions, this study considers young people's access to services that are relevant to promoting and protecting sexual health and reproductive health. These include, but are not limited to: education and counselling in relation to sexual and reproductive health, contraception, family planning, abortion, pre-natal and postnatal care, maternal and infant mortality, gender affirmation services, and services related to the prevention and treatment of sexually transmitted infections (STIs) and HIV/AIDS, as well as sexual and gender-based violence.

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[1] World Health Organisation, "Defining Sexual Health", retrieved on 30 September 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

[2] World Health Organisation, "Reproductive Health", retrieved on 30 September 2015 from http://www.who.int/topics/reproductive_health/en/.

[3] For more detail on the range of sexual and reproductive rights, see the International Planned Parenthood's 'Charter Guidelines on Sexual and Reproductive Rights', available at: http://www.ippf.org/sites/default/files/ippf_charter_on_sexual_and_reproductive_rights_guidlines.pdf

3 Conceptual Framework

Understanding the influence of law and legal rules on young people's access to SRH services in practice is a complex task. It involves understanding both what the law is, and how it is applied; as well as what young people and service providers know and understand about the law, and if and how such perceptions shape their choices, expectations and practices accessing or providing SRH services. Finally, it involves understanding how the law interacts with other key social, political, personal, economic (etc.) factors, which play a role in determining young people's access to services. The research inquiry was structured with a mind to gathering evidence on three central, interrelated questions; namely:

- (What are) the legal rules that regulate young people's access to SRH services, and how are they applied?
- (What do) young people and health professionals' know about the law, and (how do) they perceive or interpret such laws as pertaining to themselves?
- (How does) law, and knowledge and perceptions of law, impact on young people's opportunities to seek out, and be provided, SRH services, and why?

In designing the methodology for the study, it was recognised that law may influence or impact on young people's access to SRH services in various ways: the law may act as a barrier to young people's access to services through both direct and indirect means. In other cases, the law may actively facilitate young people's access to services.

Direct legal barriers are understood to be laws which explicitly and purposefully restrict access to services either universally or for certain groups of people in certain circumstances. In order to examine and determine the direct legal barriers that impact on young people's access to SRH services in the Philippines, researchers examined areas of law related to regulating access to and capacity to provide consent for: medical treatment (in general); reproductive services, such as access to birth control, abortion and sterilisation; sexual health services, such as access to STI counselling, treatment and services; access to gender reassignment or affirmation services for young people including surgical and hormonal interventions; and access to sexual and reproductive education, advice and counselling.

Indirect legal barriers are laws that do not directly impose restrictions on access to SRH services, but nonetheless may function this way in a particular context. For example, statutory rape laws - which establish a minimum legal age for consent to sexual activity, minimum age of marriage laws, and laws establishing a minimum age for legal majority, may create indirect legal barriers to young people's access to services. Young people and service providers may interpret these rules as forbidding persons under these legal ages from accessing SRH services. Furthermore, these laws may have a normalising influence on existing social taboos associated with childhood and youth sexuality, particularly among unmarried girls.

In order to identify and explore potential indirect legal barriers to young people's access to SRH services, researchers examined areas of law relevant to regulating young people's gender and sexuality identities behaviours and relationships, including: laws that define and criminalise different forms of sexual

violence, including statutory rape laws; laws that regulate marriage and divorce; laws that regulate the sale of sex; laws that impact on gender and sexual minorities, such as laws that criminalise same-sex sexual acts, or that prescribe and define binary gender categories, and laws that create barriers to gender/sex transition.

Finally, laws do not only function as barriers to accessing SRH services. Laws can also facilitate access to services, where they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights to sexual and reproductive health are protected and promoted without discrimination. Confidentiality duties imposed on SRH service providers which mandate protection of young people's privacy and laws that enshrine or affirm a positive right for young people to access SRH services are examples of facilitative laws.

In order to identify and explore potential facilitative laws, the research examined laws that affirm the right to health in general, and sexual and reproductive health in particular, especially for adolescents; laws that protect individuals from forms of gender and sexuality based discrimination, and laws that protect and promote individuals right to free and confidential access to sexual and reproductive health services.

4 Methodology

Understanding the influence of law and legal rules on young people's access to SRH services in practice is a complex task. It involves understanding both what the law is, and how it is applied; as well as what young people and service providers know and understand about the law, and if and how such perceptions shape their choices, expectations and practices accessing or providing SRH services. Finally, it involves understanding how the law interacts with other key social, political, personal, and economic factors, which play a role in determining young people's access to services.

In order to address these different elements of inquiry, the study employed a mixed methods design, combining both qualitative and quantitative approaches; to gather objective, comprehensive and measurable data, as well as evidence that was in-depth, and explanatory. A variety of different strategies and methods were employed to gather data to answer the research questions set out above.

4.1 Site selection

Sites were selected to facilitate access to a diverse range of participants and suitable key informants; the selection of sites was practically limited to include those locations where FPOP were able to facilitate access to communities and respondents according to their existing networks, and included the following:

	Metro Manila (Quezon City)	Pampanga (San Fernando, Angeles)
Geographical location	National Capital Region	Central Luzon

All locations comprised diverse (mostly urban) communities. Angeles was purposefully selected as it contains one of the country's largest 'red light' districts, in which a comprehensive registration system applies to registered sex workers. This allowed researchers to include young people who sell sex within the sampling frame, and to examine the impact of city regulations / ordinances on sex workers' access to SRH services.

4.2 Legal review

At the outset of the study, a desk-based review and analysis of existing laws and regulations was carried out in order to establish the content of legal provisions regulating young people's sexuality and access to SRH services in the Philippines. This legal review informed the design of primary data collection tools.

4.3 Collection of primarily qualitative data

4.3.1 Individual interviews

Individual semi-structured interviews were carried out with (SRH) service providers (nurses, doctors, counsellors, pharmacists etc.), to gather data on respondents' knowledge and perceptions of legal rules, as well as their experiences in relation to SRH service seeking provision. In addition, a number of key informants participated in individual interviews in

order to give a broad 'bird's eye' view and insights into the research topics. Interview guides were developed in order to provide a level of standardisation in the data collected; however, these were implemented flexibly to allow for a participant-directed interaction. Participant selection for service provider and key informant interviews was purposive: the aim was to include a wide and diverse range of different 'types' of service providers; key informants were selected on the basis of their role within relevant government departments, and non-government organisations.

In total, 15 service providers and six key informants were involved in semi-structured interviews. A more comprehensive list of research participants is included in Annex A.

4.3.2 Focus group discussions (FGDs)

In addition, a number of focus group discussions were carried out with young people, to allow them to explore and share ideas in a relaxed and communal setting. Topic guides were developed to guide focus group discussions to encourage participants to explore general themes surrounding the law and sexual health in hypothetical and scenario-based format.

Participants were purposively sampled to capture to the greatest extent possible the views and experiences of individuals from different age-groups, socio-economic groups, and backgrounds. A number of FGDs were also carried out with young people who may have particular SRH needs or have particular vulnerabilities that influence their access to SRH services: research was carried out with young mothers, young sex workers and LGBT young people. Respondents in focus group discussions were separated according to gender due to the sensitive nature of the issues under discussion.

In total, 12 FGDs were carried out involving 60 young participants.

4.3.3 Transcription and analysis of data

All raw qualitative data was transcribed and uploaded into Nvivo software. It was then coded to identify key themes, patterns, relationships and explanations relevant to the research questions. Findings from the legal review were integrated into our analysis of primary data to help understand the relationships between legal rules, how they are interpreted, and how they function.

4.4 Surveys

Given time and resource constraints it was not feasible to conduct a comprehensive, nationally representative survey. Nonetheless, two short survey tools were developed – one for young people and one for service providers – to collect some basic descriptive and standardised data that could be analysed objectively, in relation to respondents' knowledge, understanding and perceptions of law, and experiences accessing or providing services.

Researchers used a mixed sampling method, combining both purposive and probability techniques, in order to access a range of different groups of young people and health professionals, with diverse SRH needs/services, and from a wide variety of socio-economic, ethnic, religious and geographical

contexts. In addition, Family Planning Organisation of the Philippines (FPOP) were able to mobilise their contacts on the ground to enable access to particularly marginalised and vulnerable groups, such as young people engage in sex work, Men having Sex with Men groups, transgender communities, and street children.

Enumerators were instructed to distribute the survey to groups of young people and service providers who had not participated in FPOP activities, or received unusual levels of sensitisation or education about the law, in order to avoid obtaining heavily biased results. After surveys had been completed, responses were entered into data entry sheets by local FPOP volunteers, who received training on data entry from the international researcher.

4.4.1 Profile of young people's survey

Surveys for young people were distributed manually by FPOP staff within educational institutions and community centres in Quezon City in Metro Manila and San Fernando in Pampanga (Angeles City was used as a location for qualitative data collection only). In total, the young people survey included **412 respondents**, with 212 young people in Quezon City and 200 young people in San Fernando. Of the 412 young people surveyed, 207 were girls (50%), 172 were boys (42%), and 33 individuals (8%) did not identify as either male or female and instead chose the 'other' category. The mean age of the Quezon City sample was 18 years, with the minimum reported age of respondents being 14 and the maximum being 26 years. As in Quezon City, the mean age of the San Fernando sample was 18 years. However, the minimum age of respondents was 15 years in this case, and the maximum age was 28 years.[4]

Of all 412 respondents included in the survey, around 50.5% indicated that they lived in an urban neighbourhood, 24% reported that they lived in a rural area, 17.5% reported that they lived in an urban slum, and 8% of young people indicated that they lived in a suburban area. Of all 98 young people who indicated that they lived in a 'rural area', the overwhelming majority (96%) were accessed in San Fernando (only three young people accessed in Quezon City indicated that they lived in a 'rural area').

A large majority (64%) of young people included in the survey indicated that they had completed secondary education. 27% indicated that they had completed university-level education, 7% of respondents only completed primary education, and the remaining respondents either had no education (0.7%), only primary education (0.5%), or chose not to answer the question (1%).

The overwhelming majority of the sampled young people indicated that they did not work (85%), while 11% indicated that they were employed in part-time jobs, and 4% indicated that they were working full-time. Interestingly, around 10% of the surveyed young people indicated that they had engaged in sex work.

[4] While the study focused on persons aged up to 24 years ('young people', as set out in Section 2) and 99.03% of the survey sample identified as being aged 14-24, 4 survey respondents did identify as being outside this age category (i.e. aged 25-28). Survey responses from these 4 individuals were nonetheless included, as they were able to provide data relating to their experiences as a young person. However, given that only four individuals identified as being older than 24, excluding these observations from the statistical analysis did not result in any significant changes to the results presented in this report.

4.4.2 Profile of service providers' survey

Surveys for service providers were distributed manually by FPOP staff in public and private clinics, school-based health centres, pharmacies and other facilities providing SRH services. Institutions were purposively selected to represent some of the diversity amongst SRH service providing facilities in the Philippines.

Researchers collected responses from a total of **50 service providers** (25 in Quezon City and 25 in San Fernando). Of the total 50 service providers surveyed for this study, 34 were female (68%), 15 were male (30%), and one identified as neither. Around 38% of service providers worked in public health centres, 12% worked in private fee-paying clinics, 16% worked in school-based health centres, 14% of service providers worked in facilities specialising in SRH services, 10% worked in pharmacies, one service provider worked in a hospital, and four worked in 'other' unspecified facilities.

For a more detailed discussion of the study methodology, including sampling design and data analysis techniques, please see Annex A. The 'interview schedule' used during the in-depth interviews with service providers can be found in Annex B. The 'group discussion schedule' used during the FGDs with young people and parents can be found in Annex C. The survey questionnaires are included in Annex D.

4.5 Limitations

While the desk review of the relevant legislation aimed to be comprehensive, given the broad focus on the enquiry (particularly under the category of 'indirect barriers' it was not possible to conduct and exhaustive view of all laws that may influence or have an impact (e.g. detailed review of all marriage/ divorce laws, all laws that have implications for forms of gender based discrimination); the most pertinent and relevant pulled out, but this was necessarily a judgment call.

Further, not all potentially relevant materials (especially regulations and sub-national legislation) were available publicly and in English language. As a result, it is likely that at least some potentially relevant materials were not captured by the desk review. Whenever possible, researchers used officially translated English versions of the relevant legislation. However, in a few cases, researchers needed to revert to unofficially translated versions of legislation or regulations. These English translations were read and interpreted by researchers with the necessary amount of caution.

Whilst participants in focus groups were separated according to gender and also divided according to age groups, it is likely that power dynamics within each group biased the discussions (and findings) in favour of the more outspoken and assertive participants. Researchers took care to enable equitable discussions amongst participants; however, participants who were too shy or afraid to answer were never singled out by researchers.

Translators were used throughout the qualitative interactions. While emphasis was placed on literal translation of every statement and simultaneous translation was avoided, it is likely that some nuances of the participant's responses were 'lost in translation'.

The implementation of the surveys (both with service providers and with young people) also entailed a number of methodological limitations. In practice, it was difficult to ensure that individual institutions were selected randomly from within the pre-specified strata, and that the survey was then distributed on a purely random basis to young people and service providers within these institutions. Researchers often needed to rely on the connections of FPOP in order to gain access to particular target groups/institutions. This is likely to bias the discussion/findings in favour of target groups/institutions that had pre-existing connections to the local IPPF member associations. While care was taken to distribute questionnaires to a random selection of individuals within each selected institution or target group, surveys were filled out on a voluntary basis which is likely to have introduced some bias into the sample.

Due to time and resource constraints (but also in order to ensure the confidentiality of the respondents), the survey questionnaires were self-administered. While enumerators instructed survey respondents on how to fill out the survey, the self-administered survey format resulted in relatively large non-response biases, as respondents were either unsure how (or unwilling) to fill out all questions in the surveys. Non-response was particularly pronounced in the service provider survey, which may be due to the time constraints amongst health professionals.

Finally, given the nature of the research (which involved qualitative data collection and the administration of small surveys, carried out and distributed in locations in two districts), and the primarily purposive sampling techniques, the results are of course not representative of the whole population of the Philippines in the strict sense. It is also noted that research locations were limited to urban areas with very limited populations of religious and ethnic minorities. The findings should be read in this light: inclusion of populations of young people from religious or ethnic minorities and young people from rural areas may have identified different experiences of legal (and other) barriers.

4.6 Ethical protocol and tools

The research was carried out by trained and vetted research consultants, with extensive experience in conducting research with children and young people. Data collection was carried out in accordance with Coram International's Ethical Guidelines for Field Research (see Annex E). Procedures were developed for obtaining informed consent, ensuring voluntary participation, ensuring anonymity, and protecting the safety and privacy of research participants at all times.

5 Socio-legal Dimensions of Youth and Sexuality

"We have a sensitive culture about sex. We are a Catholic-dominated country. The thinking is that if you have sex outside marriage, it is a big sin. So if that is what the church and community think, of course, those young people will not tell you they are doing the act because it's a sin. They will be sinners. And they are afraid of being labelled as a sinner. So they do it secretly." [5]

The expression of youth sexuality in the Philippines is constrained by a set of social and religious norms that prescribe what is, and what is not, 'legitimate' sexual activity, and the context(s) in which it may or may not be expressed. These norms are both reflected in and reinforced by laws that prescribe the circumstances in which sexual activity and sexual expression is permitted, and which can function to further entrench restrictive norms that stigmatise (youth) sexual activity and expression, and restrict young people's access to SRH rights and services.

5.1 Marriage, youth and sexuality

Marriage appears to be the precondition for legitimate and acceptable sexual activity among young people in the Philippines. Research participants tended to express the view that sex is only acceptable within marriage; this appeared to be linked to cultural and religious influences, as illustrated in the following excerpts from interviews and FGDs:

> "Pre-marital sex is against the law of god, so most of the young people are worried about this; that they shouldn't have sex because it's a sin."[6]

> "Before you have sex, you need to get married. It is based on our culture; our culture promotes purity of a girl before she gets married."[7]

Pre-marital sex, particularly where there is 'evidence' of sexual activity (i.e. a pregnancy), appears to be heavily stigmatised.

> "There is a stigma associated with young people having sex, especially if they get pregnant too early. This may cause them to be expelled from school and be the talk of the school: 'that girl is a flirt, she is a bitch' etc."[8]

As indicated by the illustrative quote above, pre-marital sex is particularly stigmatised in the case of girls. It appears that girls are held to a particularly high moral standard and subjected to strict social expectations that they will remain virgins until they are married. Research participants expressed this social expectation in terms of girls 'losing more' than boys if they have sex before marriage. While many respondents suggested that this was because girls can get pregnant and will have to take responsibility for a baby (causing her to miss out on schooling etc.), the data was also suggestive of deeply discriminatory norms that require girls to remain 'pure' for their future husbands; boys on the

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[5] Individual Interview with Nurse from an NGO specialist sexual health clinic, Pampanga, 6 December 2016.
[6] KII with Director. FPOP, Metro Manila, 6 December 2016.
[7] FGD with eight young women, 15 – 18 years, Metro Manila, 1 December 2016.
[8] Individual Interview with School Nurse and Midwife from an NGO-run sexual health clinic, Metro Manila, 2 December 2016.

other hand, do not appear to be subjected to these tight restrictions on pre-marital sex. Consider the following quotes from focus groups discussions with young people and parents:

> "Virginity is very precious for girls because when you get married, it is something that your husband will value."[9]

> "In the Philippines, they say 'lucky is the man who is the girls' first and lucky is the woman who is the man's last."[10]

The importance of virginity appears to be linked to gender norms that require girls and women to conform more closely to social expectations concerning pre-marital sex; there is an expectation that they behave 'respectably' and have 'dignity'. Boys, on the other hand, appear to have more freedom to transgress social norms, including the prohibition of sex outside of marriage.

> "Parents are being over-protective with girls as the community expects girls to be respectable. So if girls engage in sexual activity, it will cause disappointment to the family and community."[11]

> "In our culture, in the Philippines, girls have to act respectably. If you don't respect yourself, then others will not respect you. If the community knows you had sex with someone, the respect will be lost. It is more expected for girls to act firmly and girls are not allowed to act maliciously, because the girl needs to be respectable and remain with the image of being respected."[12]

> "Boys are more explorative than girls. They go anywhere and can have sex anywhere, but they think that girls should stay home and be more contained. Girls are being protected. Their parents will get mad if they find out that the girls are sexually active."[13]

There was some evidence, particularly among young people involved in the research, that community views on pre-marital sex may be becoming less absolute. This is supported by the Young Adult Fertility and Sexuality Study of the Philippines, in which it was found that the proportion of young people who thought it was 'not important' for a woman to remain a virgin until marriage rose from 8.5% in 1994 to 20.3% in 2013.[14] Similarly, the approval of premarital sex among women appears to have increased: 23.4% of young people reported acceptance of premarital sex for women – a significant rise from 12.8% in 1994.[15] However, some participants tended to link (pre-marital) sex strongly with childbirth; indicating that sex is considered to have a predominantly reproductive function, even outside of marriage. These participants tended to suggest that a girl should not be having sex unless she was ready, i.e. that she was sure that her partner would marry her or enter into a live-in union with her if she became pregnant.

> "If they can't manage a baby yet, they should not be having sex. If you're not yet ready to be a mum, you shouldn't be having sex."[16]

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[9] FGD with eight young women, 15 – 18 years, Metro Manila, 1 December 2016.
[10] FGD with three mothers of adolescents, Metro Manila, 1 December 2016.
[11] FGD with six young men, 16 – 18 years, Metro Manila, 1 December 2016.
[12] FGD with seven young men, 15 – 22 years, Metro Manila, 1 December 2016
[13] Individual interview with community health worker, Metro Manila, 2 December 2016
[14] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, *The 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 60.
[15] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, *The 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 61.
[16] Individual interview with midwife from a private clinic, Metro Manila, 2 December 2016.

> "If you become pregnant, do you think the guy would take care of you and your baby? If not, do you think you can give the best to your baby?"[17]

Of course, the views illustrated by the above excerpts may also be linked to the limited access that young people have to contraceptives and abortion (see below).

5.2 Legal thresholds: Age of marriage and sexual consent

Dominant social norms restricting young peoples' sexuality are reinforced by laws that regulate (youth) sexual acts, behaviours and relationships. Laws that provide a minimum age at which young people can lawfully have sex can have a normalising influence on social taboos associated with youth sexuality. Laws setting out minimum ages for marriage also delineate the ages and circumstances in which sex is considered acceptable and legitimate, and can in turn influence the sexual health-seeking behaviours of young people.

In the Philippines, the law establishes different and seemingly confusing age thresholds for sexual activity in different circumstances and for marriage. The age at which girls and boys can legally consent to sex is 12 years.[18] However, in some defined circumstances, the law prohibits adults aged over 18 years from engaging in sexual acts with under-18s.[19]

The legal age of marriage in the Philippines is 18.[20] However, marriage of a person aged 18, 19 or 20 requires parent or guardian consent.[21] The legal age of marriage is defined differently under the *Code of Muslim Personal Laws of the Philippines* (hereinafter referred to as the 'Muslim Code'), which applies to Muslims across the country and provides for the enforcement of Islamic law within their communities. According to this Code, any Muslim male who is at least 15 years of age and any Muslim female 'at the age of puberty or upwards and not suffering from any impediment under the provisions of this Code' may contract marriage. Whilst Muslim females reach puberty at varying ages and, therefore, may marry at varying ages, they are presumed to reach puberty by the age of 15 according to the Code. The Muslim Code is particularly discriminatory against young women, allowing their marriage at a very young age. However, according to an Official Ruling (Fatwa) issued in 2015 by Islamic leaders in Mindanao (Fatwa on the Modern Family in Islam), while 'Islam does not precisely fix any marriageable age', it is generally accepted that the marriage age for Muslims is 20 years for men and 18 years for women. It is noted that the Fatwa recommends different marriage ages for men and women, which is discriminatory.[22]

The different and inconsistent legal age thresholds appear to have led to confusion among professionals and young people about the circumstances in which sexual activity is lawful and

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[17] FGD with six young men, 16 – 18 years, Metro Manila, 1 December 2016

[18] *Anti-Rape Law of 1997*, Available at: http://www.chanrobles.com/republicactno8353.htm#.WCSJZtJ96M9 (Last access 10 November 2016), Article 266A.

[19] The *Special Protection of Children Against Abuse, Exploitation and Discrimination Act* establishes that, 'children, whether male or female, who for money, profit, or any other consideration or due to the coercion or influence of any adult, syndicate or group, indulge in sexual intercourse or lascivious conduct, are deemed to be children exploited in prostitution and other sexual abuse.' It is not clear what constitutes 'coercion or influence' by an adult, although if interpreted broadly may be used to prosecute over-18s who engage in sexual acts with under-18s where it can be proven that the over-18 party 'coerced or influenced' the party under-18.

[20] Family Code of the Philippines (1987), Available at: http://www.chanrobles.com/executiveorderno209.htm#.WCISQVV97IU (Last access 8 November 2016), Article 5.

[21] Family Code of the Philippines (1987), Available at: http://www.chanrobles.com/executiveorderno209.htm#.WCISQVV97IU (Last access 8 November 2016), Article 45.

[22] Official Ruling (Fatwa) on Early and Forced Marriage, Pre-Marriage Counseling, Comprehensive Gender and Health Education for Youth and Gender-Based Violence: The Model Family in Islam (2015)

unlawful, as articulated by two key informants:

> "The Laws are confusing – for example, the statutory rape law – it can only be considered rape if the child is below 12 years. Marriage is 18 years. Medical consent is 18 years. Sexual debut can be legally at 12. Criminal liability is at 15."[23]

This was consistent with both the quantitative and qualitative data, according to which there is a very low level of knowledge among young people and service providers of the legal age of sexual consent and of marriage.

Interestingly, the quantitative data demonstrated that the majority of service providers and young people thought (incorrectly) that the age of marriage for (non-Muslim) boys and girls was different. According to the data, set out in the table below, the majority of service providers and young people thought that the legal age of marriage for girls with and without parental consent is 18 years and for boys is 21 years (or 18 years with parental consent, among the young people surveyed).

Age of marriage: Response of largest proportion of service providers and young people

		Girls	Boys
Service providers	*With parental consent*	18 years (46%)	21 years (44%)
	Without parental consent	18 years (52%)	21 years (68%)
Young people	*With parental consent*	18 years (39%)	18 years (31%)
	Without parental consent	18 years (41%)	21 years (48%)

The majority of both service providers and young people also demonstrated limited knowledge of legal marriage ages under the Muslim Code.[24] For example, a plurality (38%) of surveyed service providers and around one in three young people indicated that they did not know the legal age of marriage for Muslim girls and boys, either with or without parental consent. However, it should be noted that, due to the research locations selected, only a very small number of survey respondents (three young people and no service providers) identified as Muslim.

The quantitative data findings were consistent with the qualitative data: research participants tended to believe that the age of marriage was different for boys and girls, with respondents commonly believing that marriage of boys was lawful from 21 years, while girls were able to be lawfully married *at a younger age*; typically believed to be 18 years. According to the qualitative data, the (mis) perception that the legal age of marriage is lower for girls reflects norms relating to gender roles and hierarchies. It appears that girls are expected to 'mature' earlier than boys, and be more 'responsible' from a younger age. This expectation is reflected in formal debut ceremonies, in which girls and boys are presented to society as 'mature' at different ages (18 for girls and 21 for boys). This is illustrated in the following excerpts from the FGDs:

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[23] KII with HIV Programme Officer at UNICEF and the and HIV/AIDS and Adolescent Health Focal Person at the Council on the Welfare of Children, Department of Social Welfare and Development, Manila, 6 December 2016

[24] Unfortunately, none of the service providers included in the survey identified as Muslim (i.e. they were Catholic, Protestant, or 'Other'), so it was not possible to examine differences in knowledge about the Muslim Code between Muslim and non-Muslim service providers.

> "If you're a girl, the legal age to get married is 18. It's 21 for boys.
>
> *Why is it different?*
> It depends on when they make their 'debut' and when they are considered mature by society.
>
> *Why are girls considered to mature earlier than boys?*
> Girls have to be more responsible than boys. They are expected to be responsible."[25]

Among research participants, girls were thought to mature earlier than boys as they are expected to be responsible from a young age for household duties – a responsibility they are expected to have once married. This appears to reflect dominant gender norms that require women to be responsible for household work and childcare.

> "Girls are more emotional and they are the ones responsible in the households; that is why they have to be more responsible – because they are responsible for the household from a young age."[26]
>
> "It's the responsibility of a man to look after a girl. It's not good to see that a girl is working while a man is not.
> Now, based on my opinion, it's OK to both work. But if they have a child, it's the responsibility of the man to take care of the family and the woman to stay at home and take care of the baby."[27]

It appears that the age of sexual consent is not widely known among service providers or young people. None of the service providers or young people who responded to the survey correctly identified the age of sexual consent (12 years). Interestingly, respondents appeared to conflate the legal age of marriage with the legal age of sexual consent: the majority identified either 18 or 21 years as the age of sexual consent. Among service providers, 21 years was the most frequently chosen age threshold for boys (44% of respondents), and 18 was the most frequently chosen age threshold for girls (50% of respondents). The perceived close connection between marriage eligibility and sexual consent was further evidenced by the fact that a significant proportion of service providers (14% and 18% respectively) thought that, according to the law, boys and girls can only consent to sex when they are married. Young peoples' understanding of the law on sexual consent mirrored that found amongst service providers: respondents frequently chose 18 or 21 as minimum age thresholds for sexual consent, both for girls and boys.

These findings illustrate the strength of social norms that prohibit pre-marital sex. The quantitative data also indicated the persistence of discriminatory gender norms that make sexual activity amongst young women more acceptable provided that there are married: 20% of respondents thought that girls can only consent to sex when married, whereas a lower 15% of respondents thought that boys can only consent to sex when married.

These (mis)understandings of the law on sexual consent were consistent with the qualitative data, which illustrated the strong influence of religious tradition and social norms on pre-marital sex. Focus group participants tended ether to report that there is no legal age of consent (but that sex 'should' only be practiced within marriage), or conflated the age of sexual consent with their understandings

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[25] Individual interview with two nurses at a public sexual health clinic, Angeles, 30 November 2016
[26] FGD with six young men, 16 – 18 years, Metro Manila, 1 December 2016
[27] FGD with seven young men, 15 – 22 years, Metro Manila, 1 December 2016

of the legal age of marriage. For example:

> *"Is there a law about the age at which young people can have sex?*
> Yes.
> *What is the age limit?*
> I'm not aware of that.
> It's based on the bible: you are prohibited from having sex unless you are married.
> Based on my opinion, it's 21, because I'm relating it to the age of marriage.
> You need to get married before having sex."[28]

> "If the regulations of the church are to be followed, I need to advise my children that sex can only happen if they are having a legal relationship as a couple."[29]

While social norms dictate that marriage is a precondition for sexual activity, and the law requires young people to be 18 years old before they can legally marry, data demonstrates that many young people become sexually active at ages below these thresholds and outside the context of marriage. According to PDHS data from 2013, 608 000 Filipino adolescent girls (aged 15 – 19) were sexually active (had sex in the last three months or were married). On average, among adolescent girls who had sex before the age of 20, they had their first sexual intercourse at age 17.3 years.[30] According to the 2013 Young Adult Fertility and Sexuality Study, the medium age of sexual initiation was 17.8 years for young men and 18.2 years for young women.[31] Amongst our own survey respondents who reported to having previously had sex, the mean age of their first sexual encounter was 17 years, with the youngest first sexual encounter reported at age 9. However, the data suggests that Filipinos are getting married later. In 2014, the Philippine Statistics Authority estimated that the peak age of marriage for women was in the age group of 20-24 years, and for men was in the age group 25-29 years.[32]

There is therefore a certain disconnect between socio-legal norms that prohibit sex outside of marriage (which is lawful at a minimum age of 18 years) and the practices of young people. There also appears to be a rising proportion of young people who are having sex before marriage in the Philippines. According to the 2013 Young Adult Fertility and Sexuality Study, 35.8% of young men and 28.1% of young women reported their first sexual experience as being pre-marital.[33] This represents a significant increase from 1994, when 26.1% of young men and only 10.1% of young women reported their first sexual experience as being pre-marital.[34] This has led to significant gaps between the SRH needs of young people and their access to SRH services, which is controlled by restrictive social norms and reinforced by laws. Some research participants highlighted the mismatch between norms, laws and practices among young people, and suggested that it creates tension in

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[28] FGD with seven young men, 15 – 22 years, Metro Manila, 1 December 2016

[29] FGD with three mothers of adolescents, Metro Manila, 1 December 2016

[30] WHO and Human Reproductive Programme, *Adolescent contraceptive use: Data from the Philippines Demographic and Health Survey* (2013), available at http://www.who.int/reproductivehealth/adol-contraceptive-use/en/

[31]

[32] Philippine Statistics Authority: Marriages in the Philippines decline by 17 percent in 2014. Available at: https://psa.gov.ph/content/marriages-philippines-decline-17-percent-2014 [accessed 01.02.2017]

[33] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, *The 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 87

[34] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, *The 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 87

their ideas relating to sexual activity, as illustrated by the following FGD discussion on the use of contraception:

> *"Is it a good idea for young people to use contraceptives?*
> With our generation, it is very common for young people to engage in sex, so it's much better to know about how to use contraception. But they are still too young to engage in sex.
> Yes, because they should protect themselves, but because of their age they should not be engaging in those activities."[35]

Some key informants linked this mismatch between social expectations and law on the one hand and the sexual practices of young people on the other to the rate of teenage pregnancies in the Philippines, which, in 2016, was found to be the fastest growing in the Asia Pacific Region[36] (according to DHS data from 2013, one in ten Filipino women aged 15 – 19 years had already begun childbearing[37]).

> "The majority of Filipinos are Roman Catholic, but the influence is starting to wane, considering that the teen pregnancy rate is the highest in Asia. This means that young people are not abiding by the Catholic Church teachings. The problem is that they don't have access to services to stop them getting pregnant."[38]

5.3 Gender identity and hetero-normativity

According to the law in the Philippines, marriage is defined exclusively as between a man and a woman,[39] and same-sex marriages or unions are not legally recognised. Given the importance of marriage in legitimising sexual relationships, activity and expression in the Philippines, lack of recognition of same-sex marriage is highly significant. Denial of the legality and legitimacy of same-sex unions can increase shame and stigma and result in a vacuum in policy and SRH services to meet the needs of LGBTI persons.

It is also important to note that it is not possible for an individual to legally change their gender in the Philippines; nor is it possible, legally, to identify outside the gender-binary (for example as third gender). This was confirmed by a Supreme Court decision in 2007, which ruled that individuals do not have the right to change their official documents to reflect their true gender identity, even if they have undergone hormone replacement therapy (HRT) and/or gender affirmation surgery. The Court held that allowing a legal gender change would 'substantially reconfigure and greatly alter the laws on marriage and family relations.' In 2008, the Supreme Court of the Philippines recognized the right of an intersex person to change his birth certificate, gender and name to match his gender identity.[40] However, this applies only in cases where a person is recognized medically as intersex.

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[35] FGD with four LGBT young people, 13 – 17 years, San Fernando, Pampanga, 29 November 2016

[36] UNFPA 2016 Sexual and Reproductive Health of Young People in Asia and the Pacific: A review of issues, policies and programmes.

[37] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, *The 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 85

[38] KII with Director. FPOP, Metro Manila, 6 December 2016.

[39] Family Code of the Philippines (1987), Available at: http://www.chanrobles.com/executiveorderno209.htm#.WCISQVV97IU (Last access 8 November 2016), Article 1: *Marriage is a special contract of permanent union between a man and a woman entered into in accordance with law for the establishment of conjugal and family life. It is the foundation of the family and an inviolable social institution whose nature, consequences, and incidents are governed by law and not subject to stipulation, except that marriage settlements may fix the property relations during the marriage within the limits provided by this Code.*

[40] International Commission of Jurists (2008) *Republic of the Philippines v. Jennifer Cagandahan, Supreme Court of the Philippines, Second Division (12 September 2008),* Available at: http://www.icj.org/sogicasebook/republic-of-the-philippines-v-jennifer-cagandahan-supreme-court-of-the-philippines-second-division-12-september-2008/ (Last access 8 November 2016).

The legal imposition of the gender binary in law appears to be reflected in social norms, which require (young) people to identify as male or female, even where their identity does not conform to this binary. When asked 'how many genders are there?', research participants generally recognised only male and female, and appeared to confuse sexuality with gender identity, as illustrated by the following quotes:

> *"How many genders are there?*
> Four - boy, girls, lesbian, gay."[41]

> *"Is it possible to be neither male nor female?*
> Yes, you can be bisexual
> Yes, if you are an alien [laughter]
> You should know if you're a boy or a girl. You should be one or the other.
> It's not possible to not be a boy or a girl."[42]

> *"How many genders are there?*
> Two – female, male – these are the legal genders.
> Even for LGBT persons, they still need to opt to be male or female."[43]

Even among LGBTI persons in the Philippines, gender identities appear to be rigidly enforced, and there appears to be limited acceptance of a diverse range of sexualities and gender identities. For instance, men appear to be accepted as gay only when they are feminine / identify as a woman; a separate term, 'bisexual', is often applied to 'masculine' gay men, or men who have sex with men but do not identify as gay, as suggested by one specialist service provider:

> "There are lots of men who have sex with men and don't identify as gay…The colloquial term for 'bi' is that it means the 'masculine gay', but if you are 'gay' then that is the 'feminine gay'… So the discrimination within the LGBT community is strong. Just check out Grindr – if you go on Grindr, one of the first things you will see is 'straight acting' or 'discreet', as if it's one of the qualifications for the people to have sex with you."[44]

These understandings of sexuality and gender identity may be associated with gender hierarchies that value dominant masculine identities over femininity (and over masculine identities that do not conform to the dominant idea of masculinity), as a specialist service provider suggested:

> "Because of the strong patriarchal culture, there is a strong negative feeling towards femininity….It used to be a thing that, if you had inclination towards liking men, it was automatically assumed that you wanted to be a woman…Because of this culture (and pop culture strengthens this idea) being gay means that you are automatically are cross-dresser…. The term 'gay' [*backlert*] means you are automatically supposed to be feminine."[45]

These laws and social norms impose hetero-normative and binary understandings of sexuality and gender identity. The lack of legal (and social) recognition of diverse gender identities may restrict an individual's access to SRH services through their fear of persecution or stigma. It may also mean that services are not made available that meet the needs of LGBTI (young) people, as their status has limited recognition in law (these points are discussed further below).

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[41] FGD with four young women, 15 – 16 years, San Fernando, Pampanga, 30 November 2016
[42] FGD with eight young women, 17 – 22 years, Metro Manila, 1 December 2016
[43] FGD with three parents of adolescents (mothers), Metro Manila, 1 December 2016
[44] Individual interview with coordinator of community-based HIV screening centre, Metro Manila, 6 December 2016
[45] Individual interview with coordinator of community-based HIV screening centre, Metro Manila, 6 December 2016

OVERVIEW OF PHILIPPINES LAW ON SRH

The Philippines' legal system is a blend of statutory, common, indigenous and Islamic law. For Muslims, the Code of Muslim Personal Laws is relevant to SRH and applies to matters such as marriage, custody, customary contract and divorce; the Code also established shariah law courts to adjudicate on these matters.[46]

The Constitution of the Republic of the Philippines 1987 mandates that the State secure the 'physical, moral, spiritual, intellectual, and social well-being' of youth in the country and protect and promote the health of the people.[47] Section 11 of the Constitution requires the State will to endeavour to make affordable health services available, particularly for women and children, including free care to 'paupers'.[48] The Republic Act 9710 ('Magna Carta of Women') also provides the right to health for women[49], and this explicitly includes SRH (pre- and post-natal healthcare, family planning, sexuality education and so on).

In 2014, the Government of the Philippines passed an historic law guaranteeing the right to reproductive health services for its population. Before that, the *Responsible Parenthood and Reproductive Health Act of 2012* (RHA) had been held up in Congress for fourteen years due to the staunch Catholic opposition to the bill.[50] The guiding principles of the law include the right to free and informed choice; respect for the fulfillment of reproductive health and rights; provision of reproductive health services that are of a high quality; access to all methods of family planning; equitable access to services; access to care for post-abortion complications; emphasis on the poor, marginalized populations; and a life-cycle approach to reproductive health.

However, a subsequent Supreme Court case declared various provisions of the RHA 'unconstitutional', limiting its scope. The declarations of unconstitutionality, in sum, secure the right of health providers to conscientiously object to the provision of reproductive health services, information and referrals in a variety of circumstances and roll back the right to informed, independent consent of certain groups of minors, as well as married individuals.[51]

It is worth noting that the Office of the President recently issued an Executive Order[52], which sets out a number of directions to 'intensify and accelerate the implementation of critical additions necessary to attain and sustain "zero unmet need for modern family planning" for all poor households by 2018, and of all Filipinos thereafter.' Significantly, the Order directs the National Youth Commission to 'ensure the integration of adolescent reproductive health concerns in youth development agenda and strategies.'[53]

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[46] Milagros Santos-Ong (2015) Globalex Update: Philippine Legal Research, Available at: http://www.nyulawglobal.org/globalex/Philippines1.html#_Toc414054146 (Last access 7 November 2016).

[47] Constitution of the Republic of the Philippines (1987), Available at: http://www.gov.ph/constitutions/1987-constitution/ (Last access 10 November 2016), Section 13.

[48] Constitution of the Republic of the Philippines (1987), Available at: http://www.gov.ph/constitutions/1987-constitution/ (Last access 10 November 2016), Section 11

[49] Section 17, Republic Act 9710

[50] International Planned Parenthood Federation (2013) Reproductive Health Law is historical victory for Filipino women. Available at: http://www.ippf.org/news/reproductive-health-law-historical-victory-filipino-women (Last access 7 November 2016).

[51] Supreme Court of the Republic of the Philippines (2014) Press briefing, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016).

[52] Office of the President, Executive Order No 12, "Attaining and sustaining 'Zero unmet need for modern family planning' through the strict implementation of the Responsible Parenthood and Reproductive Health Act, providing funds therefor, and for other purposes", January 2017, available at: http://www.gov.ph/downloads/2017/01jan/20170109-EO-12-RRD.pdf

[53] Section 3(c)(iii)


I decide
REMOVE RESTRICTIONS AMONG MINORS ON VOLUNTARY COUNSELING AND TESTING
I decide
CLINIC HOURS MUST BE FLEXIBLE TO THE AVAILABILITY OF YOUNG PEOPLE!
I decide
TO UNDERSTAND THE BODY, PUBERTY & ADOLESCENCE AT GRADE 5 LEVEL.
I decide
LEARN TO DEVELOP MY OWN DECISION MAKING AND NEGOTIATION SKILLS AT GRADE 8.
I decide
EXPLAIN ACCURATE INFORMATION ON GENDER IDENTITY, SEXUAL ORIENTATION AND GENDER EXPRESSION AT GRADE 8.
I decide
Discuss ways to PROMOTE and PROTECT a positive and responsible sense of SEXUALITY at Grade 7.

6 Access to Comprehensive Sexuality Education

6.1 Legal review

The Government of the Philippines recognizes and guarantees the right to reproductive health information and education in the RHA's *'Declaration of Policy'* (Section 2). 'Education and counselling on sexuality and reproductive health' and 'reproductive health education for adolescents' are also included as key 'elements' of reproductive health care in Section 4(q). The recent Executive Order issued by the Office of the President instructs the Department of Education to 'implement gender-sensitive and rights-based comprehensive sexuality education in the school curriculum.'[54]

Section 4(t) of the RHA defines reproductive health and sexuality education as follows: 'A lifelong learning process of providing and acquiring complete, accurate and relevant age- and development-appropriate information and education on reproductive health and sexuality through life skills education and other approaches.'

Beyond articulating the right to information and education about sexuality and reproductive health, the RHA also specifies the topics and manner in which it is to be taught, in Section 14:

> *'The State shall provide age- and development-appropriate reproductive health education to adolescents which shall be taught by adequately trained teachers in formal and non-formal educational system and integrated in relevant subjects such as, but not limited to, values formation; knowledge and skills in self-protection against discrimination; sexual abuse and violence against women and children and other forms of gender based violence and teen pregnancy; physical, social and emotional changes in adolescents; women's rights and children's rights; responsible teenage behaviour; gender and development; and responsible parenthood.'* [55]

Furthermore, Section 8(c)(2) of the Revised Philippine HIV and AIDS Policy and Program Act of 2012 mandates the 'age-appropriate instruction on the causes, modes of transmission and ways of preventing the spread of HIV and AIDS and other sexually transmitted infections in subjects taught in public and private schools.'[56]

The implementing guidelines for the RHA (the IRR) mandate that responsible parenthood and reproductive health education and information shall be provided in public health facilities to all clients regardless of age, sex, marital status, disability or background, as well as in public and private educational institutions.[57] Importantly, Section 11.01 also grants private schools (e.g. religious educational institutions) the right to develop their own curriculum, subject to approval by the Department of Education (DoE).

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[54] Office of the President, Executive Order No 12, "Attaining and sustaining 'Zero unmet need for modern family planning' through the strict implementation of the Responsible Parenthood and Reproductive Health Act, providing funds therefor, and for other purposes", January 2017, available at: http://www.gov.ph/downloads/2017/01jan/20170109-EO-12-RRD.pdf, section 3(b)

[55] Congress of the Philippines (2012) T*he Responsible Parenthood and Reproductive Health Act of 2012*, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016), Section 14.

[56] *The Revised Philippine HIV and AIDS Policy and Program Act of 2012* is available at:https://www.scribd.com/document/122593743/The-Revised-Philippine-HIV-and-AIDS-Policy-and-Program-Act-of-2012

[57] Department of Health of the Philippines (2013) Implementing Rules and Regulations of Republic Act No. 10345, Available at: http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf (Last access 7 November 2016), Section 4.03.

Despite the legal mandates for education to be provided on responsible parenthood and reproductive health and for the DoE to integrate the abovementioned topics into the curriculum within 90 days (after issuance of the IRR), little action has been taken, as of April 2017. While CSE has yet to be included in the school curriculum, it is also important to note that the DoE has taken first steps towards implementation, by commissioning a study on gaps in the health service provision in schools, according to information provided by FPOP. Problems with implementation persist despite pressure from civil society organisations.[58] Furthermore, it seems that the DoE has not yet started to train teachers on how to deliver 'age-specific sexuality and reproductive health education', as mandated by the HRA and IRR.[59]

It also appears that the DoE may have restrictive and conservative views on promoting access to SRH for young people. For example, while the Department of Health has publicly stated that it wants to distribute condoms in schools as part of its strategy to prevent HIV infections amongst adolescents. However, the DoE has rejected this programme, as it believes that distributing condoms in schools will be seen as 'encouraging pre-marital sex' amongst adolescents.[60]

6.2 Uneven access to comprehensive sexuality education (CSE)

CSE in schools is mandated by law, which means that most school children in the Philippines will receive at least some form of SRH education during their schooling. This is to some extent reflected in the quantitative data collected for this study. For example, around 70% of the young people surveyed in San Fernando and Quezon City indicated that they had received some form of education about sexual and reproductive health in school. However, a sizeable minority (18%) of surveyed young people also indicated that they had received *no* education on sexual and reproductive health, suggesting that mandatory CSE in schools is still not fully implemented.[61] Qualitative interviews highlighted that, for out-of-school and unemployed youth, there are often no alternative options for receiving sexuality education, and that these young people may lack important skills related to sexual and reproductive health. Consider, for example, the following quote from a key informant interview with a representative of a UN organisation in Manila:

> "We have a very high rate of out-of-school youth [in the Philippines], which are not covered by CSE in schools … We also can't be sure that they are working, as we have a high unemployment rate. [In any case] not all the skills being taught in employment and vocational education would include these life skills."[62]

The study also revealed that *in practice* young people's access to CSE is highly uneven (across different schools and regions) and not provided in a systematic way, as required by the RHA.

Evidence from interviews and focus group discussions also suggests that the quality and nature of SRH information provided will often depend on the particular school that young people attend or even the individual teachers tasked with teaching CSE. Consider, for example, the following exchange from a focus group discussion with young men in Manila:

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[58] Family Planning Organisation of the Philippines (2016) Report on the Sexual Rights Situation in the Philippines for the UPR (3rd Periodic Review, 27th Session, Apr-May 2017). (Not available online)

[59] http://www.rappler.com/nation/139118-sex-education-philippines-unfpa (accessed 06.02.17).

[60] http://www.sbs.com.au/news/article/2017/02/04/philippine-education-ministry-rejects-school-condoms (accessed 06.02.17)

[61] 20% of respondents indicated that they received some form of CSE from community or religious leaders, with the same percentage (20%) indicating that they had received CSE from an NGO. The categories were not mutually exclusive.

[62] KII with HIV Programme Officer at a UN Organisation, Metro Manila, 6 December 2016

> *"What do young people learn at school about sex and reproductive health?*
> Human anatomy, reproduction, gender equality… But it depends on the school – in my school they don't teach anything about sex. In some schools, there is no in-depth discussion about sex. What you learn from school is just 10% of what you need to learn… Some teachers are not comfortable using words like 'penis.' It's about the teacher – they can be close-minded."[63]

Strong social stigma and taboos associated with young people's sexuality appears to inhibit teachers from speaking openly about topics that should, according to law, be covered in CSE. This socio-cultural barrier was, for example, highlighted by an informant from the DoH interviewed for this study:

> "Only a few teachers can talk about sex, because it is very taboo. They don't feel comfortable talking about sex. We even told them that it's like 'eyes, ears, or nose' when you say 'vagina or penis'; but it is very hard for them."[64]

In other cases, teachers appeared to be willing to include a discussion of contraceptive methods into the curriculum, which highlights the extent to which young people's access to CSE can depend on individual teachers.

> *"Where do you get information about SRH?*
> In science classes we learn about same sex marriage, STIs, and HIV. Some teachers teach us how to use condoms by showing us a movie about how to do it."[65]

However, this appears to happen largely on an ad-hoc basis rather than in a systematic manner. As mentioned above, the RHA grants private schools the right to develop their own curriculum, subject to approval by the DoE. As a result of this rule, it appears that Catholic educational institutions in particular can restrict the amount and type of SRH information they provide to their pupils. This was, for example, highlighted by a NGO representative interviewed in Manila:

> "[For CSE] private schools will copy the public school curriculum, but it's not mandatory in private schools. Church groups [schools] do not have to go deep into the sexuality aspects of CSE."[66]

6.3 Limited scope of CSE

Qualitative and quantitative evidence collected for this study suggests that young people who receive SRH information in school do not necessarily receive sufficient or adequate information, as recommended by international guidance on sexuality education.[67] Interviews with service providers as well as young people indicate that the quality and scope of sexuality education provided in schools is often limited to a discussion of reproduction, the physiology of sexual organs and the risks associated with sex (e.g. HIV/AIDS). Consider, for example, the following excerpt from a group discussion with male school children in Pampanga:

> *"Do they teach you about SRH at school?*
> Yes, in science, physical education and health classes.

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[63] FGD with seven boys, aged 15 – 19 years, Quezon City, Metro Manila, 1 December 2016
[64] KII with DoH Adolescent Health Cordinator
[65] FGD with LGBT youth, Pampanga
[66] KII with FPOP Director, Manila
[67] International Technical Guidance on Sexuality Education http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

What topics do you cover? Reproductive organs and how reproduction happens.
What about skills, like condom use etc.?
No."[68]

HIV/AIDS in particular appears to be a topic that is frequently covered in SRH education in Philippine schools. According to survey respondents, of the 337 who received any form of SRH education, nearly 70% indicated that this included information on HIV/AIDS. The topics that seem to receive the least attention in SRH education classes were sterilisation (13%), STIs (39%) and sexual violence (41%). 'Healthy relationships' was another topic that was found to be covered less frequently (43%).

6.4 Misperceptions about SRH

Misperceptions or 'myths' about SRH and its potential consequences for adolescents appear to be widespread amongst Philippine youth as well as adult community members. Respondents interviewed for this study often justified the current school curriculum's focus on physiology, reproduction and the risks of sex with reference to the perceived dangers of an open discussion about young people's sexuality and reproductive health. In particular, pre-marital sex and risky sexual behaviour were widely perceived as potential consequences of providing young people with 'too much' information about sexuality and reproductive health. Consider, for example, the following interaction with a group of adult community members in Pampanga.

"Should schools be teaching about contraceptives? [Laughter] No, it is not included in the curriculum. It is prohibited to give this information.
Why is this prohibited?
If they give information, young people risk becoming more promiscuous, if they know how to protect themselves. If you teach them about contraceptives, they will feel more able to have sex; they will feel protected."[69]

This view is also echoed in official government policy on SRH education in schools. For example, the DoH and DoE have publicly stated that providing information about condom-use amongst adolescents should be treated as a 'last resort' by teachers, and that teachers should always follow the 'ABC approach' to sexuality education, which prioritises 'Abstinence' and 'Being faithful' before 'Condom use'.[70]

However, avoiding an open discussion about contraception and other aspects of sexuality can have negative consequences for young people, especially in light of the general decline in the age of first sexual encounters, the increase in adolescents who report casual and pre-marital sex, and high rates of unprotected sexual activity amongst Filipino youth.[71]

Key informants interviewed for this study highlighted the potentially negative consequences of restricting young people's access to CSE. Consider, for example, the following excerpt from a key informant interview with a representative of the National Youth Commission:

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[68] FGD, four boys, 14 – 17 years, San Fernando, Pampnga, 29 November 2016

[69] FGD with four parents of adolescents, San Fernando, Pampanga, 30 November 2016

[70] See e.g. http://cnnphilippines.com/news/2017/01/11/DOH-condom-distribution-schools-sex-education-counseling.html (accessed 07.02.17)

[71] See e.g. Jose, E. (2013) Filipino Adolescents' Sexual Attitudes and Behaviours: Results from a University Cohort. *Academic Journal of Interdisciplinary Studies, Vol. 2, Nr.8;* See also the quantitative evidence from the Young Adult Fertility and Sexuality Study available at: https://www.drdf.org.ph/yafs4 (accessed 07.02.17)

> "People are quick to judge young people for their risky behaviour, without understanding the reasons for the risky behaviour. Risky behaviour is all about having unprotected sex. But young people have unprotected sex because they have no information or education on healthy sexual behaviour."[72]

This restriction of access to meaningful and comprehensive sexuality education, in turn, is likely to (re)produce 'myths' about sexuality and sexual behaviour amongst Filipino youth and adult community members. The following quotes from interviews with service providers and key informants illustrate this:

> *"Where do they [young people] get the idea that condoms are not healthy?*
> Their work mates will tell them that 'if you are going to engage in sex, do not use a condom, because it is not healthy. Instead, use withdrawal as it's much more effective."[73]
> ...
> "Some [young people I talked to] said, 'if I ask a girl to pee or jump after sex, she won't get pregnant."[74]

While there are some NGOs that conduct outreach information sessions to fill the knowledge gaps left by the school CSE curriculum, these activities are not necessarily regular or frequent and appear to be mostly aimed at particularly vulnerable groups (e.g. out-of-school youth, sex workers, etc.); they cannot fill the gap left by inadequate CSE in public and private schools.

6.5 Alternative information sources

Perhaps as a result of their restricted access to CSE in schools, young people in the Philippines appear to look for information about SRH elsewhere. The nature and quality of this information can, however, be incorrect or unscientific, age-inappropriate, and may perpetuate discriminatory gender norms and misperceptions about sexuality. The interviews with young people and service providers conducted for this study revealed that young Filipinos frequently turn to the Internet, pornography or their peers as sources of information about sex and/or SRH. Consider, for example, the following quotes from interviews conducted in Angeles City and Manila:

> "Nowadays, the children already know about sex from a young age, even preschool children.
> *Why?*
> Because of technology, the Internet – they search Facebook and YouTube.
> *What are they learning from Internet?*
> Technology is not good for the children. There is a lot of lack of parental guidance. They watch porn too. As an adult, when we see children watching porn, it is shocking. Even at the age of 7 years."[75]

> "Young people turn to the Internet or their peers, where they mostly get the wrong information."[76]

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[72] KII with Commissioner, National Youth Commission, Quezon City, Manila
[73] Individual interview with SP in pharmacy, Pampanga
[74] KII with Commissioner, National Youth Commission, Quezon City, Manila
[75] Individual interview with SP, sexual health nurse, Angeles City
[76] KII with Commissioner, National Youth Commission, Quezon City, Manila

7 Access to Sexual and Reproductive Health Services

7.1 Access to contraception[77]

7.1.1 Legal review

The Philippine law contains both 'restrictive' as well as 'facilitative' elements in relation to young peoples' access to contraception, including information and advice and contraceptive products. The *Responsible Parenthood and Reproductive Health Act of 2012 (RHA)* guarantees 'universal access to medically-safe, non-abortifacient, effective, legal, affordable and quality reproductive care services, methods, supplies.'[78] Overall, the RHA recognizes the right to reproductive health as well as corresponding rights to access services, make informed decisions, receive reproductive health education and determine family size. The principle of non-discrimination is articulated throughout the law and implementing regulations, as well as that of equitable access for adolescents and other marginalized populations.[79] The implementing guidelines for the RHA - the *Implementing Rules and Regulations of Republic Act No. 10345 (IRR)* - reiterates these principles, and also specifies that no discrimination on the basis of marital status is permitted in the context of reproductive health care provision.[80] Section 7.04 of the IRR also gives the Food and Drug Administration the power to determine whether any given drug is, in fact, abortifacient.

Despite the guarantee of a right to reproductive health for all, several provisions of the RHA and the IRR restrict this right in a manner that may place a greater burden on adolescents seeking independent access to contraceptive services or information, and limit the availability of contraceptives. In addition, a legal challenge to the RHA's constitutionality led to eight provisions of the law being struck out by the Supreme Court in 2014; many of which may directly impact access of vulnerable adolescents to services, information and referrals for reproductive health services.

Restrictions on availability of contraceptives: Access to contraceptives is limited to those that are classified as 'non-abortifacient' by the Food and Drug Administration. This has resulted in the prohibition on several types of contraceptives. Emergency contraception has not been legally available in the Philippines since 2001, when the drug, Postinor, was delisted by the Food and Drug Authority from the drug registry.[81] The RHA also explicitly prohibits the

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[77] This section deals with young people's access to non-permanent forms of contraception (including emergency contraception). Sterilisation (a 'permanent' form of contraception) is covered in separate section.

[78] Congress of the Philippines (2012) *The Responsible Parenthood and Reproductive Health Act of 2012*, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016). Section 2

[79] Congress of the Philippines (2012) *The Responsible Parenthood and Reproductive Health Act of 201*2, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016). See inter alia Sections 2, 3(b), 4(g), 4(s), 4(w), 14, 17. Department of Health of the Philippines (2013) *Implementing Rules and Regulations of Republic Act No. 10345*, Available at: http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf (Last access 7 November 2016), Section 4.03.

[80] Department of Health of the Philippines (2013) *Implementing Rules and Regulations of Republic Act No. 10345*, Available at: http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf (Last access 7 November 2016), Section 2.01 (e): The provision of reproductive health care shall not discriminate between married or unmarried individuals, for all individuals regardless of their civil status have reproductive health concerns.

[81] Bureau of Food and Drugs, Delisting of Levonorgestrel 750 mcg (Postinor) from Bureau of Food and Drugs Registry of Drug Products, Bureau Circular No. 18 of 2001 (7 December 2001), available at http://www.fda.gov.ph/attachments/article/28978/bc%2018%202001.pdf (last accessed 7 March 2016)

purchase or acquisition of emergency contraceptives by national hospitals.[82] In addition, a Supreme Court decision in 2015 issued a temporary restraining order on the Department of Health in 'procuring, selling, distributing, dispensing or administering, advertising and promoting' two implant contraceptive products in the Philippines: Implanon and Implanon NXT. A temporary restraining order also put on hold the issuing and renewing of licenses for the distribution and sale of *all* family planning commodities. The restraining order was upheld again in August 2016, despite an appeal from the Health Secretary.[83] In addition, Barangays have enacted ordinances that limit the distribution of contraceptives within their jurisdiction (however, the legality of these ordinances have been questioned by the Commission on Human Rights).[84]

'Conscientious objection': The IRRs, state that private health facilities do not have to provide family planning services if they are affiliated with a religious group. However, to opt out of providing contraceptive services, religiously-affiliated health facilities must apply for an exemption through the Department of Health.[85] As a result of the 2014 Supreme Court ruling, private health facilities (or those run by religious groups) no longer have to refer patients for services at other facilities unless it is an emergency or life-threatening situation, and providers may no longer be punished for failing or refusing to provide information or referrals.

Parental consent requirements: Whilst stating that no person shall be denied access to family planning services and information, Section 7 of the RHA articulates a parental or guardian consent requirement for minors (under 18) to access modern methods of family planning in the Philippines.[86] Whilst the RHA initially exempted minor parents and minors who had experienced a miscarriage from the parental consent requirement, this provision was declared unconstitutional by the Supreme Court in 2014. However, in all emergency and life-threatening cases, parental or guardian consent is not required.[87]

Spousal consent requirements: The 2014 Supreme Court ruling on the RHA also resulted in Section 23(a)(2)(i) being struck down, which in its original form prohibited the requirement of spousal consent for an individual to undergo a reproductive health care procedure.[88] It is unclear whether the term 'procedure' in the Act refers solely to permanent contraceptive procedures such as sterilisation, or whether it is broadly applicable to all reproductive health services. However, based on the adv ice of FPOP, it appears to be applied only to permanent contraceptive procedures in practice.

7.1.2 Restrictions on availability of contraceptives

Unsurprisingly, it appears that the Food and Drug Administration licensing regulations related to contraception and Supreme Court temporary restraining orders (set out above) have tightly

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[82] Section 9, RHA; Rule 7.01 IRR

[83] Philippines News Now (2016) DOH *Appeals SC to lift TRO vs contraceptive Implanon*, Available at: http://www.philippinenewsnow.com/2016/10/doh-appeals-sc-to-lift-tro-vs-contraceptives-implanon/ (Last access 7 November 2016).

[84] See Commission on Human Rights and UNFPA, *National Inquiry on Reproductive Health Rights (2016)*, available at http://www.asiapacificforum.net/media/resource_file/CHR_National_Inquiry_on_Reproductive_Health.pdf (last accessed 7 March 2017); Barangay ordinances restricting contraceptives are not considered in this report, as there were no such ordinances in place within the research locations.

[85] Department of Health of the Philippines (2013) *Implementing Rules and Regulations of Republic Act No. 10345*, Available at: http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf (Last access 7 November 2016), Section 5.22.

[86] Congress of the Philippines (2012) *The Responsible Parenthood and Reproductive Health Act of 2012*, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016). Section 7.

[87] Supreme Court of the Republic of the Philippines (2014) *Press briefing*, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016).

[88] Supreme Court of the Republic of the Philippines (2014) Press briefing, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 7 November 2016).

restricted the availability of some types of contraceptives for (young) people. According to the quantitative data, while condoms and contraceptive pills appear to be widely available in most SRH facilities (and pharmacies) in the research locations, other types of contraceptives (in particular, emergency contraceptives and implants) are not. Sixty-eight percent (68%) of health professionals who responded to the survey indicated that they provided condoms, and 60% indicated that they provided the pill. Other types of (non-permanent and non-emergency) contraception appear to be less available, with injections provided by 44% of surveyed service providers, implants provided by 34%, non-hormonal IUDs provided by 18%, and hormonal IUDs provided by only 8%. Supplies of particular types of contraceptives appear to be particularly limited in rural areas: service providers located in rural areas were significantly *less* likely to indicate that they provided injections and implants.[89]

According to the qualitative research, the temporary restraining order relating to implants has had a direct and immediate impact on the supply and availability of implants. In accordance with the Supreme Court temporary restraining order, implants cannot be procured, sold or distributed by the Department of Health.

> "There is a huge supply of implants that are 'rotting' in warehouses at the Department of Health because of the Supreme Court decision. That's why I know a lot of CSOs that are requesting the implants to be released. But the problem is that the Department of Health, under the procurement law, cannot distribute the implants because they will be audited and found out."[90]

While the second Supreme Court temporary injunction can be applied to licensing and supply of all contraceptives, it appears that, in practice it is applied in an uneven and inconsistent manner (at least in public health facilities).

> *"What type of family planning services do you provide at the health centre?*
> IUD, injections; though we haven't had a supply of injections for the past two months. They're being held in the Quezon City health office because they need to be registered in Bureau of Food and Drugs."[91]

> "We had a problem with injections because they didn't have registration. One community based volunteer was reprimanded and told her license would be revoked if she continued to give injections.
> *Why are injections a problem? Why aren't they licensed?*
> The Bureau of Food and Drugs are registered there and checked it out. But even though IUD registration is expired, it is still given in the community. There is a selective process. Even though IUDs do not a have a permit, they are provided. Injections for two months were not registered, so the community-based volunteer gave one and three month injections."[92]

Key informants expressed concern that, in the coming years, the supply of all contraceptive products may become scarce due to the temporary restraining orders, leading to acute shortages in availability of contraceptives. SRH produce certifications are in place for five years, and all current SRH product certifications are due to expire in 2020 (at different points). The

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[89] Chi-square test, $p < 0.05$, only public and private providers were compared.
[90] KII with Commissioner, National Youth Commission, Metro Manila, 28 November 2016
[91] Individual interview with nurse at public health clinic, Metro Manila, 2 December 2016
[92] Individual interview with sexual health nurse from an NGO health clinic, San Fernando, Pampanga, 5 December 2016

certifications cannot currently be and renewed due to the Supreme Court temporary restraining order, issued in 2015. The Supreme Court directed the FDA to conduct a hearing and allow petitioners to be heard on the recertification of contraceptive drugs and devices. It also directed the FDA to formulate rules of procedure in the screening, evaluation and approval of all contraceptive drugs and devices.[93] The Court, in directing that these rules must be drafted such that only contraceptives that do not 'harm or destroy the life of the unborn from conception /fertilization' shall be certified, confirmed the very broad application of certification rules to potentially all forms of contraception.

> *"How does the Bureau [of Food and Drug Administration] registration restrict supply of SRH services?*
> It'll have a big impact in the coming years; [it] means that we cannot import family planning supplies to the country because the Food and Drug Administration will not issue a product certification. Without the supply coming into the country, the existing supply here will expire – it is a very dire scenario in 2018 [2020]. If they don't run out, the product certification will expire.
> *Will they renew product certification?*
> No they cannot do this because of the restraining order not to issue new product certification, and not to continue using implants. They allow the existing supplies at DOH like pills, injections, IUDs but for these, the certification will expire in 2018 [2020]. They will not renew it."[94]
> ...
> *"Does the Supreme Court decision affect all contraceptives?*
> The Supreme Court decision could even be applied to the pill."[95]

According to the qualitative data, the temporary restraining order is already having an impact on the availability of contraceptives, as providers are concerned about using up their existing supplies.

> ...
> "When the SRH products from IPPF came to us, we sought a certification from FDA. The FDA said they couldn't issue certification as long as the injunction in place. I thought the injunction was just for implants, but they said 'no.' The FDA needs to declare that each contraceptive is non-abortifacient."[96]

The effects of the temporary restraining order, and its potential impact in the coming years, is likely to be felt in government-run and private health facilities, drying up supply of essential contraceptive products. According to the Department of Health (DoH), if the temporary restraining order is not lifted soon, 'companies and distributors cannot supply the market with these commodities, making them scarce not only in government-run health centres, but in the private market as well.'[97]

Emergency contraception is not certified and its purchase and procurement is prohibited in the Philippines, and this has directly impacted on its availability. According to the quantitative

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[93] Alliance for the Family Foundation of the Philippines et al v Garin et al; Noche et al v Garin, G.R 217872 & 221866, 24 August 2016.
[94] KII with Director of Family Planning Organisation of the Philippines (FPOP), 6 December 2016
[95] KII wit Commissioner, National Youth Commission, 28 November 2016
[96] KII with Director of Family Planning Organisation of the Philippines (FPOP), 6 December 2016
[97] Interview with Health Secretary, Janette Garin, 'Supreme Court TRO stalling government family planning programme', The Inquirer, 4 June 2016 available at http://newsinfo.inquirer.net/789107/supreme-court-tro-stalling-govt-family-planning-program-doh

data, only one of the 50 surveyed SRH professionals (i.e. 2%) indicated that they provided emergency contraception. Based on the qualitative data, it is possible that 'emergency contraception' in this case was not a recognised form of emergency contraception such as the morning after pill, but may involve the prescription of the regular contraceptive pill at a higher dosage.

According to service providers, emergency contraception, such as the morning after pill, is banned and because of this, they are unable to acquire and provide it. Due to the absolute nature of the prohibition on emergency contraceptives, it does not appear to be available even in cases of specific need, including for victims of rape.

The only service provider who reported to have a supply of the morning after pill was the sexual health clinic in Angeles City. It is unclear why this was the case, and whether this is part of a special SRH programme targeting sex workers. Though, it was noted that none of the research participants who were involved in sex work knew about the availability of the morning after pill.

> "Can you get the morning after pill?
> No, I'm not aware of this.
> I heard one of customer talking about one of these pills.
> When they had the FPOP clinic here, they had clients requesting emergency contraception.
> But they only knew about the everyday contraceptive pill."[98]

According to participants, given the lack of supply of the morning after pill, service providers use the regular contraceptive pill in higher doses as a de facto emergency contraceptive product (the 'Yuzpe regimen'). While this method, if administered properly, is not harmful, it is slightly less effective than emergency contraceptive pills and more likely to result in short-term side effects, such as nausea, vomiting and dizziness.[99]

Young people were also reported to use the contraceptive pill without medical advice as an alternative to an emergency contraceptive pill, sometimes taking a large and harmful dose.

> "Emergency contraception is banned – instead, women are taking the regular contraceptive pill. They take five at a time, but it has side effects: nausea, mood swings etc."[100]

> "Usually, for emergency contraception, people buy a package of normal contraceptive pills for one month and use it – they will take the whole packet for one month in a day and hope that it works as emergency contraception."[101]

7.1.3 Service providers' knowledge and perceptions of the law

The complex legal framework regulating access to contraception in the Philippines appears to have led to a certain amount of confusion amongst service providers in the study locations. For example, 70% of the surveyed service providers (wrongly) believed that there were 'no prohibitions' on the provision of contraceptives. In contrast, only 30% of service providers (correctly) indicated that they thought the law only permits access to safe, 'non-abortifacient' contraceptives.

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[98] FGD with four young sex workers, 18 – 25 years, Angeles city, Pampanga, 30 November 2016

[99] See e.g. Task Force on Postovulatory Methods of Fertility Regulation, 'Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception', Vol. 352 No. 9126, The Lancet, 8 August 1998, p. 428 – 433.

[100] KII with Founder, Safe Abortion Network, Metro Manila, 5 December 2016

[101] Individual interview with pharmacy assistant, San Fernando, Pampanga, 29 November 2016

Confusion also appeared to exist amongst service providers as to what the term 'abortifacient' means. While 46% of respondents suggested that 'abortifacient' services only refer to *medical abortions*, sizeable minorities of respondents thought that they refer to *all hormonal contraceptives* (16%), to medical abortion and emergency contraception only (10%), to medical abortion, emergency contraception and implants (12%), or to medical abortion, emergency contraception, implants and hormonal intrauterine devices (16%).

Confusion also appeared to exist in relation to the legal requirements for young people's **access** to contraceptives. Interestingly, a large majority of service providers appeared to believe that the law sets an age threshold for legal access to contraception. 60% of respondents indicated that, according to the law, young people could only access (non-abortifacient) contraceptives at the age of 18. This misperception may be related to service providers' understanding of the law on parental consent requirements for minors (under-18s).

When asked about **parental consent** requirements for young people accessing contraceptives, service providers also appeared to have very different understandings of the law. For example, 44% of surveyed health professionals believed that parental consent was required for all under-18 year olds who tried to access contraceptives. In contrast, 22% thought that there were no parental consent requirements whatsoever for young people seeking access to contraceptives. A further indication of a lack of understanding of the law amongst service providers is that a sizeable minority of respondents (12%) indicated that they simply did not know whether parental consent was required by the law. There was no evidence in the survey data that private and public service providers differed in their understanding of parental consent requirements.

42% of surveyed health professionals thought that, for married couples, **spousal consent** was not required by the law when providing contraception services. However, a sizeable proportion (26%) suggested that the law required them to always seek spousal consent, and the same proportion (26%) thought that spousal consent was required only for access to permanent contraception (e.g. sterilisation).[102] As with parental consent, there was no evidence that private and public providers differed in their understanding of spousal consent requirements.

The qualitative data was largely consistent with this evidence. Service providers expressed a range of views on the circumstances in which they are lawfully able to provide advice and contraceptives to young people. However, one strong pattern among service providers was the perception that it is unlawful to provide contraceptive advice and products to persons under the age of 18 years, unless they are already pregnant / have a baby.

> "The case varies according to whether the young person has a child already. If they have a child already, they can be seen by the ob-gyn, but if they don't have children, we will usually only give them the oral contraceptive pill where it is used to correct a hormonal imbalance, not for contraceptive purposes."

> "As much as possible, we discourage young people from using contraceptives unless they are already mothers and if their parents are amenable and give consent to them having contraceptives, in which case we can administer them."[103]

[102] 6% of respondents did not know the answer.
[103] Individual interview with doctor based at a public health clinic in San Fernando, Pampanga, 29 November 2016

Service providers were generally of the view that it is lawful to administer contraceptive advice and products to young people where they have parental consent; though it was noted that it is highly unlikely that young people will present to a service provider with their parents / parental consent (unless they are already pregnant or have a baby). Among service providers who participated in the research, parental consent was strongly associated with the (legal) concept of parental responsibility (the duties, powers and responsibilities, defined in law, that parents have in relation to their children).

> "Everything happening to a woman or a man under 18 years, you must have their parents' consent. Parents need to take responsibility. Otherwise, who will take responsibility if something happens?"[104]

Service providers involved in the qualitative research tended to believe that spousal consent is not required in order to administer (non-permanent) contraceptives. However, it appears likely that spousal consent, while not considered to be legally required, is strongly encouraged by some service providers.

> *"Do you require spousal consent if a woman is married?*
> Yes, this is needed.
> *Even if they are trying to get the pill?*
> Yes. A woman needs to be with her husband as we have to counsel them…for us to be sure that it is a joint decision, for the girls not to keep it a secret, it should be a joint decision.
> *Would you be able to provide the pill to a woman without her husband's consent?*
> Oh yes, if the girl wants it, it's her decision. But it's good if it's her husband's decision too."[105]

Impact of the law

The quantitative evidence suggests that the law has a direct restrictive impact on the provision of contraception to young people. When asked whether they had ever denied a young person under the age of 19 access to condoms because of the law, more than half (52%) of service providers surveyed for this study indicated that they had done so. 28% also indicated that they had denied a young person access to contraceptive pills because of the law. This is broadly consistent with the qualitative data, in which service providers tended to report denying young people access to contraceptives if they are under 18 years, do not already have a child and / or do not have parental consent.

According to the qualitative data, it appears that service providers in public clinics risk losing their jobs if they violate the laws on providing contraception to under 18s, without parental consent. Private clinics risk being in breach of DoH registration requirements if they do not comply with the law; a condition necessary for them to continue operating. While there was no evidence, in the qualitative data, that public and private clinics differed in their understandings of the law on access to contraceptives, the qualitative data indicated that NGO-run and private clinics are more flexible in their application of the law to young people, and are considered less 'bound' by the legal restrictions.

Religious beliefs of health professionals also appear to play an important role in restricting service provision of contraceptives to young Filipinos. The majority (56%) of service providers

[104] Individual interview with school nurse and midwife at NGO-run sexual health clinic, Metro Manila, 2 December 2016
[105] Individual interview with midwife from a private clinic, Metro Manila, 2 December 2016

suggested that they had denied a young person access to condoms because of their religious beliefs. Thirty-two percent (32%) of respondents also indicated that they had denied young people access to contraceptive pills because of their religion.

Again, this was consistent with the qualitative data: views of service providers appeared to be informed by dominant religious-social norms on pre-marital sex and the use of contraceptives more generally.

> *"Do you sell condoms?*
> No
> *Why not?*
> Because of our name: we are St Joseph's drug store, so we can't really sell condoms.
> But why can't you sell condoms because of your name?
> St Joseph is a saint, so the owners can't sell condoms…the owner doesn't want to provide that kind of service, because he doesn't believe in SRH rights. He advocates only natural contraception."[106]

Service providers appear to enforce their own judgment on the appropriateness of sexual activity among young people when considering the circumstances in which they will permit young people to access contraceptives. In particular, service providers involved in the research tended to have the perception that allowing young people access to contraception will encourage them to have sex (which, outside of marriage, is considered unacceptable).

> "Once I saw a young person coming to the pharmacy to buy condoms. They whispered to me 'can I buy condoms?' I couldn't even hear the sounds coming from their mouth; they were so quiet, so shy. I didn't sell them the condoms because they are too young…I was worried that if I gave them the condoms, they will go and do something."[107]

One public health clinic in Pampanga reported having a team of nurses that 'counsel' young people about abstention when they try to access contraceptives, even where they have parental consent.

> "We are not allowed to give minors contraceptives. Instead of giving them contraceptives, we encourage them, with the help of their parents, to abstain from sex…we will have them counseled by persons tasked to talk about abstention; people based at the regional hospital."[108]

7.1.4 Young people: Knowledge, perceptions and practice

Knowledge and perceptions

A plurality of young people surveyed for this study (42%) thought that, according to the law, only over-18s are allowed access to contraception. A significant minority (14%) also thought that the law only permits over-21s access to contraception (this could reflect the strength of association between 'legitimate' sexual activity and marriage; for which 18 and 21 years are significant ages). Another 10% thought that access to contraception becomes legal for young people 'at puberty', and 7% thought that access to contraception is only legal for married couples.[109]

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[106] Individual interview with pharmacy assistant, San Fernando, Pampanga, 29 November 2016

[107] Individual interview with pharmacy assistant, Metro Manila, 2 December 2016

[108] Individual interview with doctor based at a public health clinic in San Fernando, Pampanga, 29 November 2016

[109] The remaining respondents chose different age thresholds between 11 and 21 years, at any age, when parent of at least one child, or never.

A similar pattern was revealed when looking at young peoples' own opinions about what the law on access to contraception *should say*. Thirty-five percent (35%) of surveyed young people were of the opinion that access to contraception should only be legal at 18 years of age. Fifteen percent (15%) thought that contraception should only be available for over-21s, 9% were of the opinion that contraception should be available *'at puberty'*, and 6% said 'only for married couples'.[110] The data revealed a significant relationship between respondents' likelihood to think the law makes contraception legal at 18 and respondents' likelihood to be of the opinion that contraception *should* be legal at 18 years.

There appears to be a significant amount of uncertainty amongst young people regarding parental consent requirements for accessing contraception. While a large proportion of respondents (32%) thought (correctly) that parental consent was required for all under-18s (similar to the findings from service providers), many respondents also indicated that they 'don't know' (18%) or that parental consent for accessing contraceptives is only required for unmarried individuals regardless of their age (13%). Only 3% of respondents thought there were no parental consent requirements in the law.

According to the qualitative data, young people (and their parents) appeared to think that contraceptives are not available for under-18s, unless they are already pregnant or have a baby, which largely mirrors the perceptions of service providers. Interestingly, some research participants tended to believe that it is unlawful to obtain contraceptives under the age of 18 years, even with parental consent (unless a young person is pregnant / has a baby).

> "Under the age of 18, they can't get contraceptives. They can only get contraceptives over the age of 18. It is against the law.
> Even with their parents' consent, they can't buy condoms because they are under age, they are not legal; they are minors."[111]

Young research participants tended to believe that spousal consent is not a legal requirement for accessing (non-permanent) contraception, but that it is highly desirable for a couple to be in agreement and attend a health clinic together to obtain contraceptives.

Access in practice

Perhaps unsurprisingly, given the legal restrictions and perceptions and interpretations of these legal restrictions among young people and service providers, young people appear to experience significant difficulties accessing contraceptives. Available data has demonstrated that there is a very low rate of contraceptive use among sexually active Filipino youth. According to PDHS data from 2013, while 80.5% of adolescent girls who were unmarried and sexually active reported not wanting a child in the next two years, only 30.5% of them were using a method of contraception to prevent pregnancy. Of those in a union (married or cohabiting) 70.9% reported not wanting a child in the next two years, yet only 45.5% report not using a form of contraception.[112] According to the 2013 Young Adult Fertility and Sexuality Study, 77% of young people reported not having used any form of contraception during their first sexual experience.[113]

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[110] The remaining respondents chose different age thresholds between 11 and 21 years., at any age, when parent of at least one child, or never.

[111] FGD with four parents of adolescents, Metro Manila, 1 December 2016

[112] WHO and Human Reproductive Programme, Adolescent contraceptive use: Data from the Philippines Demographic and Health Survey (2013), available at http://www.who.int/reproductivehealth/adol-contraceptive-use/en/

[113] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, The 2013 Young Adult Fertility and Sexuality Study in the Philippines (2016), p. 90

Our own data found that, of those young people using contraception, condoms were the most common contraceptive method used. Amongst those 103 young people who reported to be sexually active,[114] more than half reported to have tried to access condoms.[115] 20.39% of sexually active young people reported that they had tried to access contraceptive pills, with - perhaps unsurprisingly - girls being significantly more likely than boys to report having tried to access contraceptive pills.[116] The data did not reveal a significant relationship between respondents' age and reported access to contraceptive pills. Only a minority of sexually active young people reported having tried accessing emergency contraception (8.4% of respondents), contraceptive injections (10.7%), implants (6.8%), non-hormonal IUDs (3.9%), and hormonal IUDs (4.9%).

Of young people who reported that they had previously tried to access condoms, 30% were denied access by service providers. Seventy percent (70%) of these respondents in turn indicated that they had been denied access *because of their age*, most of which were 18 years or under (70%). Of those young people who had reported that they had previously tried to access contraceptive pills, 30% were denied access by service providers. The majority of these respondents (63%) in turn indicated that they had been denied access *because of their age*, most of which (68%) were again 18 years or under.[117]

This is broadly consistent with the qualitative data: young people involved in FGDs tended to report that it is unlikely that young people will use contraceptives when they have sex, especially for the first time. According to the qualitative data, legal requirements appear to function as a barrier to young people accessing contraceptives, and this is compounded by the restrictive religious-social norms that stigmatise pre-marital sex. This impacts on SRH health-seeking behaviours of young people by preventing them from attempting to access contraception and also through denial of contraception by service providers.

As noted above, young people tend to believe that it is unlawful for persons aged under 18 years to access contraception – this is the case even where they are attempting to buy condoms from a pharmacy or shop. This appears to be a strong deterrent to young people accessing contraceptives. While it was noted that some young people are able to access condoms through Barangay or NGO outreach programmes, some young research participants reported that the only way they are able to access contraceptives (condoms) is by asking an older friend to buy them from a pharmacy or store.

> *"Where do young people get condoms?*
> From the 7-11 or pharmacy.
> *Do young people get refused condoms because they are too young?*
> If you are under 18, you can't buy condoms, but if you have a friend who is over 18, then you can ask the friend to buy the condoms for you."[118]

[114] 'Sexually active' respondents are those respondents who indicated that they had previously had sex. Respondents who preferred not to answer the question were coded as sexually inactive.

[115] T-test, $p < 0.05$. However, the difference between older and younger respondents in relation to their service seeking behaviour disappears when looking only at sexually active respondents.

[116] Chi-square test, $p < 0.05$

[117] This section only examines denial of access to condoms and contraceptive pills. Given the small number of respondents (<20) who reported trying to access other types of contraception (including emergency contraception), denial of access to these services was not further analysed using the quantitative survey data.

[118] FGD with four young women who have been pregnant, San Fernando, Pampanga, 30 November 2016

The law also appears to reinforce social stigma: a strong pattern from the qualitative research was that the young research participants appear to have internalized dominant social norms that stigmatise pre-marital sexual activity and sex under the legal age of marriage. They reported feeling 'embarrassed' or 'ashamed' of having sex 'underage' and / or outside of marriage, and this is a clear deterrent to them accessing contraceptives. Young people reported fear of being judged by service providers and, in the case of shops and pharmacies, by other customers and onlookers.

> "The hindrance is that you are not confident to go to the public clinic to get a condom, especially when you have neighbours who might see you. So we have no guts to go to the health centre. People will judge you if they see you in the health centre getting condoms."[119]

> "No one will go to the clinic if they are under 18 to ask for a condom or pills and say 'hey nurse, can you give me some condoms or pills?' because it'd be embarrassing and we would be judged."[120]

> *"Is it strange that you've never had a minor come in (who doesn't already have a baby)?*
> I don't know. Based on my experience, maybe it's because they are shy to ask about contraceptives.
> *Why are they shy?*
> Because they are minors and they have lovers already. They are shy about this."[121]

Another significant barrier, particularly in a context in which pre-marital and 'underage'[122] sex is heavily stigmatized, is the legal requirement for persons aged under 18 years to get parental consent before they are able to access contraceptives. The general social stigma surrounding pre-marital sex and sex under the legal age of marriage appears to have fueled a culture of silence on youth sexuality, in which it is unacceptable and deeply embarrassing for parents to engage in conversations with their children about sex and sexual health.

> *"Do you talk to your children about sex and sexual health?*
> [Loud laughter] no, no, no.
> We talk to our peers, friends; but our children? No! We don't talk about sex with them!
> *Why not?*
> It's bad. We feel awkward to talk about sex with our children.
> My son asks me about sex, and I divert his attention so that he stops talking about it.
> When my child reaches the legal age, then he will realize himself how to do it.
> One of my children asked me how she was made. I was embarrassed. I said: 'you came out of my anus' [laughter]"[123]

> "Culture makes it very awkward for parents to talk about sex. It is very taboo in our country."[124]

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[119] FGD with four young women who have been pregnant, 18 – 24 years, San Fernando, Pampanga, 30 November 2016
[120] FGD with four girls, 15 – 16 years, San Fernando, Pampanga, 29 November 2016
[121] Individual interview with nurse from a public health clinic, San Fernando, Pampanga, 29 November 2016
[122]
[123] FGD with four mothers of adolescents, San Fernando, Pampanga, 30 November 2016
[124] KII with Adolescent Health Coordinator, Department of Health, Metro Manila, 5 December 2016

In this context, having a parental consent requirement as a condition for young people (aged under 18) to access contraception is a strong barrier to access, as illustrated by the excerpts below.

> "The parental consent requirement restricts access by acting as a deterrent to the health-seeking behaviour of young people. No 15 year old would approach their parents and tell them that they are sexually active and 'can you help me access condoms?' Because their parents will freak out and will not allow the kid to get condoms."[125]

> *"Can you ask your parents for permission to use contraceptives?*
> No, they will get angry. The first thing that will come to their minds is that 'we are going to have sex and going to do bad things'. Having sex under 18 is not applicable in our culture."[126]

The stigma against pre-marital sex and sex under the legal age of marriage is heightened among certain groups of young people, notably girls and LGBT young people. As noted above, girls face more stringent social expectations around pre-marital sex, and this may compound feelings of embarrassment, acting as a strong deterrent to accessing contraceptives (and getting parental consent to do so).

> "It's embarrassing for a women to go into the clinic to get contraceptives; our dignity will go down. It is not dignified.
> *What about for boys?*
> For boys, they don't feel embarrassed."[127]

> *"Do health clinic staff judge LGBT young people?*
> "I'll feel like I'm being judged....
> For lesbian and gay young people, they are not too judged. But if a girl wanted contraceptives, she would be judged."[128]

It is also worth noting that, because young people are not 'supposed' to be having sex, particularly those under 18 and those who are not married, sexual health services do not appear to cater to young people; health centres are generally not 'youth friendly' as they are not supposed to be serving this group. According to the qualitative research, sexual health services appear to aim at providing 'family planning' advice and products to married couples to help them space their children and control the number of children that they have. The lack of SRH services aimed at young people also appears to create a barrier to access for young people (unless, of course, they are already pregnant / have a child).

According to the qualitative research, the lack of access that young people have to sexual health advice and contraceptives unsurprisingly results in unhealthy and risky sexual behaviours, such as having unprotected sex and reusing condoms.

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[125] KII with Commissioner, National Youth Commission, Metro Manila, 28 November 2016
[126] FGD with eight young women, 17 – 22 years, Metro Manila, 1 December 2016
[127] FGD with four girls, 15 – 16 years, San Fernando, Pampanga, 29 November 2016
[128] FGD with four LGBT young people, San Fernando, Pampanga, 29 November 2016

Impacts of lack of access to contraceptives: qualitative data

"I know someone who is 15 years old. She sells sex. She went to the pharmacy to buy condoms, and she was denied them, because she is only 15. So they continued the sex without the condom."[129]

"I was 18 years old and I went to a clinic to get the pill. I got denied it. They said that they can only give pills to those aged 19 years and above. It was the first time that my boyfriend and I had sex. So I tried to buy some condoms at a pharmacy, but I was also denied so I just walked out. I didn't end up getting any contraceptives, even condoms."[130]

"There are cases of boys recycling condoms – using them on one girl, then another. They do this because they are ashamed to buy condoms. They don't know the procedure. Don't know how to use condoms properly. Don't know that they are disposable."[131]

Cost is another barrier to accessing some forms of contraceptives; a finding that was particularly associated with young people who sell sex. According to the qualitative data, for registered sex workers in Angeles, condoms are provided free in the entertainment bars (unregistered sex workers - particularly those aged under 18 - are extremely vulnerable and face significant additional barriers in accessing SRH services; this is discussed below). However, they are required to pay for other forms of contraception. As a result, sex workers may not access other forms of contraception. According to the data, sex workers do not necessarily insist on their clients using condoms, as clients may not want to use them and may offer more money for sex without a condom.

"Do clients have a problem with using condoms?
You can use a condom or not, it depends on you.
Do you use other types of contraceptives?
No.
No.
[shaking heads]
Why not?
Condoms are the only free contraceptives. I've stopped using other types of contraception."[132]

"Most clients of sex workers don't want to use condoms as they don't feel the penetration."[133]

"They [sex workers] would rather get more money because the clients want to bareback. They would rather risk their health for more money. It doesn't necessarily mean they're poor; they would just rather get more money."[134]

Lack of access to affordable contraception therefore puts young people who sell sex at significant risk.

[129] FGD with eight young women, 15 – 18 years, Metro Manila, 1 December 2016
[130] FGD with eight young women, 15 – 18 years, Metro Manila, 1 December 2016
[131] FGD with six young men, 16 – 18 years, Metro Manila, 1 December 2016
[132] FGD with four young women who sell sex, Angeles City, Pampanga, 30 December 2016
[133] Individual interview with two sexual health nurses, Angeles City, Pampanga, 30 December 2016
[134] Individual interview with Coordinator, Community-Based HIV Screening Centre, Metro Manila, 5 December 2016

7.2 Access to sterilisation

7.2.1 Legal review

Female sterilisation has been available in the Philippines as a form of permanent contraception since 1976, following a presidential decree amending the *Philippine Medical Care Act 1969*.[135] Sterilisation falls under the definition of 'modern methods of family planning' (Section 4(l). As such, the law regulating young people's independent access to non-permanent contraception also applies to sterilisation services. However, the 2014 *Philippine Clinical Standards Manual on Family Planning* provides further guidelines ('soft law') about when sterilisation is appropriate; and service providers are 'encouraged to use these tools as a guide in determining the suitability of clients.'[136]

The *Manual* states that service providers should exercise 'caution' before performing sterilisation on patients of a young age (which applies to female and male sterilisation), but it does not set a specific age threshold below which sterilisation is not recommended.[137] The *Manual* also does *not* establish a requirement for women to have had a certain number of children. Rather, it emphasises the importance of allowing each woman (or man) to decide for themselves whether they want to undergo the procedure.[138]

The guidelines (in the 2014 Manual) relating to both male and female sterilisation state that spousal involvement is required by service providers in order to undergo the procedure.[139] The section on male sterilisation also references the RHA as requiring spousal consent.[140] In relation to the provision of sterilisation procedures for adolescents, the Manual advises service providers to use these methods 'with caution', and advises service providers to provide counselling to adolescents on the availability of other methods that provide safe, long-term, but reversible contraception.[141] Sterilisation is thus a highly discouraged procedure that is nonetheless legally available to Filipino young people.

7.2.2 Knowledge, perceptions and practice

According to the qualitative data, research participants tended to believe that, if a person is over the age of 18 years, they will be able to access sterilisation, but only after they have had a certain number of children (usually three). Some perceived this requirement as being a law; for others, it was recognised as a requirement of their local health centre.

> *"What about sterilisation? Can this be provided to young people?*
> No, even if she is 18.
> In the hospital, even if you are of age and deliver one child, if you want to have sterilisation, they will not do the procedure if you only have one child.
> *Why not?*
> Because you only have one child.

[135] EngenderHealth (2002) Contraceptive Sterilisation: Global Issues and Trends, Available at: https://www.engenderhealth.org/files/pubs/family-planning/factbook_chapter_4.pdf (Last access 8 November 2016), p 100.
[136] *Philippine Clinical Standards Manual on Family Planning* (2014), http://www.doh.gov.ph/sites/default/files/publications/FPCSM_2014.pdf (Last access 8 November 2016), p. 185.
[137] *Philippine Clinic Standards Manual on Family Planning* (2014) Available at: http://www.doh.gov.ph/sites/default/files/publications/FPCSM_2014.pdf (Last access 8 November 2016), p 185-187, 199.
[138] *Philippine Clinic Standards Manual on Family Planning* (2014), p 193, 204.
[139] *Philippine Clinic Standards Manual on Family Planning* (2014), p.194, p.204
[140] *Philippine Clinic Standards Manual on Family Planning* (2014), p. 204.
[141] *Philippine Clinic Standards Manual on Family Planning* (2014), p 212.

So it's not about the age, but the number of children you have?
If you have at least three children, you can go for the procedure; but if not, the doctor won't do it. This is the law."[142]

Service providers who were interviewed tended not to frame the delivery of sterilisation services in terms of the law. The decision to recommend or provide ligation appears to be made by research participants by applying the regulations of the health centre, and/or their own judgement, based on what is considered the desirable number of children a woman has, rather than her age (it was noted that ligation is far more 'popular' than vasectomy). This tended to reinforce social expectations that women will have a reasonably large family (at least three children).

"What about ligation? In what circumstances do you provide this?
For those who have many children already.
What is 'many'?
4, 5, 6, 8
If someone had only one child and wanted ligation, would you recommend it?
No. Maybe in time, they will regret the decision but they will already be ligated. So we don't recommend it."[143]

"If there is a case of an 18 or 20 year old who already has three children, if she wants sterilisation so bad, I'd do counselling and test her with scenarios to test her decision. If the girl is very decided, it's her decision so I'd let it be."[144]

In practice, it appears that sterilisation services are not easily accessible in the research locations. For example, only one of the 50 service providers surveyed for this study indicated that they provided sterilisation services.[145] Furthermore, the quantitative data suggest that Filipino adolescents rarely seek access to sterilisation services.

7.3 Access to STI and HIV testing and treatment

While the Philippines is considered a 'low-HIV-prevalence' country, it is also one of only seven countries globally where, according to UNICEF, the number of new HIV-positive cases has increased by over 25% from 2001 to 2009.[146] In 2016, 97% of newly diagnosed HIV cases were male, with more than half belonging to the 25-34 age group and 27% to 15-24 age group.[147] The HIV epidemic is largely concentrated in the Metro Manila Region (though there are also significant concentrations in several other regions) and amongst younger population groups with specific risk behaviours, such as those engaging in unprotected male-to-male sex, transactional sex and intravenous drug use.[148]

7.3.1 Legal review

As mentioned earlier, Section 7 of the RHA articulates a parental or guardian consent requirement for minors (i.e. under-18s) who want to access 'modern methods of family

[142] FGD with four mothers of adolescents, San Fernando, Pampanga, 30 November 2016
[143] Individual interview with midwife at a private clinic, Metro Manila, 2 December 2016
[144] Individual interview with nurse at a public clinic, Metro Manila, 2 December 2016
[145] Though it should be noted that 10% of survey respondents were pharmacies and 16% were school-based health clinics, which would of course not be expected to perform sterilization.
[146] https://www.unicef.org/philippines/hivaids.html#.WJM_8dKLQdU [accessed 02.02.16]
[147] http://www.doh.gov.ph/sites/default/files/statistics/EB_HIV_Mar-AIDSreg2016.pdf [accessed 02.02.16]
[148] https://www.unicef.org/philippines/hivaids.html#.WJM_8dKLQdU [accessed 02.02.16]; http://www.doh.gov.ph/sites/default/files/statistics/EB_HIV_Mar-AIDSreg2016.pdf [accessed 02.02.16]

planning' in the Philippines. According to the definition of 'modern methods of family planning' provided in Section 3(l)) of the RHA, this consent requirement does *not* apply to young people who want to access HIV testing or STI testing.

Young people's access to HIV testing is also regulated by the Act Promulgating Policies and Prescribing Measures for the Prevention and Control of HIV/AIDS in the Philippines, Instituting a Nationwide HIV/AIDS Information and Educational Program, Establishing a Comprehensive HIV/AIDS Monitoring System, Strengthening the Philippine National AIDS Council, and for Other Purposes, 1998 ('the HIV/AIDS Act'). According to this Act, persons may consent to HIV testing if they are 'of legal age' or if they have obtained parental consent (in the case of a 'minor'). The Act does not contain a definition of 'legal age' or 'minor'; however, the Act should be interpreted in line with the age of majority in the Family Code of the Philippines (which is 18 years).

A Bill before Parliament, the *Revised Philippine HIV and AIDS Policy and Program Act of 2012 (HIV Bill)*, proposes lowering the age at which young people can consent *independently* to HIV testing to 15 years if certain 'maturity' criteria are met. For young people between 15 and 18 years old, these 'maturity' criteria include: whether the person expresses an intention to submit to a test, whether reasonable attempts have been made to obtain the consent of the parents, and whether s/he is at higher risk of HIV according to Section 3(O) of the HIV Act..

In contrast to HIV testing, there do not appear to be any laws or policies that explicitly regulate young people's access to STI testing in the Philippines. It appears that STI testing 'slips between the cracks' of the HIV Act and the RHA, as it is not mentioned explicitly in either.

7.3.2 Service providers: Knowledge, perceptions and practice

Availability of services

The overwhelming majority of service providers surveyed for this study did *not* provide HIV testing (80% of service providers) and STI testing (82%). Service providers who did not provide HIV testing were also significantly less likely to provide STI testing.[149] Public providers were found to be significantly more likely than private providers to provide HIV and STI testing.[150] None of the health professionals that provided HIV and STI testing were located in rural areas.[151]

However, according to service providers involved in the qualitative research, health clinics tend to refer clients to specialised 'hygiene clinics' for HIV and STI testing, so the survey results may not provide a good indication of service availability for HIV and STI testing in the research locations.

Knowledge

The overwhelming majority (64%) of surveyed health professionals (correctly) reported that HIV testing is only legally available to those aged 18 and above. 16% of service providers thought there are no legal restrictions on young people's access to HIV testing.

[149] Chi-square test, $p < 0.01$

[150] Chi-square test, $p < 0.05$. This test only compared public and private providers. School health centres, specialised SRH clinics, pharmacies and hospitals were excluded.

[151] Note: the survey is not nationally representative and was only conducted in Quezon City and Pampanga.

Service providers' understanding of the law regulating young people's access to STI testing appears to be relatively limited. Fifty-six percent (56%) incorrectly thought that STI testing is only legally available to young people at the age of 18, even though the law appears to be mute on this point. Twenty-eight percent (28%) in turn thought that STI testing services are legally available 'at puberty' and only 12% of service providers correctly thought that there are no legal restrictions on access to STI testing.

Regarding parental consent requirements for HIV testing, the majority of service providers (52%) identified (correctly) that parental consent is required for under-18s. However, a significant minority (16%) of surveyed health professionals also thought that there are *no* parental consent requirements for young people seeking access to HIV testing.[152]

Service providers' view on parental consent requirements for STI *testing* was a bit more uncertain, which may be reflective of the lack of explicit legal provisions on this matter. Even though a significant proportion (48%) again thought that parental consent is required for all under-18s, a large minority (12%) indicated that they 'don't know' what the law says about parental consent for STI testing. Eighteen percent (18%) in turn thought that parental consent is required for all *unmarried* persons (regardless of age).

Most service providers appear to think that spousal consent is not required for married persons seeking access to STI and HIV testing. Sixty-two (62%) of service providers thought that are *no* spousal consent requirements for married individuals accessing HIV testing (58% for STI testing), in line with the law, which appears to be mute on this point. Thirty-six percent (36%) incorrectly thought that they always need to seek spousal consent *before* testing married individuals' HIV status (36% for STIs). Service providers who thought that spousal consent is required before HIV testing were significantly more likely to think that spousal consent is also required before STI testing.[153]

Denial of access

Of those health professionals who provided HIV testing, only 30% indicated that they had previously denied this service *because of the law*,[154] and only 10% indicated that they had previously denied this service *because of their religion*.[155] Of those health professionals who provided STI testing, only 33% indicated that they had previously denied this service *because of the law*,[156] and 22% indicated that they had previously denied this service *because of their religion*.[157]

According to the qualitative data, service providers tended to identify that persons aged under 18 years require parental consent before they are able to carry out HIV or STI testing and treatment. This was the case across public, private and NGO-run clinics; however, NGO-run clinics appear to be more flexible in their application of the law (and will, it appears, allow STI and HIV testing of under-18s in practice, without parental consent), believing that no penalties will be applied if they are 'found out.'

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[152] 10% thought the legal threshold is 17 and 8% thought parental consent was required for unmarried individuals regardless of their age. Other answer options were chosen by less than 4% of respondents.

[153] Chi-square test, $p < 0.01$

[154] 60% *never* denied access because of the law, and 10% preferred not to answer the question.

[155] 80% *never* denied access because of their religion, and 10% preferred not to answer the question.

[156] 56% *never* denied access because of the law, and 11% preferred not to answer the question.

[157] 78% never denied access because of their religion.

> *"Are there any limits on the services that you can provide to young people?*
> The only cases [involving under 18s] that have been referred have been STI cases. But we will give the services regardless of age. I ask the programme officers: 'are we safe to give services to young people?' They say, in the law, only public providers are unable to give services to young people. And there is no punishment anyway, no fine."[158]

It was reported that some clinics would evade parental consent requirements by obtaining the proxy consent of a social worker, particularly for at risk individuals for whom it may be harmful to seek parental consent.

> "With HIV, there is a strict age wherein you can get tested. But what other more progressive clinics can do is that they push for testing minors anyway, because there are no penalties in the law. Whoever wrote the law did not put in penalties. Some are more brave and just say, 'let's get this kid tested. We don't care. We won't get jailed anyway.' As for other things, they find loopholes, like getting the consent of a social worker instead of parent. Especially if the particular kid is high risk – engaging in sex work or being raped, where getting parents' consent will be detrimental to the child's safety or health. There are some clinics that do this but not all."[159]

7.3.3 Young people: Knowledge, perceptions and experiences

Knowledge and perceptions

Young people's understanding of the law regulating access to HIV and STI testing appears to mirror service provider's understanding of the law. For example, a significant proportion (43%) of surveyed young people correctly identified that independent access to HIV testing is only legal for over-18s. The same proportion (43%) thought that this age threshold also applies to STI testing. A relatively large minority of young people also thought that individuals need to be older than 21 years in order to legally access HIV testing (12%) and STI testing (15%).[160]

The quantitative data revealed that young people's understanding of parental consent requirements for accessing HIV is somewhat limited. While 30% of respondents identified (correctly) that parental consent was always required for under-18s accessing HIV testing, another 22% indicated that they *don't know* about parental consent requirements for HIV testing.

This pattern was mirrored for young people's understanding of parental consent requirements for STI testing. Again, a large proportion (25%) of respondents understood 18 years to be the relevant legal threshold. Twenty-two percent (22%) of respondents in turn indicated that they *don't know* what the law says about parental consent requirements for STI testing.[161] Only 1% of respondents correctly indicated that there are no (explicit) parental consent requirements in the law regulating access to STI testing.

Experiences

Twelve percent (12%) of young people surveyed for this study indicated that they had previously tried to access HIV testing services. The data did not reveal significant differences

[158] Individual interview with sexual health nurse, NGO-run clinic, San Fernando, Pampanga, 5 December 2016
[159] Individual interview with Coordinator, Community-Based HIV Screening Centre, Metro Manila, 5 December 2016
[160] Other answer options were only chosen by less than 10% of respondents.
[161] Other answer options were only chosen by less than 12% of respondents.

between girls and boys in relation to their reported HIV-related service-seeking behavior.[162] Neither did the data reveal significant differences between young people living in rural and urban areas.[163] Perhaps unsurprisingly, respondents *over* the age of 18 were significantly more likely to report having tried to access HIV testing than respondents under the age 18 years.[164]

Only 4% of respondents reported that they had previously tried to access STI testing. As with HIV testing, the data did not reveal differences between girls and boys in relation to their reported STI service-seeking behavior.[165] Interestingly, respondents under the age of 18 were found to be more likely than those over 18 to have tried to access STI testing.[166]

Denial of access

Around half (49%) of young people who had tried to access HIV testing also reported having been denied access to this service. Eighty percent (80%) of these young people thought that they had been denied access to HIV testing *because of their age*, which is not surprising, as more than half of these respondents were under the age of 18.

The overwhelming majority (76%) of respondents who had tried to access STI testing also reported having been denied access to this service. All of these young people in turn thought that they had been denied access to STI testing *because of their age*. Eighty-five percent (85%) of these respondents were under the age of 18, which, together with service provider's dominant understanding of the law (see above), helps to explain the high rate of service denial found amongst young people trying to access STI testing.

Research participants involved in the qualitative data did not tend to report experiences of young people accessing STI and HIV testing. However, the data did indicate that unregistered (young) sex workers in Angeles are a particular group that face barriers in accessing testing and treatment (registered sex workers are required to have regular STI and HIV screening). While, in some parts of the country such as Angeles, sex work forms a significant part of the economy and is somewhat accepted and formalized, it nonetheless appears to be stigmatized, and this can create a barrier to unregistered sex workers ('freelancers') accessing STI and HIV testing.

> "If you're a 'freelancer', you don't have a registration card; they don't come for check-ups. They are afraid of being stigmatized. They are afraid of knowing that they have infections…they are afraid to go for a smear because, if they will be found to have an infection, they won't be able to work…Sometimes they have 'self-stigma' and think that the STIs are coming from being a sex worker. They think because they are a sex worker they're expected to get STIs."[167]

7.4 Privacy and confidentiality

7.4.1 Legal review

In a context in which pre-marital sexual activity and sex under the legal age of marriage is heavily stigmatised, laws guaranteeing patient privacy and confidentiality for SRH service provision are paramount. Individuals in the Philippines have a constitutional right to privacy

[162] Chi-square test; $p > 0.05$
[163] Chi-square test; $p > 0.05$; note that the survey is not nationally representative
[164] Chi-square test; $p < 0.05$
[165] Chi-square test; $p > 0.05$
[166] Chi-square test; $p < 0.05$
[167] Individual interview with sexual health nurse, NGO-run clinic, San Fernando, Pampanga, 5 December 2016

(Article 3(3)), and the country has one of the most stringent Data Privacy Acts in the region (2012). Confidentiality within the context of access to health care is not explicitly mandated in primary legislation (with the exception of the HIV/AIDS Act 1998), which may create uncertainty for young people seeking confidential access to contraceptive services, as they cannot trust that service providers will keep their interactions confidential. While the *Philippines Clinical Standards Manual for Family Planning* states that adolescents must be assured that family planning counselling sessions and visits are confidential, the *Manual* was published before the RHA, and it is unclear whether it still embodies the most up-to-date guidance for service providers.[168] Other guidelines – published before and after the RHA - also highlight the importance of adolescents' confidentiality in health care settings,[169] but it is unclear whether the guidelines only cover counselling and advice, or whether they encompass adolescents' access to contraceptive services. In addition, rights to privacy and confidentiality and data protection exist in guidelines followed by major hospitals and other health entities, such as accreditation bodies and specialist medical bodies. It is noted that a Bill before Parliament, the Magna Carta of Patients' Rights and Obligations (2013) includes a comprehensive provision setting out the right to privacy in health settings.

It is also worth noting, of course, that parental consent requirements (detailed above) also function to deny confidential access to SRH services to those aged under 18 years.

Child protection laws and obligations are also relevant to privacy and confidentiality, as they may require service providers to disclose to the authorities cases in which they believe children to be at risk (e.g. of sexual abuse or exploitation). Particularly where these reporting obligations are mandatory, adolescents may be 'put off' accessing services where they fear their confidentiality will be breached against their wishes, even if the purpose of the reporting is to ensure they are protected from harm. According to the Republic Act 7610 Special Protection of Children against Abuse, Exploitation and Discrimination Act Implementing Rules and Regulations, persons may report a belief that a child has suffered abuse to the DSW, Police or Barangay Council for the Protection of Children. Particular professionals have *mandatory* reporting obligations, including health professionals and institutions. An Executive Order issued by the Department of Justice in 2011 elaborates reporting obligations for particular professionals in cases of child abuse, neglect and exploitation.[170] According to this Order, health professionals (including Heads of public and private hospitals and health clinics and attending doctors and nurses) have a mandatory obligation to report cases of child abuse and exploitation to the Department of Social Welfare. Failure to report attracts a criminal sanction (a fine or other disposition).[171] The obligation applies to cases of child abuse and exploitation, including to persons under the age of 18 years who are involved in prostitution.

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[168] *Philippine Clinic Standards Manual on Family Planning* (2014) Available at: http://www.doh.gov.ph/sites/default/files/publications/FPCSM_2014.pdf (accessed 10 November 2016), p 15.

[169] The *National Policy and Strategic Framework on Adolescent Health and Development* - published after the RHA - emphasizes respect for adolescents' right to privacy in the context of health counselling and advice sessions as a guiding principle. The *National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services* - published before the RHA - considers privacy and confidentiality as crucial elements to ensuring adolescents' comfort and ease at health facilities. Guidelines in this document mention the importance of privacy in client registration forms, filing, record storage, access to records and clinic set-up.

[170] Department of Justice, Executive Order Number 53, *Strengthening the Committee for the Special Protection of Children* (2011)

[171] Department of Justice, Executive Order Nu mber 53, *Strengthening the Committee for the Special Protection of Children* (2011); Department of Justice, Committee for the Special Protection of Children, Protocol for case management of victims of abuse, neglect and exploitation (2013), available at: https://www.doj.gov.ph/files/transparency_seal/2016-Jan/CPN-CSPC%20Protocol%2026Nov2014.pdf

7.4.2 Confidentiality in practice

Young people appear to have limited understanding of confidentiality, which may be unsurprising given the uncertainty fostered by the laws and regulations. According to the quantitative data, the majority of young people (41%) indicated that health professionals can inform parents *against* a young people's wishes if they are under the age of 18 and try to access contraceptives. Only 10% thought that service providers could *under no circumstances* inform parents against young people's consent. 10% of respondents stated that health professionals are not mandated by law to provide confidential access.

These understandings of the law relating to confidentiality are likely to operate as a significant barrier. Given the stigma associated with and pre-marital sex and sex under the legal age of marriage, young people may be 'put off' accessing SRH services where they fear that the service providers will not be able to guarantee their confidentiality. A perception that service providers may breach confidentiality will inevitably have a disproportionate impact on groups of young people that are stigmatized, including LGBT young people, or for whom sexual activity is particularly stigmatized (girls).

Despite the apparent confusion amongst young people about the law on parental consent and confidential access to contraception, most young people appear to think that, in practice, health professionals will keep their information confidential. Thirty-eight percent (38%) thought that service providers would always keep their information confidential if they tried to access contraception, and 26% thought that their information would remain confidential 'except when they are at risk'. Only 10% thought that their information would not remain confidential and 25% said that they were unsure as to whether their information would be kept confidential.

7.4.3 Impact of reporting obligations

Service providers appear to have a variety of understandings of their reporting obligations, as illustrated in the following excerpts from interviews with service providers.

> *"Are there any cases in which you'd make a child protection referral if a young person came to you and reported sexual violence?*
> I would report it [to the Barangay official or the police].
> *Even if they asked you not to? Do you have an obligation to report it anyway?*
> Yes – it is the right of the child to be protected."[172]

> *"What about in a child protection situation? Say where you thought they were being abused?*
> We haven't had cases like this so far, but if we did, we would advise them to report it, but we wouldn't feel we had to report it if they didn't want us to."[173]

> *"Do you have an obligation to report when you suspect that a child is being abused or is at risk?*
> Yes, I have to report it, even if they don't want me to.
> *What about young people having sex under 12, is that a child protection issue regardless of the circumstances?*

[172] Individual interview with Community Health Worker, Metro Manila, 2 December 2016
[173] Individual interview with midwife at a private health centre, Metro Manila, 2 December 2016

> Yes, I think I have to report this to the school guidance counsellor. They will refer this to Department of Social Welfare."[174]

As illustrated in the last quote above, it is possible that service providers may perceive that they have an obligation to report all cases of children engaging in sexual activity under the age of sexual consent. According to quantitative data, most service providers believe they will face sanctions if they fail to report a case of a child having sex under the age of sexual consent (12 years). The overwhelming majority (80%) of surveyed service providers thought that failure to report sexually active under-12 year old boys and girls to the authorities would result in some form of negative sanction (either criminal conviction, revocation of their licence, or a financial penalty). Only 20% of surveyed service providers thought that 'nothing at all' would happen if they failed to report sexually active under-12 year old girls or boys to the authorities.

Losing permission to practice was the most frequently mentioned sanction for failure to report. 50% of respondents indicated that they risked losing their jobs if they failed to report a sexually active boy under the age of 12 to the authorities. Forty-four percent (44%) of surveyed service providers thought that failure to report an under-12 year old sexually active girl would entail job loss. Service providers who thought they would risk losing their job when failing to report a sexually active under-12 year old girl were also found to be significantly *more* likely to think that they would risk losing their job when failing to report a sexually active under-12 year old boy.[175] A smaller proportion of surveyed service providers thought that they would risk going to jail for failing to report sexually active girls (22% of respondents) and boys (28%).

Ten percent (10%) of surveyed service providers indicated that they had previously reported a girl to the authorities because they learnt that she was sexually active under the age of 12 (i.e. the age threshold established by the Philippine's statutory rape law). Fourteen percent (14%) also indicated that they had reported a boy for the same reason.

While child protection reporting is crucial for ensuring that children are protected from abuse, (perceptions of) service providers' reporting obligations can function as a barrier for young people in seeking SRH – and other – services. Children may be discouraged from seeking SRH services if they are in a situation that they fear may be interpreted as abusive by service providers, and for which they do not wish to be reported to the authorities. Also, it is possible that service providers, concerned about the consequences of failing to report, may feel obligated to do so even where this may not be in the best interests of the child.

> "If you are a nurse and learn of child who sought your services, you are liable. This is a barrier. Their license is something nurses care about – they worked hard to get it and to have it removed for not reporting one case would be too much for them…This is a problem. Even if they need a social worker, children do not go to see them, as they will get reported and go into protective custody and they don't want to."[176]

According to the qualitative data, it is likely that young people who sell sex face significant barriers in accessing services, due to the requirement of service providers to make a child protection referral in relation to any person under the age of 18 years who is engaged in sex work.

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[174] Individual interview with school nurse and midwife at an NGO-run clinic, Metro Manila, 2 December 2016

[175] Chi-square test, $p < 0.01$

[176] KII with HIV Programme Officer at UNICEF and the and HIV/AIDS and Adolescent Health Focal Person at the Council on the Welfare of Children, Department of Social Welfare and Development, Manila, 6 December 2016

> "Do you report anyone under 18 who does sex work, or does it depend on the circumstances? What if they don't want you to refer the case?
> Anyone under 18 gets referred to the VAWC [police violence against women and children counsellors].
> What if a young person who is a sex worker comes to you to access services and they don't want to disclose that they are prostitute?
> We can't accept under 18s."[177]

Knowing that they will 'automatically' be referred to the police or other authorities is likely to deter those aged under 18 years who sell sex from accessing SRH services.

7.5 Access to abortion

7.5.1 Legal review

Abortion has been criminalized in the Philippines for over a century; the penal provisions relating to abortion were written during US occupation. The law concerning abortion is found in the *Revised Penal Code of 1930*, in the Chapter entitled 'Crimes against Persons,' Section Two on 'Infanticide and Abortion.' Article 256 states that anyone who causes 'intentional abortion' will be punished with imprisonment of varying degrees, depending on whether the abortion was carried out with violence, with or without consent.[178] Health professionals who perform abortion services with the consent of the pregnant person are subject to up to six years' imprisonment and potential suspension of their professional license, and a woman who performs an abortion on herself to 'conceal her dishonour' attracts the minimum penalty.[179]

There are no legal exceptions to the prohibition of abortion in the Revised Penal Code. In jurisdictions where there is such a blanket prohibition, some legal scholars have suggested that the criminal law defence of 'necessity' applies, which would allow abortion to save the life of a pregnant person.[180] The general criminal law principle of 'necessity' is enshrined in Article 11(4) of the Revised Penal Code. However, as a 2010 report from the Centre for Reproductive Health observes, 'there is nothing definitive in the law, or in any policy, regulation, or case law that

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[177] Individual interview with two sexual health nurses, sexual health clinic, Angeles City, Pampanga, 30 November 2016

[178] Revised Penal Code of the Philippines (1930), Available at: http://www.un.org/Depts/los/LEGISLATIONANDTREATIES/PDFFILES/PHL_revised_penal_code.pdf (Last access 7 November 2016), Articles 256 - 259: *Art. 256. Intentional abortion. — Any person who shall intentionally cause an abortion shall suffer: 1. The penalty of reclusion temporal, if he shall use any violence upon the person of the pregnant woman. 2. The penalty of prision mayor if, without using violence, he shall act without the consent of the woman. 3. The penalty of prision correccional in its medium and maximum periods, if the woman shall have consented Art. 257. Unintentional abortion. — The penalty of prision correccional in its minimum and medium period shall be imposed upon any person who shall cause an abortion by violence, but unintentionally. Art. 258. Abortion practiced by the woman herself of by her parents. — The penalty of prision correccional in its medium and maximum periods shall be imposed upon a woman who shall practice abortion upon herself or shall consent that any other person should do so. Any woman who shall commit this offense to conceal her dishonor, shall suffer the penalty of prision correccional in its minimum and medium periods. If this crime be committed by the parents of the pregnant woman or either of them, and they act with the consent of said woman for the purpose of concealing her dishonor, the offenders shall suffer the penalty of prision correccional in its medium and maximum periods. Art. 259. Abortion practiced by a physician or midwife and dispensing of abortives. — The penalties provided in Article 256 shall be imposed in its maximum period, respectively, upon any physician or midwife who, taking advantage of their scientific knowledge or skill, shall cause an abortion or assist in causing the same. Any pharmacist who, without the proper prescription from a physician, shall dispense any abortive shall suffer arresto mayor and a fine not exceeding 1,000 pesos.*

[179] Women on Waves (no date) Philippines: Abortion Law, Available at: http://www.womenonwaves.org/en/page/4889/phillippines--abortion-law (Last access 7 November 2016). - *This source was used to determine the penalties for abortion offenses due to the difficulty in reading the online copy of the Revised Penal Code.*

[180] Women on Waves (no date) Philippines: *Abortion Law,* Available at: http://www.womenonwaves.org/en/page/4889/phillippines--abortion-law (Last access 7 November 2016).

confirms the existence of such an exception. Consequently, there is a lack of clarity regarding the circumstances under which an abortion may be legally performed or be considered legally justifiable.'[181]

Estimates suggest that over half a million women in the Philippines try to terminate pregnancies in an unsafe manner every year, and in 2008 alone it was estimated that the ban on abortion was responsible for the deaths of at least 1,000 women who died as a result of complications during 'unsafe abortions'.[182] Young women are more vulnerable to unintended pregnancy and, thus, unsafe abortion for a combination of reasons, including a lack of sexuality education and difficulties accessing contraceptives.[183]

It is noted that the DoH issued a 'National Policy on the Prevention and Management of Abortion Complications' in November 2016. The Policy sets out rights, entitlements and standards of care for women and girls suffering abortion complications, providing that they are 'entitled to humane, non-judgmental and compassionate post-abortion care' and that 'no woman or girl shall be denied appropriate care and information on the ground that she is suspected to have induced an abortion.'

7.5.2 Service Providers: Knowledge and perceptions of the law

The quantitative data collected for this study suggests that service providers' are generally well aware of the prohibition on abortion services in Philippine law, even though a sizeable minority appears to think that abortions are permitted in some circumstances. Sixty-six percent (66%) of surveyed service providers indicated that abortions are 'never' permitted under the law, whereas 34% indicated that, depending on the circumstances, it is sometimes permitted to perform abortions. Sixty-six percent (66%) of respondents also indicated that in their own opinion abortions should never be allowed, regardless of what they thought the law says, which highlights the importance of dominant socio-religious norms in shaping service providers' understanding of abortion and when it is justifiable.

Of those respondents who thought abortion is permitted depending on particular circumstances, around half (52%) agreed that abortion was permitted in order to preserve a woman's health, which is reflective of the uncertainty in the law regarding the legality of abortions conducted out of 'necessity' (see the legal review above).[184]

7.5.3 Young people: Knowledge and perceptions of the law

Young people also appear to be relatively well aware of the strict legal prohibition on abortion in the Philippines. Of the 412 young people surveyed in San Fernando and Quezon City, 68% stated that, according to the law, abortion was 'never' permitted. Twenty-eight percent (28%) of respondents believed that the law permits abortion depending on the particular circumstances, and only 4% thought that there were 'no legal restrictions' on accessing abortions.

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[181] Center for Reproductive Rights (2010). *Forsaken Lives. The Harmful Impact of the Philippine Criminal Abortion Ban.* p.15. Available at: http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/PHL/INT_CAT_CSS_PHL_23583_E.pdf (accessed 07.02.17)

[182] Center for Reproductive Rights (no date) *Facts on Abortion in the Philippines: Criminalization and a General Ban on Abortion,* Available at: http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_philippines_1%2010.pdf (Last access 7 November 2016).

[183] Guttmacher Institute (2013) *Unintended Pregnancy and Unsafe Abortion in the Philippines: Context and Consequences,* Available at: https://www.guttmacher.org/report/unintended-pregnancy-and-unsafe-abortion-philippines-context-and-consequences (Last access 7 November 2016).

[184] 17% of respondents agreed that abortion was permitted to save a pregnant women's life, and 12% agreed that abortion was permitted in cases of rape or incest. However, none of the respondents believed that abortion was permitted if the child would be born with a disability.

The qualitative interactions with young people also revealed the important influence of religious norms in shaping young people's understanding of when abortions are justified and /or legal, with respondents frequently treating legal and religious norms as synonymous. Consider, for example, the following two excerpts from focus group discussions in Manila and Pampanga.

> *"What if a 15 year-old girl in your community got pregnant – what options would she have?*
> She would need to continue being pregnant.
> *Why?*
> It's because of our religion. She needs to continue being pregnant. We are Catholic. It is very illegal for us to have an abortion.[185]

> *"Why is abortion illegal in the Philippines?*
> It's like taking life.
> *According to whom?* According to the 10 commandments…
> What is your own opinion on abortion? It should be illegal because the unborn must be given the opportunity to live."[186]

Young people's own opinions about abortion appear to be largely in line with their understanding of the law on abortion, with 70% of survey respondents being of the opinion that abortion should never be allowed under any circumstance. Interestingly, the survey data did not reveal a significant difference between girls' and boys' opinion about whether abortion services should be legally available or not.[187]

These results are broadly consistent with the 2013 Young Adult Fertility and Sexuality Study, which found extremely restrictive views on the acceptability of abortion among young people. According to this research, only 4.2% of young people expressed the view that they approve of a woman having an abortion.[188] Only 35.9% reported that they approve of abortion where the woman's life is in danger (representing a drop in acceptance in these circumstances from 1994 in which it was found that 51% of young people thought abortion was acceptable in this circumstance). Only 15.1% and 12.4% of young people expressed acceptability of abortion where the pregnancy is the result of incest or rape, respectively.[189]

The survey data also suggests that young peoples' understanding of exceptions in the abortion law is similar to service providers' understanding of (perceived) exceptions. For example, of those young people who thought abortion was permitted depending on particular circumstances, roughly half (51%) agreed that abortion was permitted in order to preserve a woman's health.[190] As with general restrictions on access to contraception, qualitative research participants tended to justify the prohibition of abortion by saying that increased access would

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[185] FGD with five parents of adolescents, Metro Manila (disadvantaged community), 1 December 2016

[186] FGD with five young men, aged 14 – 17 years, San Fernando (school), Pampanga, 29 November 2016

[187] Chi-square test, $p > 0.05$

[188] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, *The 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 59

[189] Demographic Research and Development Foundation Inc., University of the Philippines Population Institute, T*he 2013 Young Adult Fertility and Sexuality Study in the Philippines* (2016), p. 59

[190] 28% of respondents agreed that abortion was permitted to save a pregnant women's life, and 21% agreed that abortion was permitted in cases of rape or incest. Again, only a very small fraction of respondents (6% of young people) thought that abortion was permitted if the child would be born with a disability.

encourage young people to engage in sexual activity at an earlier age and before marriage. Consider, for example, the following excerpt from a focus group discussion with LGBT youth in Pampanga, which highlights well these misperceptions about abortion.

> *"Do you think abortion should be illegal?*
> Yes, it should be illegal. For minors, it should be strictly prohibited. So that it will lessen the chances of teens engaging in pre-marital sex, as they think abortion is an option. If it's easy to abort, more girls will have sex young."[191]

7.5.4 Access to safe and legal abortions

Survey data indicates that service providers do implement legal restrictions on abortion in practice, and that, as a result, young people's access to safe and legal abortion is severely restricted.

None of the 50 service providers surveyed in Quezon City and San Fernando indicated that they performed medical or surgical abortions. This is unsurprising, given the blanket ban on abortion services under the Revised Penal Code of the Philippines 1930. However, the data may also be reflective of service providers' desire to be (seen as) acting in accordance with the law, rather than their actual practice in relation to providing abortion services.

While a few service providers (and young people) perceived abortions to save the life of a pregnant woman as acceptable exceptions to the blanket ban on abortion, *in practice*, access in these exceptional cases is by no means guaranteed. Instead, it appears that women's access will depend on specific service providers' attitudes towards abortion. Consider, for example, the following excerpt from a focus group discussion with young men in Quezon City:

> "Is abortion legal in any *circumstances*?
> No.
> What about if mother's life is in danger?
> It depends on the decision of the doctor. If having the baby is detrimental to the mother they can do the procedure, but it is the doctor who will decide."[192]

Health professionals who provide abortions 'under the table' risk losing their license and going to jail, and those who advocate for a relaxation of abortion laws operate in a climate of fear, harassment and repression, as highlighted by an NGO representative interviewed for this study:

> *"Do you feel at risk doing abortion advocacy?*
> Yes, I've had a lot of encounters and harassment online. When we started [our advocacy] online, there were a lot of people harassing us. I feel every day I need to be careful. There are a lot of risks and we would lose everything if we were found out. I am now afraid of extra-judicial killings. The President has a war on drugs, and now he is even targeting users of softer drugs. Will he start tracking down those who do safe abortion next? He is very anti-abortion."[193]

Of course, the general unavailability of abortion services does not mean that there is no *demand* amongst young women to access abortion services. The survey data suggest that, despite the strict prohibition on abortions in the Philippines, service providers are frequently

[191] FGD with LGBT youth, Pampanga
[192] FGD with six young men, aged 16 – 19 years, Metro Manila, 1 December 2016
[193] KII with Representative of Philippines Safe Abortion Network and sexual health nurse, Manila

approached by women who seek abortion services. For example, 26% of service providers indicated that they had been approached by women who wanted to access abortion services.

While less than 4% of surveyed young people indicated that they had previously tried to access medical or surgical abortion services, it is important to remember that the survey data may also reflect respondents' reluctance to report having tried to access abortion, rather than actual access-seeking behavior.

The survey data also revealed that the legal prohibition on abortion has a direct impact on how service providers deal with women who approach them for abortion services. For example, of those service providers who had been approached for abortion services, more than 50% indicated that they had been denied abortions services *because of the law*.

Interestingly, dominant religious norms that stigmatise abortion appear to play an even more restrictive role than the law in relation to young people's access to abortion services. This is evidenced by the fact that more than 60% of service providers who had been approached for abortion services also indicated that they had denied access because of their own religious beliefs.

Denial of access to abortion services was also frequently experienced by young people surveyed for this study. Of those young people who had tried to access medical abortion services, the overwhelming majority reported to having been denied access (76%). This pattern was found to be even more pronounced for surgical abortions: 85% of young people who had tried to access surgical abortion services indicated that they had been denied access.

7.5.5 Impact of lack of access to safe and legal abortion

The qualitative interactions with service providers and young people revealed how the (nearly) insurmountable barriers to accessing safe and legal abortions in the Philippines leads young women to resort to unsafe methods to end unwanted pregnancies. Consider, for example, the following excerpt from a group discussion with young mothers in Pampanga:

> *"Is it easy for a young woman to access an abortion?*
> No, it's very hard to find and get an abortion. But there are herbs like 'serpentine' to abort a baby and people can drink alcohol or take pills – like anti-acidic stomach pills."[194]

The practice of drinking large amounts of soft drink together with painkillers was frequently mentioned by respondents as a method by which young women try to abort unwanted pregnancies.

> *"How would a young woman in your community get an abortion?*
> It's under the table… they will take tablets.
> *Which tablets?*
> Cortal tablets together with Sprite."[195]

The fact that young women do not have access to safe and legal abortion services may have serious consequences, as was, for example, highlighted during a focus group discussion with young women in Manila:

[194] FGD with young mothers, Pampanga
[195] Cortal is an Aspirin-based painkiller available in the Philippines. FGD with boys, Manila.

> "Some experience bad effects after giving themselves an abortion. Some get sepsis as parts of the baby are left inside the mother's womb. Some die and some are mentally challenged after the procedure. My friend asked a guy to punch her stomach and she bled and lost the baby."[196]

Women from poor and disadvantaged backgrounds appear to be particularly likely to resort to 'unsafe' and dangerous abortion methods, as they often cannot afford to pay a nurse or private health provider to conduct an abortion 'under the table'. This dynamic was, for example, highlighted during a group discussion with young men and LGBT youth in Pampanga:

> *"Can girls get an abortion here?*
> Yes, they can take medicine or they can pay for the midwife to do an abortion underground. What if they can't pay?
> They will punch their stomachs. Or they will do worse thing, like drinking alcohol."[197]

> "There are some service providers who do abortions. It's easy [to access abortions] as long as they have money to give them."[198]

[196] FGD with young women, Quezon City, Metro Manila
[197] FGD with young men, Pampanga school
[198] FGD with LGBT youth, Pampanga

8 Non-discrimination

There are wide-reaching protections against discrimination in the Philippines, including on the basis of gender and sexual identities. The Constitution provides that '[t]he State values the dignity of every person and guarantees full respect for human rights.[199] Article III, Section 1 guarantees equal protection under the law.[200] The Republic Act 9710, otherwise known as the Magna Carta of Women, provides that: '[a]ll individuals are equal as human beings by virtue of the inherent dignity of each human person. No one should therefore suffer discrimination on the basis of ethnicity, gender, age, language, sexual orientation, race, color, religion, political or other opinion, national, social or geographical origin, disability, property, birth, or other status as established by human rights standards.'[201]

In relation to SRH service provision specifically, the RHA prohibits the refusal of information and services on account of a person's marital status, gender, age, religious convictions, personal circumstances, or nature of work. However, service providers may conscientiously object to providing services and/or information and do not have an obligation to refer patients onto another conveniently accessible service unless it is an emergency or serious case.[202] The RHA's IRR contain strong non-discrimination language, including specific mention of the right of unmarried individuals to access reproductive health care and the right to access information, regardless of age, sex, disability, background or marital status.[203] Further, the *National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services* mandate that providers should provide services in a non-judgmental way and not deprive adolescents of services on the grounds of gender, education, social class, marital status, religious and political beliefs and sexual orientation.[204]

Generally, the laws and regulations of the Philippines are comprehensive, and protect against discrimination on the ground of a number of characteristics, including age, marital status, sexual orientation and gender identity. However, in practice, particular groups of persons face additional barriers to accessing services. This section will consider the impact of laws and social norms on access to SRH services by two particularly marginalized or vulnerable groups: girls and women who are survivors of sexual and gender-based violence and LGBTI young people.

8.1 Gender and violence

Limited legal definitions of sexual violence, and the failure in law to protect individuals from sexual and gender based violence (SGBV) in all contexts, creates barriers to access to SRH services for those

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[199] Constitution of the Republic of the Philippines (1987) Available at: http://www.gov.ph/constitutions/1987-constitution/, Article II, Section 11: *The State values the dignity of every human person and guarantees full respect for human rights.*

[200] Constitution of the Republic of the Philippines (1987) Available at: http://www.gov.ph/constitutions/1987-constitution/, Article III, Section 1: *No person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied the equal protection of the laws*

[201] Magna Carta of Women (2008) Available at: http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_9710.pdf (Last access 11 November 2016), Section 3.

[202] Congress of the Philippines (2012) *The Responsible Parenthood and Reproductive Health Act of 2012*, Available at: http://www.gov.ph/2012/12/21/republic-act-no-10354/ (Last access 11 November 2016), Section 23(a)(3)

[203] Department of Health of the Philippines (2013) *Implementing Rules and Regulations of Republic Act No. 10345*, Available at: http://pcw.gov.ph/sites/default/files/documents/laws/republic_act_10354_irr_0.pdf (Last access 11 November 2016), Section 4.03.

[204] Department of Health (2010) *National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services,* Available at: http://www.expandnet.net/PDFs/3.%20%20Philippines%20%20AFHS_Standards%20and%20Implementation%20Guide.doc (Last access 11 November 2016), p 14.

survivors who are not protected in law. On the one hand, limited legal definitions, detailed below, exclude some survivors from being eligible for support services; on the other hand, survivors of violence may be less likely to recognise violence when it occurs, and to identify themselves as having been subject to abuse. In circumstances where survivors would like to access help and support, they may fear that their claims will be viewed as lacking legitimacy and justification.

In the Philippines, comprehensive laws criminalise a wide range of sexual offences; however, limitations on the criminalisation of sexual violence within marriage can be seen to limit understandings of violence and effectively legitimise or normalise acts of violence in this setting.

8.1.1 The law and violence within marriage

Rape is criminalised in the Philippines, including within marriage.[205] However, certain legal exceptions to rape and other sexual offences apply in the context of marriage or pre-marriage. In particular, a conviction of rape may be pardoned if the offender and victim marry subsequent to the act or, if the rape occurs within marriage, the wife forgives her husband.[206] Marriage between the offender and victim is also a defence to crimes of lasciviousness, seduction and rape as per Article 344 of the Penal Code.[207] This is highly problematic: permitting subsequent marriage as a defence to rape has the effect of legitimising violence within the context of marriage and normalising acts of sexual violence within this setting, narrowing understandings of sexual violence more generally.

Family law in the Philippines can also be seen to promote tolerance of violence within marriage. In particular, the Philippines are the only country in the world other than Vatican City that does not allow for divorce. Secular annulment - the only legal way to end a marriage – is available in a limited number of defined circumstances (mostly where meaningful consent to marriage has not been found – for example, where either party is of 'unsound mind' or where consent was obtained by fraud or force etc.),[208] and is very expensive and 'almost impossible to obtain'. A recent attempt by the main author of the RHA to legalize divorce for couples who have irreconcilable differences in order to protect women from abusive relationships failed.[209] The Muslim Code does allow for divorce, but most of the conditions under which it is allowed are prejudicial to women.[210] The law therefore prevents women who are in abusive marriages from divorcing their husbands.

8.1.2 Access to services for victims of sexual violence

Laws that provide a defence for sexual violence within the context of marriage (or 'pre-

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[205] Larano and Cuneta (2014) *Philippine Supreme Court Affirms Rape in Marriage can be Prosecuted*, Available at: http://www.wsj.com/articles/SB10001424052702304908304579565734151261484 (Last access 10 November 2016).

[206] Anti-Rape Law of 1997, Available at: http://www.chanrobles.com/republicactno8353.htm#.WCSJZtJ96M9 (Last access 10 November 2016), Article 266C: E*ffect of Pardon. - The subsequent valid marriage between the offended party shall extinguish the criminal action or the penalty imposed. In case it is the legal husband who is the offender, the subsequent forgiveness by the wife as the offended party shall extinguish the criminal action or the penalty: Provided, That the crime shall not be extinguished or the penalty shall not be abated if the marriage is void ab initio.*

[207] Revised Penal Code (1932) Available at: http://www.un.org/Depts/los/LEGISLATIONANDTREATIES/PDFFILES/PHL_revised_penal_code.pdf (Last access 10 November 2016), Title XI.

[208] Article 45, Family Code of the Philippines

[209] De Mesa Laranas, Gin (2016) Will the Philippines Finally Legalize Divorce, Available at: http://www.nytimes.com/2016/07/29/opinion/will-the-philippines-finally-legalize-divorce.html?_r=0 (Last access 10 November 2016).

[210] Muslim Code of Personal Laws of the Philippines (1977), Available at: http://www.lawphil.net/statutes/presdecs/pd1977/pd_1083_1977.html (Last access 10 November 2016), See Chapter 3.

marriage') legitimise violence and limit understandings of what amounts to violence; particularly where family law promotes the 'sanctity' of marriage and limits a woman's ability to separate from an abusive husband. This can create a culture of acceptance of sexual violence within the context of marriage.

During the focus group discussions, participants were presented with a scenario concerning a young women (a daughter or friend) who is forced into sex by her husband: the young woman does not want to have sex as she is using the rhythm method to prevent pregnancy. While respondents tended not to approve of the husband's actions, they generally did not see the act as amounting to sexual violence. They tended instead to focus on the 'responsibility' of the young woman to 'meet the needs' of her husband (including the need to have children), as illustrated in the following excerpts:

> "You should be obliged to your husband since you are married. You get married to have a family, so you need to meet your responsibility to your husband.
> You shouldn't get married if you don't want to have children."[211]

> "You need to give in to the needs of your husband, or else he will find someone else who can meet his needs [all nodding]."[212]

> "If you can afford to raise a child, then let it be…
> You need to give yourself to your man as you are already married."[213]

Research participants also mentioned that the stigma surrounding having a baby outside of marriage could mean that a victim of abuse is encouraged to enter a relationship with a perpetrator of sexual violence. It appears that, in these circumstances, the sexual violence leading to the pregnancy is tolerated if the perpetrator 'takes care of the baby', as articulated by a key informant:

> "Young women are particularly vulnerable. We've known of cases wherein the father of a pregnant girl's child is much older. This is abuse and there could be violence involved. There are situations in which victims are stigmatized – it is very difficult to get victims to file cases and the thing that happens is that perpetrators get a free pass if they promise to provide for the child of the victim. So this kind of stigma is very prevalent and it's very disempowering for women."[214]

These limited understandings of what does and does not amount to sexual violence can act as a barrier for survivors of sexual violence subsequent to and within marriage, as they may not be considered victims of violence and therefore may not be empowered to seek SRH (and other) services. It can also disempower girls and women to report violence and access services: where the violence they have experienced takes place within a context in which it is tolerated or normalised, they may feel shame and blame for the violence, and may be deterred from

[211] FGD with seven young men, 15 – 22 years, Metro Manila, 1 December 2016
[212] FGD with eight young women, 15 – 18 years, Metro Manila, 1 December 2016
[213] FGD, four boys, 14 – 17 years, San Fernando, Pampnga, 29 November 2016
[214] KII with Commissioner, National Youth Commission, Metro Manila, 28 November 2016

seeking support and services. This was illustrated in an interview with a service provider in Pampanga:

> "Some don't report it [sexual violence] because the victim feels that they have caused the violence. They feel guilt, so if they told relatives or others, they feel that they have somehow participated in the violence."[215]

8.2 The law and LGBTQI persons

One of the most important ways in which law may impact on young people's access to services, is through the regulation of young people's gender and sexual identities and behaviours. Individuals who fail to conform to dominant categories established in law are likely to face significant barriers accessing services, either because they fear prosecution, or because government services fail to contemplate and provide for their needs.

8.2.1 Discrimination and lack of legal identity

In the Philippines, same-sex sexual activity is not criminalized.[216] Also, as set out above, anti-discrimination law in the Philippines provides comprehensive protection against discrimination on the basis of 'sexual orientation' (though not on the basis of gender identity[217]). However, anti-discrimination ordinances that prohibit discrimination on the grounds of sexual orientation and gender identity have been enacted in 19 local government units, including in some of the research locations: three in Quezon City and one in Pampanga (Angeles City).[218]

While anti-discrimination laws are reasonably comprehensive, LBGTQI persons are not offered the same legal recognition as heterosexual persons. As set out above, same-sex marriage is not legally recognized. Also, it is not lawful for an individual to legally change their gender in the Philippines, and it is not possible to legally identify outside the gender binary (e.g. as third gender). This lack of legal recognition of LGBTQI persons serves to reinforce the idea that LBGTQI relationships and identities lack legitimacy, which can entrench stigmatization. Research participants tended to express that LGBT persons are generally accepted in the Philippines; however, as examined above (see section 5), ideas around who may legitimately identify as 'gay' or 'lesbian' appears to be constrained, and generally, the participants did not recognize the ability of persons to identify outside the gender binary.

These limited legal categories and social norms that constrain LGBTQI identities and sexual expression mean that LGBTQI young people experience additional barriers accessing SRH services. Service providers appear to lack knowledge of the needs of LGBTQI young people and young people appear to be subjected to stereotypes that reduce and humiliate them. This is illustrated by the following quotes from an FGD with LGBTQI young people and a sexual health nurse:

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[215] Individual interview with doctor at a public health centre, San Fernando, Pampanga, 29 November 2016

[216] International Lesbian, Gay, Bisexual, Trans and Intersex Association: Carroll, A. (2016) *State Sponsored Homophobia 2016: A world survey of sexual orientation laws: criminalisation, protection and recognition*, Available at: http://ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf (Last access 10 November 2016).

[217] However, it is noted that a Bill has been introduced into Parliament: the Anti Discrimination Bill on the Basis of Sexual Orientation or Gender Identity Bill (House Bill 251) to extend legal protection against discrimination on the basis of sexual orientation or gender identity.

[218] Philippine Commission on Women (no date) E*nacting an Anti-Discrimination Based on Sexual Orientation and Gender Identity Law,* Available at: http://www.pcw.gov.ph/wpla/enacting-anti-discrimination-based-sexual-orientation-and-gender-identity-law (Last access 11 November 2016).

> "Is it difficult for LGBT young people to get SRH services?
> Yes.
> Why?
> There is an idea people have that boys will only have sex with boys if they get paid for it. … people will think I have a dirty mind if I go to the health centre." [219]

> "There are more barriers for the LGBT community. Here it is very much like the context is heterosexual…how can a lesbian go to a clinic? For me, it is very hard to go to a SRH clinic, but it's harder when they [the service providers] have different thinking and are asking 'why do you need these services?' I have a client who is a lesbian but sells sex with men. It is misunderstood. There is stigma." [220]

In addition, it appears that LGBTQI individuals do not 'exist' in the SRH policy space in the Philippines. SRH policy makers do not tend to contemplate their needs and services are not designed to meet their needs. This point was articulated by a number of key informants:

> "Sexual orientation and gender identity has appeared for many years, but we have kept silent. For example, men who have sex with men are not considered to be a group that requires a particular kind of service. The services are hetero-normative. There is this issue of not knowing much about the client." [221]

> "SOGI [sexual orientation and gender identity] is not part of the policy language in the Philippines. And if something is not part of the policy language of the country, it is difficult to promote programmes on it and it is difficult to prosecute cases on it." [222]

Lack of recognition in the policy sphere means that, in practice, LGBTQI persons do not have programmes and services that are designed to meet their needs. They may be excluded from accessing SRH services and products that are designed and delivered within a hetero-normative framework. For example, consider the following quote from a representative of the Department of Health:

> "Our family planning products are only intended for women who are of reproductive age…so LGBT people asking for family planning products? It's a no-no, because these products are not intended for them. They are only intended for women of reproductive age. If an LGBT young person comes to the health centre to ask for family planning products, we cannot give it to them because it's not for them." [223]

8.2.2 Lack of access to Hormone Replacement Therapy (HRT) and Gender Affirmation Surgery

Lack of legal recognition of trans* persons, and the lack of contemplation of their needs in policy and SRH service design and delivery has resulted in Hormone Replacement Therapy (HRT)

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[219] FGD with four LGBT young people, San Fernando, Pampanga, 29 November 2016
[220] Individual interview with a sexual health nurse at an NGO-run clinic, San Fernando, Pampanga, 5 December 2016
[221] KII with HIV Programme Officer, UN Organisation and HIV/AIDS and Adolescent Health and Participation Focal Person, Council on the Welfare of Children, Department of Social Welfare and Development, Metro Manila, 6 December 2016
[222] KII with Commissioner, National Youth Commission, Metro Manila, 28 November 2016
[223] KII with Adolescent Health Coordinator, Department of Health, Metro Manila, 5 December 2016

and Gender Affirmation Surgery being extremely difficult to access in the Philippines. Previous research has highlighted the lack of access that trans* persons have to HRT under medical supervision, and lack of information on HRT.[224]

The qualitative data was consistent with this research. There does not appear to be any guidelines for service providers on providing HRT, and there is very limited availability of HRT by service providers. Trans* persons appear to need to pay a private service provider for HRT, and this is expensive. This may result in trans* persons self-medicating and attempting HRT without any medical supervision.

> "Can young people access HRT if they are transgendered and want to do this?
> My friend's having a hard time getting access to hormone therapy. It is very expensive and they are young. It's 3,000 PHP a session.
> Most of the time, transgendered people use regular contraceptive pills instead as it's much cheaper than hormone injections."[225]

> "Because they don't have money, they start using contraceptive pills for women. They take seven tablets a day, and then after that, when they have money to buy hormonals, they buy anti-androgen, oestrogen."[226]

This can have very negative health consequences for these individuals:

> "A lot of transgender women overdose on pills, on hormones. They just take pills based on referrals from peers, friends. They think taking one whole packet of contraceptive pills over three days will make their boobs bigger. They don't worry that it'll have a very negative effect on their kidneys. I already know of transgender women who have died from kidney failure because they didn't get advice from an endocrinologist on how to use these hormones."[227]

According to the data, gender affirmation surgery is not available in the Philippines. Those who can afford it appear to travel to Thailand for surgery.

The data from the qualitative research focused mostly on trans* women, and it was noted that trans* men appear to be largely 'invisible' in the Philippines. They appear to severely lack access to advice or services, as illustrated by a key informant:

> "There are transgender men who can't even describe who they are to their families. They don't know who to contact to get help."[228]

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[224] USAID, UNDP (2014) Being LGBT in Asia: The Philippines Country Report, Available at: https://www.usaid.gov/sites/default/files/documents/1861/2014%20UNDP-USAID%20Philippines%20LGBT%20Country%20Report%20-%20FINAL.pdf (Last access 8 November 2016), p 33.

[225] FGD with seven young men, 15 – 22 years, Metro Manila, 1 December 2016

[226] Individual interview with sexual health nurse at an NGO-run clinic, San Fernando, Pampanga, 5 December 2016

[227] KII with HIV Programme Officer, UN Organisation and HIV/AIDS and Adolescent Health and Participation Focal Person, Council on the Welfare of Children, Department of Social Welfare and Development, Metro Manila, 6 December 2016

[228] KII with HIV Programme Officer, UN Organisation and HIV/AIDS and Adolescent Health and Participation Focal Person, Council on the Welfare of Children, Department of Social Welfare and Development, Metro Manila, 6 December 2016

9 Law and the Sale of Sex

Another group of individuals who experience significant barriers to access to SRH services are individuals who engage in the sale of sex, particularly those who fall outside Government registration systems.

9.1 Criminalisation of the sale of sex

Buying and selling sex (including in private), as well as some related acts, are criminalized in the Philippines. Additionally, prostitution is recognized as a form of violence against women by the Philippines' Magna Carta of Women and women in prostitution are considered one group of 'women in especially difficult circumstances (WECD)' for the purposes of the law.[229]

The Revised Penal Code criminalizes both the selling (Article 202) and buying of sex (Article 341), as well as other crimes related to sex work. Article 202, as amended by Republic Act 10158, defines prostitutes as 'women who, for money or profit, habitually indulge in sexual intercourse or lascivious conduct.' Any person found to be a prostitute is punishable by a fine of up to 200 pesos or up to thirty days in prison and repeat offenders may be subject to up to six months in prison and/or a fine of up to 2,000 pesos.[230] Article 341 of the Revised Penal Code criminalizes those who engage in the business of prostitution, profit by it, or enlist the services of another for the purpose of prostitution.[231]

Although prostitution is illegal in the Philippines, the Government recognizes that it exists and that it 'can pose a threat to public health.'[232] As such, sex workers are treated in public health facilities despite the fact that the work itself is not legally recognized. Local ordinances place requirements on sex workers who work in the regulated entertainment industry to go for regular testing for sexually transmitted infections, including HIV. Sex workers who fail to undertake such tests can be denied their health cards, which allow them to work in entertainment venues. However, sex workers who are freelancers are harder to reach with health interventions. Some local ordinances also require entertainment venues to provide condoms, have information on STIs/HIV, have posters on STIs/HIV/condoms, provide trainings on STIs and HIV for employees, and/or have trained peer educators on the premises.[234]

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[229] T*he Magna Carta of Women* (2008), Available at: https://www.hsph.harvard.edu/population/womenrights/philippines.women.09.pdf (Last access 10 November 2016), Section 4(k)(2) and Section 30.

[230] *An Act Decriminalizing Vagrancy, Amending for this Purpose Article 202 of Act No 3815, As Amended, Otherwise Known as the Revised Penal Code* (2011) Available at: http://www.gov.ph/2012/03/27/republic-act-no-10158/ (Last access 10 November 2016), Article 202

[231] Revised Penal Code (1932) Available at: http://www.un.org/Depts/los/LEGISLATIONANDTREATIES/PDFFILES/PHL_revised_penal_code.pdf (Last access 10 November 2016), Article 341: White slave trade. — The penalty of prison in its medium and maximum period shall be imposed upon any person who, in any manner, or under any pretext, shall engage in the business or shall profit by prostitution or shall enlist the services of any other for the purpose of prostitution

[232] UNAIDS, UNDP, UNFPA (2012) S*ex work and the Law in Asia and the Pacific,* Available at: http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf (Last access 11 November 2016), p 148.

[233] UNAIDS, UNDP, UNFPA (2012) *Sex work and the Law in Asia and the Pacific,* Available at: http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf (Last access 11 November 2016), p 148-9.

[234] UNAIDS, UNDP, UNFPA (2012) *Sex work and the Law in Asia and the Pacific,* Available at: http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf (Last access 11 November 2016), p 149.

It is important to note that, where persons aged under 18 years sell sex, this is legally considered to be sexual exploitation.[235] This means that persons aged under 18 years who sell sex do not fall within local ordinances that establish a registration systems for sex workers. While it is of course important to ensure that sexual exploitation of children is comprehensively covered in the law, and that perpetrators are subject to criminal sanctions, this has also resulted in adolescents being excluded from registration programmes for sex workers, driving their activities underground and limiting their access to SRH (and other) services.

9.2 Access to services for people who sell sex

Criminalisation of sex work reinforces the deep shame and stigma associated with such activities. Whilst non-coercive provisions included in local ordinances exist to safeguard the health of sex workers and communities in which they work, there is still a denial of the profession in law as well as stigma, discrimination and violence. Law enforcement practices in the Philippines contribute to the stigma, discrimination and violence faced by sex workers - all of which may deter them from accessing services and information. Both freelance and sex workers based at licensed establishments are at risk of police raids and arrest.[236]

Particularly for those working 'underground' ('freelancers'), access to sexual and reproductive healthcare and information is scarce, and arrest is more likely.

> "What about the freelancers? What problems do they face?
> They are at risk of violence, they risk STIs, like HIV. They don't have access to free condoms easily.
> They rely on outreach, but we don't do it every day."[237]

Persons under the age of 18 who sell sex, as noted above, are excluded from formal registration systems and are required to work clandestinely. They may fear approaching sexual health (and other) services due to fear of being reported; a fear that is likely exacerbated by reporting requirements of service providers (as discussed above).

> "We can't accept under-18s. Sex workers need a registration card to access free treatment, and under-18s can't get it. They can't get registered."[238]

9.3 Violence and the sale of sex

The criminalisation of sex work and stigmatisation of sex workers also creates a barrier to reporting violence and accessing services following violence. Again, these barriers are likely heightened for persons who work outside formal registration systems.

According to the qualitative data, young people who sell sex may not recognise their experiences of sexual violence as such. This may be associated with the stigmatisation of sex work. This was

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[235] Special Protection of Children against Abuse and Exploitation Act 1992
[236] UNAIDS, UNDP, UNFPA (2012) Sex work and the Law in Asia and the Pacific, Available at: http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf (Last access 11 November 2016), p 151- 152.
[237] Individual interview with sexual health nurse at an NGO-run clinic, San Fernando, Pampanga, 5 December 2016
[238] Individual interview with two sexual health nurses at a public clinic, Angeles City, Pampanga, 30 November 2016

recognised by a service provider in Pampanga:

> "They are most at risk of violence – physical and sexual. Most experience sexual violence. What makes me sad is they don't know when to identify something as sexual violence.
> *Why?*
> For example, if they do the act, and if the customer forces her to do blow job or anal or something that is not consensual, she accepts it as she is being paid. They don't recognize it as violence as they are being paid for it, because they think this is part of their job."[239]

The following excerpt from a focus group discussion with young people who sell sex in Angeles City demonstrates that the participants do not necessarily see acts of sexual violence perpetrated in the course of their work as rape.

> "There is one girl who got bruised because a man forced her to have sex not using a condom. He held her down, and she got bruises on her arm.
> *Did she report it? Will people generally report this or not?*
> No, they don't report it.
> *Why not?*
> When these things happen, the girl just ignores it.
> *Why do girls ignore reporting it?*
> They are scared because the client is a foreigner and they think they are wealthy and can just bribe the police.
> *Can victims of sexual violence get counselling?*
> If it's only bruising, they don't report it. They only report very serious offences, like serious rape."[240]

While the excerpt recognises that a barrier to reporting sexual violence is lack of confidence in law enforcement and the uneven power dynamics between the sex worker and the client, it is significant that the participants focused on the survivor's physical injury (the bruise) and classified the rape perpetrated by the client not being 'serious rape'. This indicates that the participants may not themselves consider sexual violence as such and this is likely to be a barrier to reporting and seeking services.

[239] Individual interview with sexual health nurse at an NGO-run clinic, San Fernando, Pampanga, 5 December 2016
[240] FGD with four young women who sell sex, Angeles City, Pampanga, 30 November 2016

10 Conclusion

Law and policy in the Philippines was found to restrict young people's access to sexual and reproductive health services in both direct and indirect ways. While the law in the Philippines also contains some 'facilitative' provisions in relation to young people's access to SRH services, these are generally not implemented in practice due to misperceptions about the law as well as dominant socio-cultural norms that stigmatise adolescents' sexuality, pre-marital sex and individuals that do not conform to dominant norms relating to gender identity. The following paragraphs briefly summarise the main findings of this study.

10.1 Access to comprehensive sexuality education

The study found that young people in the Philippines typically lack the knowledge and skills required to engage in healthy and responsible sexual behaviour. Despite the RHA mandating the provisions of CSE in schools, the DoE has not yet implemented this provision (though they have taken some initial steps towards implementation). Further, the law allows private educational institutions (e.g. religious schools) to develop their own curriculum on CSE, which would undermine its comprehensiveness. The current access to CSE by young people appears to vary by school and teacher, and appears to exclude important topics, such as 'healthy relationships'. It is appears to be hampered by a lack of skills and training on the part of teachers. 'Myths' and misperceptions about sex and sexuality appear to be widespread amongst young people, and this seems to negatively impact on their SRH-related service-seeking behaviour.

10.2 Access to contraception

The study found that, as a result of the legal restrictions, young people in the Philippines experience significant difficulties independently accessing contraceptives. In particular, under-18s face significant obstacles to independently accessing contraceptives as a result of parental or guardian consent requirements, which most SRH service providers appear to apply in practice.

While parental consent requirements appear to function as a direct legal barrier to young people independently accessing contraceptives, this barrier is also compounded by restrictive religious and social norms that result in the stigmatization of pre-marital sex. These dynamics impact on SRH service-seeking behaviours of young people by preventing them from attempting to access contraception in the first place, and also through denial of services by health professionals.

The temporary restraining order on the purchase of contraceptive implants was found to directly restrict young people's access to this type of contraction, and its potential impact in the coming years is likely to be felt in public and private health facilities, drying up supply of these essential contraceptive products. Furthermore, the study found that the absolute nature of the prohibition on emergency contraception creates insurmountable barriers for young people in need of emergency contraception, even in cases of particular need, including for victims of rape.

10.3 Access to sterilisation

Access to sterilisation appears to be based on service providers' considerations as to what is considered the desirable number of children for a woman to have, rather than age. This tended to reinforce social expectations that women will have a reasonably large family (at least three children).

10.4 Access to STI and HIV testing and treatment

The study found that service providers tend to believe that persons aged under 18 years need to have parental consent before they are able to carry out HIV or STI testing and treatment. In relation to the provision of HIV testing services, this suggests that health professionals are typically aware of and apply the law when granting young people access to HIV testing. This was found to be prevalent across public, private and NGO-run clinics. Young people's understanding of the law regulating access to HIV and STI testing was found to be limited, negatively impacting their service-seeking behaviours.

10.5 Confidential access

Young people were found to have limited understandings of the law relating to confidentiality. Uncertainty about whether their information will be kept confidential can act as a significant barrier for young people trying to access SRH services. In particular, given the stigma associated with pre-marital sex and sex under the legal age of marriage, young people may be 'put off' accessing SRH services where they fear that the service providers will not be able to guarantee their confidentiality. A perception that service providers may breach confidentiality inevitably has a disproportionate impact on groups of young people that are stigmatized, including LGBT young people, or for whom sexual activity is particularly stigmatized (girls).

While child protection reporting is crucial for ensuring that children are protected from abuse, adolescents may be discouraged from seeking SRH services if they fear that they may be reported to the authorities. In particular, the study found that young people who sell sex face significant barriers in accessing services, due to the requirement of service providers to make a child protection referral in relation to any person under the age of 18 years who is engaged in sex work.

10.6 Access to abortion

The qualitative and quantitative evidence collected for this study suggests that the blanket ban on abortion in the Philippine law creates (nearly) insurmountable barriers for young women who want to access safe and legal abortions. The dominance of conservative social and religious norms creates further barriers to access, as most service providers and young people agree that abortions should be illegal in all circumstances. In some cases, respondents thought that where the mother's life was in danger, abortion would be permissible, if not desirable. As a result of these legal and socio-religious barriers, young women in need of abortion services are pushed into accessing 'underground' abortion services. Those women that are well-connected or wealthy may be able to access a trained health professional who will conduct the abortion 'under the table'; but those women from poor and disadvantaged backgrounds often need to resort to a variety of potentially life-threatening methods (including the use of herbs, drugs, and punching their stomachs).

10.7 Sexual violence

The study found that laws that provide a defence for sexual violence within the context of marriage (or 'pre-marriage') legitimise violence and limit understandings of what amounts to violence; particularly where family law promotes the 'sanctity' of marriage and limits a woman's ability to separate from an abusive husband. This can create a culture of acceptance of sexual violence within the context of marriage and limit access to services for survivors of SGBV. Where the violence takes place within a context in which it is tolerated or normalised, either by law or socio-cultural norms, survivors of violence feel shame and blame for the violence, and be deterred from seeking support and services.

10.8 LGBTQI persons

The study found that limited legal categories and socio-cultural norms that constrain LGBTQI identities and sexual expression mean that LGBTQI young people experience additional barriers accessing SRH services. Service providers appear to lack knowledge of the needs of LGBTQI young people and young people appear to be subjected to stereotypes that reduce and humiliate them, which in turn negatively influence their service-seeking behaviours.

10.9 The sale of sex

The criminalisation of sex work was found to reinforce the deep shame and stigma associated with such activities. Whilst non-coercive provisions included in local ordinances do exist to safeguard the health of sex workers and communities in which they work, the study found that there is still a widespread denial of the profession in law as well as stigma, discrimination and violence. Law enforcement practices in the Philippines were found to contribute to the stigma, discrimination and violence faced by sex workers - all of which deters them from accessing SRH services and information. The criminalisation of sex work and stigmatisation of sex workers was also found to create barriers to reporting violence and accessing services following violence. The qualitative data collected for this study also revealed that young people who sell sex may not necessarily recognise their experiences of sexual violence as such, given the widespread stigmatisation of sex work. Persons below the age of 18 years are legally considered to be children who are sexually exploited, and are therefore unable to be registered as sex workers. While it is, of course, important to ensure that the law protects children from sexual exploitation, this law may be functioning as a barrier to under-18s who sell sex accessing services. It also drives their activities 'underground', placing them at greater risk.

11 Recommendations

The findings from this study reveal the power of the law in establishing both direct and indirect barriers to young people's access to SRH services in the Philippines. The findings also reveal how the law can shape and reinforce social and cultural norms that stigmatise sexual activities in particular contexts and circumstances, influencing young people's access and service-seeking behaviour. The research also has specific implications for legal reform, which are explored through the recommendations below.

11.1 Age of sexual consent

- The laws on the age of sexual consent should treat all individuals equally, regardless of their gender, sexual orientation, or religion.
- Consensual sexual activity between adolescents who are 'close in age' should not be criminalized. In the Philippines sexual activity between individuals aged 12 to 18 is not criminalized but there is lack of knowledge of the legal age of consent. This can prevent young people from accessing SRH services, as they may fear disclosure to authorities, parents or legal guardians if they (or their partner) are under the perceived age of sexual consent.
- National laws should establish clear differences between the age of sexual consent, the age of marriage, and the age of consent to medical treatment, including consent to access SRH services. Official guidance should be developed for health service providers to clarify the implications of these provisions and how they should be interpreted together.

11.2 Age of marriage

- The laws on the age of marriage should treat all individuals equally, regardless of their gender, sexual orientation, or religion.
- The current Muslim Code regulating the age of marriage for Muslim Filipinos contravenes international standards on child marriage.
- The Muslim marriage code should guarantee a minimum age of marriage for girls of 18, including in *shariah* district courts
- Provisions that allow a Muslim male who is at least 15 years of age and any Muslim female 'at the age of puberty or upwards and not suffering from any impediment' to marry are in contravention of international standards on child marriage and violate the principle of gender equality.

11.3 Access to comprehensive sexuality education

- Compulsory comprehensive and age-appropriate sexuality education should be a mandatory part of school curricula in primary and secondary school, regardless of whether the school is public or private.
- CSE should be guided by international CSE standards and focus on skills in decision-making, communication, and respect for others, with a strong gender component, which avoids propagating dominant stereotypes about sex and gender, and go beyond a narrow focus on biological and reproductive aspects of sexuality. This curriculum should also clearly explain the sexual and reproductive health services that are available for young people and the content and implications of relevant provisions in law.

- Section 11.01 of the RHA grants private schools the right to develop their own curriculum, subject to approval by the Department of Education (DoE). The DoE should ensure that CSE is provided uniformly across private and public schools and that the abovementioned topics into the curriculum, as required by the RHA's implementing guidelines.

11.4 Access to contraception

- There are a number of provisions in the current law that restrict independent access to contraceptives and family planning services for young people. These include Section 7 of the RHA, which articulates a parental or guardian consent requirement for minors (under-18s) to access modern methods of family planning, including contraceptives. This provision should be removed as it restricts independent access to contraceptives and family planning services for young people who are under the age of 18.
- The 2014 Supreme Court ruling on the RHA also resulted in Section 23(a)(2)(i) being struck down, which in its original form prohibited the requirement of spousal consent for an individual to undergo a reproductive health care procedure. This creates uncertainty amongst service providers who provide family planning services to married young people. The law should not restrict independent access to contraceptives and family planning services for married women and men. The Philippine Government should issue official guidance on how service providers should apply the Supreme Court ruling and what the term 'reproductive health care procedures' includes.
- We recommend the adoption of a positive provision stating that young people should never be denied access to SRH services based on their age or lack of consent from a parent, guardian or spouse.
- Advocacy work should be carried out with the DoH in order to establish rights-based rules and regulations for the certification of modern contraceptives.
- The availability of specific types of contraception should be regulated at the national level, and ordinances of individual Barangays that restrict availability of and access to modern contraceptives should be subjected to a legal challenge.
- As a result of the 2014 Supreme Court ruling, private health facilities no longer have to refer patients for services at other facilities unless it is an emergency or life-threatening situation, and providers may no longer be punished for failing or refusing to provide information or referrals. This 'conscientious objection' provision creates additional barriers for young people wanting to access contraception or other family planning services, and should be challenged.

11.5 Access to STI and HIV testing and treatment

- The law should explicitly allow confidential, independent access of young people's to STI (including HIV) testing and treatment. This should include a positive provision stating that young people should never be denied access to STI testing and treatment based on their age or lack of consent from a parent, guardian or spouse.

11.6 Confidential access

- Confidentiality within the context of access to health care is not explicitly mandated in primary legislation in the Philippines. This creates uncertainty for young people seeking confidential access to contraceptive services, as they cannot trust that service providers will keep their interactions confidential.

- Advocacy efforts should focus on the development and adoption of a legal rule that explicitly recognizes the capacity/competence of young people to consent to access sexual and reproductive health services, without the need for parental or other third party consent.
- Clear child protection guidelines should be put in place to ensure that instances of child abuse are identified and addressed. We recommend that these guidelines do *not* include mandatory reporting requirements or a blanket minimum age threshold, but rather empower service providers to identify and distinguish child abuse from consensual sexual activity involving young people. There is a risk that child protection procedures will simultaneously fail in their attempt to address abuse, while creating barriers to confidential access to services for children and young people who need them. This is an area that requires further research and development.

11.7 Access to abortion

- Abortion in the Philippines is currently prohibited in all circumstances. Any criminalization of abortion creates direct legal barriers to access to sexual and reproductive services. Advocacy efforts should focus on realising the ultimate goal of unrestricted access to abortion services, and protection of this right under the law. Abortion services should be made free, safe, accessible and confidential for all women and girls.
- Advocating for incremental changes to law is unlikely to have much impact on the availability of legal abortion in practice. Incorporating such efforts within a broader campaign towards full decriminalization of abortion, however, may have the potential to foster public engagement with the issue and help gain wider social and political support for the decriminalization of abortion and women's reproductive rights more broadly.

11.8 Non-discrimination

- The law should recognize all forms of sexual and gender-based violence, regardless of the context (e.g. in the home, school community or within other institutions) or relationship (e.g. whether married or not) within which it occurs.
- Legal exceptions or qualifications to rape, other sexual offences and domestic violence applicable to the context of marriage or pre-marriage should be removed. In particular, the legal provision permitting subsequent marriage as a defence to rape should be removed.
- Family law should be amended to allow for 'no fault' divorce (divorce based on irreconcilable differences).
- Strong legal provisions protecting LGBTQI persons from discrimination should be adopted. In particular, it is recommended that advocacy work be carried out to support the adoption of the 'SOGI Bill',
- The law should allow an individual to change their gender, and to identify outside the gender binary.

11.9 The sale of sex

- All laws criminalising sex work in the Philippines should be removed; regardless of whether they apply to the local- or national-level. These laws contribute to an environment where abuse and discrimination against sex workers is perceived as legitimate and officially sanctioned, which in turn has a restrictive impact on the service-seeking behaviour of sex workers.
- Young people, including those who are aged under 18 years, should be entitled to access confidential SRH (and other) services. Consideration should be given as to how under-18s, in particular, could have improved confidential access to these services.


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Annex A: Methodology

The methodology for this research builds upon Coram International's experience working with the International Planned Parenthood Federation (IPPF) Central Office and Regional Offices (SARO and ESEAOR) to conduct research on young people's access to SRH in Senegal, El Salvador and the UK in 2012 – 2013, and in India, Sri Lanka and Indonesia in 2015-2016.

The methodology used during the initial studies has been enhanced, refined and improved based on lessons learnt over the course of the studies.

1. Mixed methods approach

The study is mixed methods, comprising a legal review, secondary analysis of existing datasets, and the collection of primary and secondary qualitative data.

2. Primary data collection methods

Individual interviews

Given the sensitive nature of the research, and the fact that it will involve speaking to young people about their behaviour, choices, perceptions and experiences related to access to sexual and reproductive health services, it is important that individual interviews are carried out, to provide respondents with a private and confidential setting in which to respond. Interviews will be semi-structured in nature: interview guides will be developed in order to encourage a level of standardisation in data collection. However, these guides will not be designed to be followed strictly. Rather, interviews will be conducted in a highly participatory manner, with a view to allowing for the most authentic and responsive data.

Interviews will be carried out with young people and SRH services providers in a range of different social contexts. Interviews will aim to collect data on:

a. Respondents' knowledge, understandings of and attitudes towards relevant laws relating to gender, sexuality and health, on the part of both young people and service providers;
b. How these perceptions are linked to individual's practices, choices and experiences in relation to access to/provision of SRH services.

Interviews will include a mix of life history questions and questions that focus on perceptions of law and access to SRH services. This will allow researchers to link demographic data (e.g. gender, age, ethnicity, sexuality etc.) and data on participants' backgrounds and life circumstances, to particular perceptions about the law (and gender, sexuality and health more broadly) and experiences relating to seeking of and access to SRH services. It will also allow researchers to examine how participants' social environments and lived experiences have shaped their understandings of law and experiences relating to access. This will facilitate our understanding of whether the legal environment impacts young people's seeking of and access to SRH services differently depending on other social and environmental factors, and to determine how other factors that influence access and service seeking behaviour interact with the legal environment. Following a 'life history' structure through interviews, will also allow us to access information about how (and why) perceptions of law and access to SRH services might change over time.

Focus Groups
Focus Group Discussions (FDGs) with young people will consist of groups of 5-8 individuals. During focus groups with young people, we will separate individuals according to gender considering the sensitive nature of the issues under discussion, unless we are accessing an established mixed-gender group of young people (e.g. LGBTI young people). Data collection tools for focus group discussions will be designed so that participants are encouraged to discuss issues in a general, hypothetical, or scenario-based format, and do not feel the need to reveal information about personal experiences.

Focus group discussions can provide a useful method for exploring issues concerning different contexts of access to SRH services. For example, participants will be presented with a series of "scenarios" and asked to discuss/debate how they view the situation, as well as their perceptions of the law related to the situation (e.g. different circumstances in which an individual may seek contraception or abortion services, what the law says about this and what their opinions are about relevant laws). Exploring these issues through FGDs may be useful as participants are provided with opportunities to respond to each other's' ideas and opinions, which has the potential to stimulate discussion and debate. Focus group discussions are generally more interesting for participants than individual interviews, and can provide for a more fun and relaxed environment for young people (than a one-to-one setting). Also, as focus groups take the pressure off individual respondents, they can sometimes result in more natural and spontaneous answers than individual interviews. On the other hand, it will be necessary for researchers to consider the implications of group dynamics which have the potential to skew opinions and information.

Survey
In order to appropriately answer all the research questions we recommend conducting a limited survey with young people and with service providers. The aim of the survey will be to collect some general descriptive and standardised data that can be analysed objectively, in relation to participants' knowledge, understanding and perceptions of law, and experiences accessing services.

3. Sampling strategy

Health service providers
We are aiming to conduct 9 individual interviews with service providers based on the following categories:

- 2 general SRMH service providers from urban advantaged contexts; (1 private service, 1 public service)
- 1 general SRMH service provider from an urban disadvantaged context
- 2 general SRMH service providers from rural/peri-urban contexts;
- 1 service provider who focuses services on LGBTI communities;
- 1 service provider who provides abortion services;
- 1 service provider who provides sterilization services
- 1 service provider who provides SGBV services
- 1 school-based health provider

Legal/justice sector
If feasible we would like to conduct 3-4 individual interviews with legal and justice sector stakeholders (judges, lawyers) who have previous experience in legal cases pertaining to sexual and reproductive

rights issues. These could include cases concerning abortion, statutory rape, and any others of relevance.

Key informants

We would also be interested in conducting around 3 in-depth interviews with key informants, who can provide particular insights into the issue of young people's access to SRH services in the Philippines and/or who can give a 'birds-eye' overview of the legal framework pertaining to young people and SRH. In order to identify relevant key informants, we will need to rely on the expertise and existing contacts provided by IPPF and FPOP. However, we anticipate that key informants may include:

- Leading civil society actors/ activists working on SRH and young people, including FPOP staff;
- Local academics/scholars working on SRH and young people;
- Legislators/Parliamentarians working on legal reform in this area;

Young people

We would like to conduct 6 in-depth, life history interviews with young people ages 15-24 years who have had a particular experience in relation to SRMH. We appreciate that accesses these individuals may raise some challenging ethical issues, e.g. around confidentiality, but if possible it would be extremely valuable to speak with these individuals. The following categories are requested:

- A young mother who gave birth as a minor;
- A young survivor of SGBV;
- A young trans person who is seeking/ has sought access to medical transition services;
- A young person who started selling sex prior to the age of 18 years (please note this person may now be older than 18 years, and we can ask them about past experiences);
- A young person who has been subject to legal proceedings (as accused) concerning sexual violence/ (statutory) rape;
- A young mother with disabilities

FGDs

We would like to conduct 10 FGDs with young people aged 14-24. Each group should consist of 4-6 individuals. Groups will be separated according to gender considering the sensitive nature of the issues under discussion, unless we are accessing an established mixed-gender group of young people (e.g. LGBTI young people).

We will aim to conduct around 10 FGDs with young people. We anticipate that FGDs will include the following categories of individuals:

FGDs young females

- 1 FGD with young women (19 - 24)
- 1 FGD with older adolescent girls (17 - 18)
- 1 FGD with younger adolescent girls (14 - 16)

FGDs young males

- 1 FGD with young men (19 - 22)
- 1 FGD with older adolescent boys (17 - 18)
- 1 FGD with younger adolescent boys (14 - 16)

Specialist FGDs young people

- 2 FGD with ethnic religious minority groups
- 1 FGD with young people who sell sex
- 1 FGD with young people with disabilities

If possible we would like to conduct these interviews in both urban advantaged, urban disadvantaged and peri-urban/rural contexts, with people from diverse religious/ethnic backgrounds.

We will also aim to conduct 3 FGDs with parents/carers. Parents/carers included in the parent-only FGDs should be parents who have **adolescent children**. We anticipate that FGDs with adults will include the following categories of individuals:

- 1 FGD with parents form urban advantaged contexts;
- 1 FGD with parents from urban disadvantaged contexts;
- 1 FGD with parents from peri-urban/rural contexts;

Surveys service providers

We anticipate that surveys to service providers will be distributed manually by FPOP/ IPPF staff. We will aim to collect responses from around 50 service providers (doctors and nurses) in the following types of institutions:

- 2 general public health clinics in rural areas;
- 2 general public health clinics in urban areas;
- 2 private / fee-paying clinics;
- 2 school health service;
- 1 clinic specializing in SRMH in an urban area
- 1 clinic specializing in SRMH in a rural area.

Surveys will be distributed to **all** staff (nurses and doctors) at the clinics at work/ present on the day of distribution. Surveys will be filled out on a voluntary basis. If a staff member declines to fill out the survey, this **will be recorded/ logged** as a 'non-response'.

Surveys young people

Surveys for young people will be distributed manually by FPOP/ IPPF staff within secondary schools and youth centres. We will aim to include around 400 young people in the survey if possible.

Surveys should be distributed in the following institutions;

- 3 public schools in urban areas;
- 3 public schools in rural areas;
- 2 private schools;
- 2 youth centres for out of school youth;
- 2 youth centres for LGBT youth;
- 2 community centres for sex workers (if possible)

In the schools the survey will be distributed to **all** children in randomly selected classes across grades 8-12. Surveys will be filled out on a voluntary basis. If a student declines to fill out the survey, this **will be recorded/ logged** as a 'non-response'. If a child who is registered in the class, but is not present in

class on the day of the survey (and thus cannot fill out the survey) this should also be recorded as **absent**.

In the youth centres, surveys should be distributed to **all** young people present ages 14-25 years. Surveys will be filled out on a voluntary basis. If a student declines to fill out the survey, this **will be recorded/ logged** as a 'non-response'.

Where possible, and to ease the burden on IPPF/FPOP staff, the survey will be a written survey to be filled out by respondents themselves. If necessary, IPPF/FPOP staff may deliver the survey orally to certain participants (if participants are illiterate or unable to complete the survey themselves). Instructions for IPPF/FPOP staff on how to introduce the survey will be included on the survey form.

After surveys have been completed, responses will be entered into an excel document by IPPF/FPOP staff members, who will receive training on data entry from the international researcher during the data collection visit.

4. Data analysis

The majority of the data will be qualitative and will be analysed manually and through the use of the software package NVivo. The team will conduct a detailed examination of interview transcripts, recordings, and other materials, to identify key themes, patterns, discourses, relationships and explanations relevant to the research questions. Qualitative analysis will draw on a range of techniques including grounded theory, ethnography, case study analysis and discourse analysis, which will include an analysis of the language used by respondents to communicate about childhood, adolescence, gender, sexuality, consent, violence, and other topics relevant to the research questions.

Quantitative data collected via the survey will be collated and analysed through the use of statistical software (SPSS and/or STATA). The analysis will seek to provide a basic descriptive profile of the sample, in terms of demographics, knowledge and perceptions of law, and experiences seeking SRH services. The profile will be disaggregated to identify trends among specific groups. Subsequently, the team will embark on inferential analysis of the data, through the use of statistical tests to search for associations and relationships between different variables, and to determine the strength of these relationships. These tests may include association tests, correlation tests, and multiple regression modelling. Finally, results from the quantitative data analysis will be triangulated with the qualitative data and analysis.

5. Ethics

The research process will be conducted according to Coram International's Ethical Guidelines for Research. These guidelines contain procedures for ensuring anonymity of participants, ensuring informed consent and voluntary participation, protecting the rights and welfare of all research participants during the research, and processes for handling child protection concerns.

Annex B: Interview Guide for Key Informants and Service Providers

Key Informants

Introduction:

Introduce yourself: name, age, where from, who you work for.

Introduce your translator.

Briefly explain the purpose of the research and confirm consent of the participant.

Reassure the participant that this is not a 'test' and that there are no 'right or wrong' answers.

Ask the participant if they would like to introduce themselves.

Introductory questions

Try to collect the following information about the respondent: Name of the service/organisation/facility. Position of the respondent; number of years in the position; previous work experience; information about any training or education relevant to their work

1. Could you tell me a little about your organisation? What is your role at the organisation? How does your work/organisation pertain to young people and SRH?
2. Thinking beyond your own work/organisation, who are the main actors working on young people and SRH in the Philippines? How does your work or the work of your institution fit into this picture? Based on your experience, are there any conflicts between different actors in terms of roles and responsibilities related to SRH and young people (e.g. between different government departments)?
3. Do you do outreach work related to young people and SRH? What kind/where (i.e. in schools, universities, community centres?)

General question on SRH law

4. Are there any laws/ policies that regulate SRH for young people? Who do you consider a 'young person'? Are these laws/policies implemented in practice? What do you think of these laws/policies?
5. Are there currently any DRAFT laws/policies that have the potential to impact access to SRH services for young people in the future? How likely are they to become statutory law? When?

Sexuality education

6. Based on your experience, how well informed are young people about SRH? Where do they learn about these issues? What topics are covered? Are there any major gaps, in your opinion? Why?

Law and Consent

7. Are there any legal restrictions on access to SRH services based on age? *Probe on access to particular types of services, e.g. contraception, HIV testing, STI testing, abortion etc.*
8. In your experience, do service providers require consent from parents/ legal guardians for young people/ children to access SRH services below a specific age? At which age? For which services?

9. What is the age of sexual consent in the law? Is this law implemented in practice? Is there such as thing as a 'close-in-age' exemption for couples who have consensual sex but where at least one is under the age of sexual consent? What is the legal age of marriage? Is this law implemented in practice? Does this have any impact on accessing SRH services? How/ why? For which services?
10. What does the law say about sexually active young people below the age of sexual consent? Are there any obligations on service providers to take any action under the law? Do service providers need to report this to anyone? Who? Do you agree with this? Why/ why not?

Law and confidentiality

11. If a young person seeks to access SRH services, is it ever appropriate for the service provider to tell anyone about this? When and who? What, if anything, does the law have to say about this? Is confidentiality important for young people's access to services? Why/why not?

Law and abortion

12. Who provides abortion services in the Philippines? Are there any regional differences in the Philippines when it comes to the provision of abortion services? If so, why? Who is legally able to access abortion services and under what conditions? What are the legal restrictions on access to abortion? Do you think this creates any barriers to access to services? For whom? What are the reasons that the law is this way? What are your views on this?
13. At what age can a woman have a legal abortion? Are there any additional restrictions *(also ask about reporting requirements for rape/incest victims)*? If a young girl needs to access an abortion, does she require consent from anyone? Who? Does a married woman need the consent of her husband? What are the reasons that the law is this way? What are your views on this?
14. In your experience, is there social stigma about getting an abortion? Who/where does this come from? Do you think this currently affects how girls use SRH services?

Law and sterilisation

15. Who provides sterilisation services in the Philippines? Are there regional differences in the Philippines when it comes to sterilisation service provision? Are these services common? Who are these services generally provided to?
16. Are there any government policies (or laws) that provide for/ regulate/ restrict sterilisation services? Can you tell me about these? What do they say? What do you think of these?
17. What are your views on sterilisation? Would you ever recommend/ encourage someone to get sterilised? Who? Why/ why not? What about sterilisation for men?
18. Are there any age restrictions on access to sterilisation? Whose consent is required for sterilisation? (e.g. person being sterilised/ parent/ guardian/ spouse etc.)

Law, gender and sexuality

19. Do you know about any laws or policies that regulate these services/ access to services for trans-gender/ third sex individuals? What are they? What do you think of them?
20. Are there any additional hurdles/ challenges, do you think, for trans-gender people to access SRH services (e.g. family planning services, STI testing, HIV testing, general health care services etc.)
21. Does the law say anything about same-sex relationships/ sexual activity? What? Is this law implemented? What is the impact of this law in practice?

22. Does this create any barriers to access to services for homosexual people? Why/ why not?
23. Is there any obligation on service providers to report persons engaged in homosexual relationships/sex? Who do service providers need to report to? Does it depend on the person's age?

Law and sexual violence

24. What are the main forms of violence related to sex and gender (SGBV) that affect young people in your experience? What is the profile of these SGBV victims (age, gender, socio-economic background)?
25. Do you think the law effectively protects young people against such violence? In your experience do young people report incidents of SGBV? Are there gender differences? Are young people who report incidents of such violence believed?
26. Do you think laws in relation to SGBV have any impact on access to SRH services, especially for young people? If so, how/ why?

Conclusion

27. Do you think that young people in the Philippines have access to the SRH services they want and need?
28. What do you think are the biggest challenges in ensuring comprehensive and equitable access to SRH services for young people in the Philippines?
29. Are there any problems specifically with the law? Is there anything that should be different?
30. What are your recommendations for improving young people's access to SRH?

Interview guide: Service providers

Introduction:

Introduce yourself: name, age, where from, who you work for.

Introduce your translator.

Briefly explain the purpose of the research and confirm consent of the participant.

Reassure the participant that this is not a 'test' and that there are no 'right or wrong' answers.

Ask the participant if they would like to introduce themselves.

Introductory questions

Try to collect the following information about the respondent: Name of the service/organisation/facility. Position of the respondent; number of years in the position; previous work experience; information about any training or education relevant to their work

1. Could you tell me a little about your organisation? What is your role at the organisation? What SRH services do you provide (contraception, sexual testing, abortion, etc.), and to whom?
2. Do you provide services to young people? Who do you consider a 'young person'? Do many young people access your services? Is it easy or difficult for young people to access your services? Why? Are there any difference in services you provide to young people and those you provide to adults? When are individuals considered as 'adult'?

3. Do you do outreach services? What kinds/ where (i.e. in schools, universities, community centres?)

General question on SRH law

4. Are there any laws/ policies that regulate SRH for young people? Are they implemented in practice? What do you think of these?

Sexuality education

5. In your experience, how well informed are young people about SRH? Where do they learn about these issues? What topics are covered? Are there any major gaps in your opinion?

Law and Consent

6. Are there any legal restrictions on access to your services based on age? *Probe on access to particular types of services, e.g. contraception, HIV testing, STI testing, abortion (if applicable) etc.*
7. Do you require consent from parents/ legal guardians for young people/ children to access your services below a specific age? At which age? For which services?
8. What is the age of sexual consent in the law? Is this law implemented in practice? Is there such as thing as a 'close-in-age' exemption for couples who have consensual sex but where at least one is under the age of sexual consent? What is the legal age of marriage? Is this law implemented in practice? Does this have any impact on accessing SRH services? How/ why? For which services?
9. If a child comes to you under the legal age of sexual consent, and reveals they are sexually active – how would you manage this? Would you take any action? What does the law say about this? Are there any obligations on you as a service provider to take any action under the law? Do you need to report this to anyone? Who? Do you agree with this? Why/ why not?

Law and confidentiality

10. If a young person comes to access your service is it ever appropriate to tell anyone about this? When and who? What, if anything, does the law have to say about this? Is confidentiality important for young people's access to services? Why/why not?

Law and abortion

11. Do you provide any abortion services? Who is legally able to access abortion services and under what conditions? What are the legal restrictions on access to abortion? Do you think this creates any barriers to access to services? For whom? What are the reasons that the law is this way? What are your views on this?
12. At what age can you have a legal abortion? Are there any additional restrictions *(also ask about reporting requirements for rape/incest victims)*? If a young girl needs to access an abortion, does she require consent from anyone? Who? Does a married woman need the consent of her husband? What are the reasons that the law is this way? What are your views on this?
13. In your experience, is there social stigma about getting an abortion? Who/where does this come from? Do you think this currently affects how girls use SRH services?

Law and sterilisation

14. Do you provide sterilisation services? Are these services common? Who are these services generally provided to?
15. Are there any government policies (or laws) that provide for/ regulate/ restrict sterilisation services? Can you tell me about these? What do they say? What do you think of these?

16. What are your views on sterilisation? Would you ever recommend/ encourage someone to get sterilised? Who? Why/ why not? What about sterilisation for men?
17. Are there any age restrictions on access to sterilisation? Whose consent is required for sterilisation? (e.g. person being sterilised/ parent/ guardian/ spouse etc.)
18. (If the respondent provides sterilisation services) Would you ever consider providing sterilisation services to someone without their consent? Who? (probe: e.g. people with disabilities, mental health problems etc.)

Law, gender and sexuality

19. Do you provide any services for trans-gender/ third sex individuals? Do you provide any sex reassignment services? If not, why not? Where would a person go to access these services?
20. Do you know about any laws or policies that regulate these services/ access to services for these groups? What are they? What do you think of them?
21. Are there any additional hurdles/ challenges, do you think, for transgender people to access mainstream SRH services (e.g. family planning services, STI testing, HIV testing, general health care services etc.)
22. Does the law say anything about same-sex relationships/ sexual activity? What? Is this law implemented? What is the impact of this law in practice?
23. Does this create any barriers to access to services for homosexual people? Why/ why not?
24. Is there any obligation on you as a service provider to report persons engaged in homosexual relationships/ sex? If so, who do you need to report to? Does it depend on the person's age?

Law and sexual violence

25. Do you ever find that your patients / people accessing your services have been victims of sexual violence?
26. Do you provide any services for victims of sexual violence? What are these?
27. What are the main forms of violence related to sex and gender (SGBV) that predominantly affect young people in your experience? What is the profile of these SGBV victims (age, gender, socio-economic background)?
28. Do you think the law effectively protects young people against SGBV? In your experience do young people report incidents of SGBV? Are young people who report incidents of SGBV believed?
29. Do you think laws in relation to SGBV have any impact on access to SRH services, especially for young people? If so, how/ why?

Conclusion

30. Do you think that young people in your community have access to the SRH services they want and need?
31. What do you think are the biggest challenges in ensuring comprehensive and equitable access to SRH services for young people?
32. Are there any problems specifically with the law? Is there anything that should be different?
33. What are your recommendations for improving young people's access to SRH?

Annex C: Focus Group Discussion Guide for Young People and Parents

Introduction:

Introduce yourself: name, age, where from, who you work for.

Introduce your translator.

Briefly explain the purpose of the research and confirm consent of all participants.

Reassure participants that this is not a 'test' and that there are no 'right or wrong' answers.

Ask the participants if they would like to introduce themselves. Say they can give as little or as much information about themselves as they like, depending on what they think is most relevant. It would be advisable to get at least the age and gender of all participants.

General Questions:

1. At what age do young people in your community get married?

2. Is there a law about this? What does it say?

3. At what age do young people in your community start having sex?

4. Is there a law about this? What does it say?

5. Where do young people learn about sexual and reproductive health (SRH)? Who do you speak to about it? *(Probe to determine what kind of SRH education is available and what it does and doesn't include)*

   Scenarios: *(explain that you will present participants with a few hypothetical scenarios: These scenarios are 'not real', but similar things may be happening in your communities or families)*

6. *Your friend/sister/daughter is 15 years old. She has a boyfriend (they are not married). He keeps asking her to have sex with him.*
   - ❖ What do you think she should do? What advice would you give her?
   - ❖ Would your feelings/advice be different if your friend was a boy/your brother?

7. *What if she says no, but he won't stop pressuring her and eventually she gives in:*
   - ❖ Does this happen in your community?
   - ❖ How do you feel about this situation? What advice would you give your friend/sister?

8. *Is there such a thing as "good" and "bad" behaviour when having sex? Where do these ideas come from? Do you agree? How do you think these ideas affect young people when they try to access sexual and reproductive health services?*

See if they bring up contraception. If not, prompt them.

- A. Do you think the couple from the scenario would use contraception? What kind/type?
- B. Where would they get contraception from? *(If respondents bring up more than one type of contraception, probe to get details about each type).*
- C. Would it be difficult for them to get contraception? Yes, No, Why?
- D. Does it matter how old they are? Is this different for boys and girls?
- E. How much would it cost?
- F. Would they need anyone's permission (e.g. parents)?
- G. Who would be more likely to seek contraception? The boy or the girl? Why?
- H. Is there a law about this? What does it say?

9. *A couple of months later your friend/sister/daughter comes to you and tells you she is pregnant…*
   - What advice would you give to her?
   - Would she tell her family or anyone else? Who would she tell? Why?
   - What would her options be? *[See if they come up with abortion themselves. If not, ask follow-up questions]* Can she have an abortion? Why (not)?
   - What factors would influence her choice?
   - Would there be any costs?
   - Does her age matter?
   - Does it matter if she's married?
   - Is there a law about this? What does it say?

10. *Now imagine your friend/ sister has the baby…*
    - Is she likely to seek any other medical services? What type?
    - Are there laws that restrict the tests and scans she could request to get information about her baby? What are the benefits of this? What are the problems it could cause (if any)?
    - Is there a law about this? What does it say?
    - If she's in school, how might her school react? Would she be able to continue studying, or will she have to drop out? Who makes this decision?
    - Is there a law about this? What does it say?

11. *Another good friend of yours has just gotten married. She confides in you that she is not ready to have a baby (even though her husband wants one) just yet because she is still young...*
    - How do you feel about this situation?
    - What advice would you give her?
    - Could she access contraception if she wanted to?
    - Would she need her husband's permission? Why/ why not?
    - Is there a law about this? What does it say?

12. *Your friend decides that the best thing to do to avoid pregnancy is to abstain from sex during certain times of the month. On one of these days that she refuses sex, her husband forces her to have sex with him anyway…*
    - ❖ How do you feel about this situation?
    - ❖ What advice would you give your friend?
    - ❖ Your friend says she was raped by her husband and she wants to seek medical advice/go to the police. Is this an option?
    - ❖ Does it matter whether her husband was physically violent?
    - ❖ If your friend did seek help, how do you think she would be treated by health workers/ police?
    - ❖ Is there a law about this? What does it say?

13. `*Your friend goes to talk to her health provider and her health provider recommends sterilization?*
    - ❖ Have you heard about this procedure? Is this service often recommended? What types of people would a service provider recommend it for?
    - ❖ What do you think about sterilization? Is it a method you could imagine using one day? Is this an option for men?
    - ❖ Do you think it is ever for a service provider to encourage someone to be sterilized? Why or why not?

Questions about gender and identity:

I now have a few strange questions. They are not "trick questions". Just say what you think…

14. How many genders do you think there are? Are there any people of different genders that you know (at school or in your community)? Have you ever heard of someone being transgendered *[you may need to use the local term for transgender here, which may not correspond neatly with our (Western) definition of transgender]*? Do you have these groups here?

15. What about men who like men or women who like women? Are there people you know who identify as 'gay or lesbian'? What problems (if any) do these groups of people face? Do they face problems in the community?

16. Are there any laws related to these things? What does the law say? Is it legal to be homosexual? Is it legal to change your sex?

Final Questions:

17. Do you think that young people in your community have access to the SRH services they want and need?

18. What do you think are the biggest problems (if any) that young people face with regard to SRH?

19. Are the any problems specifically with the law? Is there anything that should be different?

Annex D: Survey for Service Providers and Young People

Survey tool Service Providers

Unique ID: SP _____

To be filled in by enumerators:
Location (where the questionnaire was distributed)

Municipality_____Barangay_____

Date (when the questionnaire was distributed):

To be filled in by respondents: Our organisation, the Family Planning Organisation of the Philippines (FPOP), is conducting research about the provision of sexual and reproductive health services.

We would like to ask you to complete this questionnaire and answer some questions about your experience and the services you provide. Please be as honest as you can in your answers: we want to learn from you!

All of the information provided is kept strictly anonymous. **Please do not write your name on the form**.

Please fill out **all** the questions on the survey form. If you do not know the answer to a question, please select your best guess.

Please only select **one answer** for each question, except where the form specifically instructs you otherwise.

Taking the survey is voluntary. Would you like to take the survey?

1 ❑ Yes 2 ❑ No

PART 1: Basic personal and household information		
1.1	Your gender (tick one)	1 ❑ Female 2 ❑ Male 3 ❑ Other
1.2	Your age	_____ (number in years)
1.3	Your religion (tick one)	1 ❑ Catholic 2 ❑ Protestant 3 ❑ Muslim 4 ❑ Buddhist 5 ❑ Other 6 ❑ No religion

1.4	**Which best describes your place of work?** (tick one answer)	1 ❑ Public clinic 2 ❑ Private (fee-paying) clinic 3 ❑ School health centre 4 ❑ Clinic specialising in sexual/reproductive health 5 ❑ Pharmacy 6 ❑ Hospital 7 ❑ Other
1.5	**How would you describe the area where you work?** (tick the best answer)	1 ❑ Urban neighbourhood 2 ❑ Urban slum 3 ❑ Sub-urban area 4 ❑ Rural area
1.6	**Which of the following services do you provide at your clinic/health centre?** (tick all the services your facility provides)	1 ❑ Male condoms 2 ❑ Contraceptive pills 3 ❑ Emergency contraception 4 ❑ Contraceptive Injections 5 ❑ Implants 6 ❑ HIV testing 7 ❑ STI testing (non HIV) 8 ❑ Gender reassignment 9 ❑ Ante natal services 10 ❑ Post-natal services 11 ❑ Rape counselling 12 ❑ Medical abortion 13 ❑ Surgical abortion 14 ❑ Sterilisation 15 ❑ IUD (non-hormonal) 16 ❑ IUD/IUS (hormonal)
PART 2: Age of consent		
2.1	**What is the minimum legal age at which a (non-Muslim) BOY can get married <u>without</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 10 years ❑ 11 years ❑ 12 years ❑ 13 years ❑ 14 years ❑ 15 years ❑ 16 years ❑ 17 years ❑ 18 years ❑ 19 years ❑ 20 years ❑ 21 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age

2.2	**What is the minimum legal age at which a (non-Muslim) GIRL can get married <u>without</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.3	**What is the minimum legal age at which a (non-Muslim) BOY can get married <u>with</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.4	**What is the minimum legal age at which a (non-Muslim) GIRL can get married <u>with</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.5	**What is the minimum legal age at which a MUSLIM BOY can get married <u>without parental consent</u>?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years

		❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.6	**What is the minimum legal age at which a MUSLIM BOY can get married <u>with parental consent</u>?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.7	**What is the minimum legal age at which a MUSLIM GIRL can get married <u>without parental consent</u>?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.8	**What is the minimum legal age at which a MUSLIM GIRL can get married <u>with parental consent</u>?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age

2.9	**In your view, when is it legal to get a divorce?**	1 ❑ Always, when at least one spouse wants to 2 ❑ Only when both spouses consent 3 ❑ Only if one spouse proves that he or she was psychologically incapacitated from the beginning of the marriage 4 ❑ Never
2.10	**What is the minimum age at which a BOY can <u>legally</u> have sex?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When he reaches puberty 77 ❑ Only when married 88 ❑ I don't know 99 ❑ No minimum age
2.11	**What is the minimum age at which a GIRL can <u>legally</u> have sex?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When he reaches puberty 77 ❑ Only when married 88 ❑ I don't know 99 ❑ No minimum age
PART 3: Service provision		
	Contraceptives	
3.1	**Does the law contain any prohibitions on the provision of contraceptives?**	1 ❑ Yes, all contraceptives are prohibited 2 ❑ No, there are no restrictions on access to contraceptives (no prohibitions) 3 ❑ Yes, the law only permits access to safe, non-abortifacient contraceptives

3.2	**In your view, which forms of reproductive service are considered to be forms of 'abortifacient contraceptives' under the law?**	1 ❑ All types of hormonal contraceptives are considered 'abortifacient' 2 ❑ 'Abortifacient' refers only to medical abortion 3 ❑ 'Abortifacient' refers only to medical abortion and emergency contraception 4 ❑ 'Abortifacient' refers only to medical abortion, and emergency contraception, and implants 5 ❑ 'Abortifacient' refers only to medical abortion, and emergency contraception, and implants and hormonal intrauterine devices (IUD/IUS)
3.3	**In your opinion, when should young people be allowed to access contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When s/he reaches puberty 77 ❑ Only when married 88 ❑ Only when has a child 99 ❑ At any age
3.4	**When does the law say that it is legal for a young person to access contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When s/he reaches puberty 77 ❑ Only when married 88 ❑ Only when s/he has a child 99 ❑ No minimum age

3.5	**Has anyone under 19 years ever come to you to access contraceptives?**	1 ❑ Yes 2 ❑ No
3.6	**Has anyone under 19 years who was also unmarried come to you to access contraceptives?**	1 ❑ Yes 2 ❑ No
3.7	**Does the law require you to seek parental consent before providing unmarried young people access to contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 77 ❑ Age doesn't matter, but parental consent is required for unmarried persons 88 ❑ No, there are no parental consent requirements 99 ❑ I don't know
3.8	**Does the law require you to seek spousal consent before providing any married person access to contraceptives?** (tick the best answer)	1 ❑ Yes, I always need to seek spousal consent 2 ❑ Yes, but only if the contraceptive method is permanent 3 ❑ No, there are no spousal consent requirements 4 ❑ I don't know
3.9	**Have you ever denied anyone under 19 years access to any of the following services *because of the law?*** (tick all that apply)	1 ❑ Male condoms 2 ❑ Contraceptive pills 3 ❑ Emergency contraception 4 ❑ Implants 5 ❑ IUD/IUS (hormonal) 6 ❑ No, I have not denied access to any of these services 7 ❑ I prefer not to say

3.10	**Have you ever denied anyone under 19 years access to any of the following services *because of your religious beliefs*?** (tick all that apply)	1 ❑ Male condoms 2 ❑ Contraceptive pills 3 ❑ Emergency contraception 4 ❑ Implants 5 ❑ IUD/IUS (hormonal) 6 ❑ No, I have not denied access to any of these services 7 ❑ I prefer not to say
	HIV testing	
3.11	**In your *opinion*, when should young people be allowed to access HIV testing?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When s/he reaches puberty 77 ❑ Only when married 88 ❑ Only when s/he has a child 99 ❑ At any age
3.12	**When does the *law* say that it is legal for a young person to access HIV testing?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When s/he reaches puberty 77 ❑ Only when married 88 ❑ Only when she has a child 99 ❑ No minimum age
3.13	**Has anyone under 19 years ever come to you to access HIV testing?**	1 ❑ Yes 2 ❑ No

3.14	**Has anyone under 19 years who was also <u>unmarried</u> come to you to access HIV testing?**	1 ❑ Yes 2 ❑ No
3.15	**Does the *law* require you to seek parental consent before providing a young person access to HIV testing?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 77 ❑ Age doesn't matter, but parental consent is required for <u>unmarried</u> persons 88 ❑ No, there are no parental consent requirements 99 ❑ I don't know
3.16	**Does the *law* require you to seek spousal consent before providing any married person access to HIV testing?** (tick the best answer)	1 ❑ Yes, I always need to seek spousal consent 2 ❑ No, there are no spousal consent requirements 3 ❑ I don't know
3.17	**Have you ever denied a young person under 19 years access to HIV testing *because of the law*?** (tick your answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
3.18	**Have you ever denied anyone under 19 years access to HIV testing *because of your religious beliefs*?** (tick your answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
	STI testing (other than HIV)	
3.19	**In your *opinion*, when should young people be allowed to access STI testing (other than HIV)?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years

		55 ❑ Older than 21 years 66 ❑ When s/he reaches puberty 77 ❑ Only when married 88 ❑ Only when s/he has a child 99 ❑ At any age
3.20	**When does the *law* say that it is legal for a young person to access STI testing (other than HIV)?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ When s/he reaches puberty 77 ❑ Only when married 88 ❑ Only when she has a child 99 ❑ No minimum age
3.21	**Has anyone under 19 years ever come to you to access STI testing (other than HIV)?**	1 ❑ Yes 2 ❑ No
3.22	**Has anyone under 19 years who was also <u>unmarried</u> come to you to access STI testing (other than HIV)?**	1 ❑ Yes 2 ❑ No
3.23	**Does the *law* require you to seek parental consent in order to provide a young person access to STI testing (other than HIV)?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 77 ❑ Age doesn't matter, but parental consent is required for <u>unmarried</u> persons 88 ❑ No, there are no parental consent requirements 99 ❑ I don't know

3.24	**Does the *law* require you to seek spousal consent before providing any married person access to STI testing (other than HIV)?** (tick the best answer)	1 ❑ Yes, I always need to seek spousal consent 2 ❑ No, there are no spousal consent requirements 3 ❑ I don't know
3.25	**Have you ever denied a young person under 19 years access to STI testing (other than HIV) *because of the law*?** (tick your answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
3.26	**Have you ever denied anyone under 19 years access to STI testing (other than HIV) *because of your religious beliefs*?** (tick your answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
	Abortion	
3.27	**In your *opinion*, when should a young woman be allowed to access an abortion?** (tick the best answer)	1 ❑ Always, there should be no restrictions on abortion 2 ❑ Never, abortion should be fully restricted 3 ❑ Sometimes, depending on the circumstances
3.28	**According to the *law*, when can a young woman access an abortion?** (tick the best answer)	1 ❑ Always, there are no restrictions 2 ❑ Never, abortion should be fully restricted 3 ❑ Sometimes, depending on the circumstances
3.29	**According to the *law*, are there any circumstances in which a woman can access an abortion?** (you are allowed to tick more than one answer)	1 ❑ Yes, if she is a victim of rape or incest 2 ❑ Yes, if it is necessary to save her life 3 ❑ Yes, if her health would deteriorate with continued pregnancy 4 ❑ Yes, if her child would be disabled 5 ❑ Yes, abortion is legally permitted in all circumstances 6 ❑ No, abortion is never legally permitted in any circumstances

3.30	**Has anyone ever come to you to access abortion services?**	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
3.31	**Have you ever denied anyone access to abortion services *because of the law*?** (tick your answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say 4 ❑ Not applicable/I do not provide abortion services
3.32	**Have you ever denied anyone access to abortion service *because of your religious beliefs*?** (tick your answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say 4 ❑ Not applicable/I do not provide abortion services
	Confidentiality	
3.33	**According to the *law*, should you inform young persons' parents / guardians without their permission if they want to access counselling and information?** (tick the best answer)	Required to inform a child's parents / guardians if the child is under…. ❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 88 ❑ Never in any circumstances 99 ❑ There is no law on this
3.34	**According to the *law*, should you inform young persons' parents / guardians without their permission if they want to access contraceptives?** (tick the best answer)	Required to inform a child's parents / guardians if the child is under…. ❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 88 ❑ Never in any circumstances 99 ❑ There is no law on this

3.35	**According to the *law*, should you inform young persons' parents / guardians without their permission if they want to access HIV testing?** (tick the best answer)	Required to inform a child's parents / guardians if the child is under…. ❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 88 ❑ Never in any circumstances 99 ❑ There is no law on this
3.36	**Would you give a parent / guardian details of a consultation with a minor, if the parent came to ask?**	1 ❑ Always 2 ❑ Never 3 ❑ Maybe, depending on the circumstances
3.37	**Have you ever reported a girl to the authorities because you learned that she was sexually active under the age of 12?** (tick your answer)	1 ❑ Yes 2 ❑ No
3.38	**What happens if you fail to report such cases?** (tick your best answer)	1 ❑ I risk going to jail 2 ❑ I risk losing my job 3 ❑ I risk having to pay a penalty 4 ❑ Nothing at all
3.39	**Have you ever reported a girl to the authorities because you learned that she was sexually active under the age of 18 with someone above the age of 18?** (tick your answer)	1 ❑ Yes 2 ❑ No
3.40	**What happens if you fail to report such cases?** (tick your best answer)	1 ❑ I risk going to jail 2 ❑ I risk losing my job 3 ❑ I risk having to pay a penalty 4 ❑ Nothing at all

3.41	**Have you ever reported a <u>boy</u> to the authorities because you learned that he was sexually active under the age of 12?** (tick your answer)	1 ❑ Yes 2 ❑ No
3.42	**What happens if you fail to report such cases?** (tick your best answer)	1 ❑ I risk going to jail 2 ❑ I risk losing my job 3 ❑ I risk having to pay a penalty 4 ❑ Nothing at all
3.43	**Have you ever reported a <u>boy</u> to the authorities because you learned that he was sexually active under the age of 18 with someone <u>above</u> the age of 18?** (tick your answer)	1 ❑ Yes 2 ❑ No
3.44	**What happens if you fail to report such cases?** (tick your best answer)	1 ❑ I risk going to jail 2 ❑ I risk losing my job 3 ❑ I risk having to pay a penalty 4 ❑ Nothing at all

Survey tool Young People

Unique ID: SP _____

To be filled in by enumerators:
Location (where the questionnaire was distributed)

Municipality_____Barangay_____

Date (when the questionnaire was distributed):

To be filled in by respondents: Our organisation, the Family Planning Organisation of the Philippines (FPOP), is conducting research about the provision of sexual and reproductive health services.

We would like to ask you to complete this questionnaire and answer some questions about your knowledge and experiences. Please be as honest as you can in your answers: we want to learn from you!

All of the information provided is kept strictly anonymous. **Please do not write your name on the form**.

Please fill out **all** the questions on the survey form. If you do not know the answer to a question, please select your best guess.

Please only select **one answer** for each question, except where the form specifically instructs you otherwise.

Taking the survey is voluntary. Would you like to take the survey?

1 ❑ Yes 2 ❑ No

PART 1: Background information		
1.1	**Gender** (tick one)	1 ❑ Female 2 ❑ Male 3 ❑ Other
1.2	**Age** (fill in)	_____ (number in years)
1.3	**How would you describe the area where you live?** (tick the best response)	1 ❑ Urban neighbourhood 2 ❑ Urban slum 3 ❑ Sub-urban area 4 ❑ Rural area
1.4	**What is the highest level of education you have completed?** (tick the best response)	1 ❑ no education 2 ❑ elementary 3 ❑ primary 4 ❑ secondary 5 ❑ university 6 ❑ other

1.5	**Do you do any work for a wage?** (tick the best response)	1 ❑ Yes, full time 2 ❑ Yes, part time 3 ❑ No
1.6	**What is your religion** (tick one)	1 ❑ Catholic 2 ❑ Protestant 3 ❑ Muslim 4 ❑ Buddhist 5 ❑ Other 6 ❑ No religion
1.7	**Which of the following is present in your household?** (tick all that apply)	1 ❑ refrigerator 2 ❑ mattress 3 ❑ television 4 ❑ computer 5 ❑ mobile telephone 6 ❑ piped water 7 ❑ flush toilet 8 ❑ gas cooker 9 ❑ car 10 ❑ internet
1.8	**What is your marital status?** (tick the best response)	1 ❑ never married 2 ❑ married now 3 ❑ separated/divorced 4 ❑ widowed 5 ❑ other
PART 2: Knowledge and perceptions		
2.1	**What is the minimum legal age at which a (non-Muslim) BOY can get married <u>without</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.2	**What is the minimum legal age at which a (non-Muslim) GIRL can get married <u>without</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years

		66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.3	**What is the minimum legal age at which a (non-Muslim) BOY can get married <u>with</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.4	**What is the minimum legal age at which a (non-Muslim) GIRL can get married <u>with</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.5	**What is the minimum legal age at which a MUSLIM BOY can get married <u>without</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age

2.6	**What is the minimum legal age at which a MUSLIM BOY can get married <u>with</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.7	**What is the minimum legal age at which a MUSLIM GIRL can get married <u>without</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.8	**What is the minimum legal age at which a MUSLIM GIRL can get married <u>with</u> parental consent?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.9	**In your view, when is it legal to get a divorce?**	1 ❑ Always, when at least one spouse wants to 2 ❑ Only when both spouses consent 3 ❑ Only if one spouse proves that he or she was psychologically incapacitated from the beginning of the marriage 4 ❑ Never

2.10	**What is the minimum age at which a BOY can <u>legally</u> have sex?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
2.11	**What is the minimum age at which a GIRL can legally have sex?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 55 ❑ Older than 21 years 66 ❑ Older than 21 years 77 ❑ When he reaches puberty 88 ❑ I don't know 99 ❑ No minimum age
	Contraceptives	
2.12	**In your *opinion*, when should young people be able to access contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never

2.13	**In your view, when is it *legal* for young people to access contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never
2.14	**In your view, does the *law* require service providers to get parental consent before providing young people access to contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 77 ❑ Age doesn't matter, but parental consent is required for unmarried persons 88 ❑ No, there are no parental consent requirements 99 ❑ I don't know
	Emergency contraceptives	
2.15	**In your opinion, when should young people be allowed to access <u>emergency</u> contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never

2.16	**When does the *law* say that it is legal for a young person to access <u>emergency</u> contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never
2.17	**Does the *law* require service providers to get parental consent before providing a young person access to <u>emergency</u> contraceptives?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Age doesn't matter, but parental consent is required for unmarried persons 77 ❑ No, there are no parental consent requirements 88 ❑ There are no parental consent requirements because emergency contraception is illegal 99 ❑ I don't know
	Implants	
2.18	**In your *opinion*, when should young people be allowed to access implants?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never

2.19	**When does the *law* say that it is legal for a young person to access implants?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never
2.20	**Does the *law* require service providers to get parental consent before providing young people access to implants?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Age doesn't matter, but parental consent is required for unmarried persons 77 ❑ No, there are no parental consent requirements 88 ❑ There are no parental consent requirements because implants are illegal 99 ❑ I don't know
HIV testing		
2.21	**In your *opinion*, when should young people be allowed to access HIV testing?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never

2.22	**When does the *law* say that it is legal for a young person to access HIV testing?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ No minimum age 99 ❑ Never
2.23	**Does the *law* require service providers to get parental consent before providing young people access to HIV testing?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 66 ❑ Age doesn't matter, but parental consent is required for unmarried persons 77 ❑ No, there are no parental consent requirements 88 ❑ I don't know
	STI testing (other than HIV)	
2.24	**In your *opinion*, when should young people be allowed to access STI testing (other than HIV)?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ At any age 99 ❑ Never

2.25	**When does the *law* say that it is legal for a young person to access STI testing (other than HIV)?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 44 ❑ Older than 21 years 55 ❑ When s/he reaches puberty 66 ❑ Only when married 77 ❑ Only when s/he has a child 88 ❑ No minimum age 99 ❑ Never
2.26	**In your view, does the *law* require service providers to get parental consent before providing young people access to STI testing (other than HIV)?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 77 ❑ Age doesn't matter, but parental consent is required for unmarried persons 88 ❑ No, there are no parental consent requirements 99 ❑ I don't know
	Abortion	
2.27	**In your *opinion*, when should young woman be allowed to access an abortion?** (tick the best answer)	1 ❑ Always, there should be no restrictions on abortion 2 ❑ Never, abortion should be fully restricted 3 ❑ Sometimes, depending on the circumstances
2.28	**According to the *law*, when can young woman access an abortion?** (tick the best answer)	1 ❑ Always, there are no restrictions 2 ❑ Never, abortion is totally prohibited 3 ❑ Sometimes, depending on the
2.29	**According to the *law*, are there any circumstances in which a woman can access an abortion?** (you are allowed to tick more than one answer)	1 ❑ Yes, if she is a victim of rape or incest 2 ❑ Yes, if it is necessary to save her life 3 ❑ Yes, if her health would deteriorate with continued pregnancy 4 ❑ Yes, if her child would be disabled 5 ❑ Yes, abortion is legally permitted in all circumstances 6 ❑ No, abortion is never legally permitted in any circumstances

Confidentiality		
2.30	**According to the *law*, can a health professional inform young persons' parents <u>without</u> their permission if they want to access counselling and information?** (tick the best answer)	Yes they can inform when a young person is under…. ❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 88 ❑ Never in any circumstances 99 ❑ There is no law on this
2.31	**According to the *law*, can a health professional inform young persons' parents <u>without</u> their permission if they want to access contraceptives?** (tick the best answer)	Yes they can inform when a young person is under…. ❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 88 ❑ Never in any circumstances 99 ❑ There is no law on this
2.32	**According to the *law*, can a health professional inform young persons' parents <u>without</u> their permission if they want to access HIV testing?** (tick the best answer)	Yes they can inform when a young person is under…. ❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 88 ❑ Never in any circumstances 99 ❑ There is no law on this

PART 3: Experiences		
3.1	**At what age did you first have sex?** (tick the best answer)	❑ 9 years ❑ 14 years ❑ 19 years ❑ 10 years ❑ 15 years ❑ 20 years ❑ 11 years ❑ 16 years ❑ 21 years ❑ 12 years ❑ 17 years ❑ 13 years ❑ 18 years 77 ❑ Older than 21 years 88 ❑ Never had sex 99 ❑ I prefer not to say
3.2	**If you ask a health professional for advice about contraception, do you think that they will they keep your information confidential?** (tick the best answer)	1 ❑ Yes 2 ❑ Yes, but not if they think I am at risk or will be harmed 3 ❑ No 4 ❑ I don't know
3.3	**Have you ever tried to access any of the following services?** (tick all that apply, otherwise leave blank)	1 ❑ Male condoms 9 ❑ Ante natal services 2 ❑ Contraceptive pills 10 ❑ Post-natal services 3 ❑ Emergency contraception 11 ❑ Rape counselling 4 ❑ Injections 12 ❑ Medical abortion 5 ❑ Implants 13 ❑ Surgical abortion 6 ❑ HIV testing 14 ❑ Sterilisation 7 ❑ STI testing (non HIV) 15 ❑ IUD (non-hormonal) 8 ❑ Gender reassignment 16 ❑ IUS (hormonal)
3.4	**Have you ever been denied access to any of the following services?** (tick all that apply, otherwise leave blank)	1 ❑ Male condoms 9 ❑ Ante natal services 2 ❑ Contraceptive pills 10 ❑ Post-natal services 3 ❑ Emergency contraception 11 ❑ Rape counselling 4 ❑ Injections 12 ❑ Medical abortion 5 ❑ Implants 13 ❑ Surgical abortion 6 ❑ HIV testing 14 ❑ Sterilisation 7 ❑ STI testing (non HIV) 15 ❑ IUD (non-hormonal) 8 ❑ Gender reassignment 16 ❑ IUS (hormonal)

3.5	**Have you been denied access to a service because of your age?** (tick all that apply, otherwise leave blank)	1 ❑ Male condoms 2 ❑ Contraceptive pills 3 ❑ Emergency contraception 4 ❑ Injections 5 ❑ Implants 6 ❑ HIV testing 7 ❑ STI testing (non HIV) 8 ❑ Gender reassignment 9 ❑ Ante natal services 10 ❑ Post-natal services 11 ❑ Rape counselling 12 ❑ Medical abortion 13 ❑ Surgical abortion 14 ❑ Sterilisation 15 ❑ IUD (non-hormonal) 16 ❑ IUS (hormonal)
3.6	**Has anyone ever had sex with you or committed sexual acts with you through force or against your will?** (tick the best answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
3.7	**Have you ever engaged in sexual activity in exchange for money, goods or favours?** (tick the best answer)	1 ❑ Yes 2 ❑ No 3 ❑ I prefer not to say
3.8	**Have you received any education about sexual and reproductive health?** (tick all that apply)	1 ❑ Yes, at school 2 ❑ Yes, from a religious or community leader 3 ❑ Yes, from an NGO /youth centre 4 ❑ No, never
3.9	**If you received any education about sexual and reproductive health, what topics were covered?** (tick all that apply)	1 ❑ Contraceptive use 2 ❑ STIs 3 ❑ HIV/AIDS 4 ❑ Abortion 5 ❑ Healthy relationships 6 ❑ Male anatomy 7 ❑ Female anatomy 8 ❑ Sexual violence 9 ❑ Sterilisation 10 ❑ Puberty

Annex E: Full List of Research Participants

Key informant interviews	Commissioner, National Youth Commission, Quezon City, 28 November 2016
	Executive Director of Family Planning Organisation of the Philippines, Quezon City, 5 December 2016
	National Coordinator, Adolescents Programme, Department of Health, 5 December 2016, Manila
	Representative, Safe Abortion Network, Quezon City, 5 December 2016
	HIV Programme Officer, UNICEF and HIV/AIDS and Adolescent Health and Participation Focal Person, Council on the Welfare of Children, Department of Social Welfare and Development, Manila, 6 December 2016
Focus group discussions	Four LGBT young people, 13 – 17 years, Public Secondary School in San Fernando, Pampanga, 29 November 2016
	Four boys, 14 – 17 years, Public Secondary School in San Fernando, Pampanga, 29 November 2016
	Four girls, 15 – 16 years, Public Secondary School in San Fernando, Pampanga, 29 November 2016
	Four young women who have been pregnant, 18 – 24 years, San Fernando, Pampanga, 30 November 2016
	Four mothers of adolescents / young people (disadvantaged community), San Fernando, Pampanga, 30 November 2016
	Four young women who do sex work, 18 – 25 years, Angeles City, 30 November 2016
	Three parents of adolescents (advantaged community), Quezon City, 1 December 2016
	Four parents of adolescents (disadvantaged community), Quezon City, 1 December 2016
	Eight young women, 17 – 22 years, Quezon City, 1 December 2016
	Eight young women, 15 – 18 years, Quezon City, 1 December 2016
	Seven young men, 15 – 22 years, Quezon City, 1 December 2016
	Six young men, 16 – 18 years, Quezon City, 1 December 2016

Individual interviews with service providers	Pharmacy worker (female), 23 years, San Fernando, Pampanga, 29 November 2016
	Nurse (female) at Public Health Clinic, San Fernando, Pampanga, 29 November 2016
	Doctor (male) at Public Health Clinic, San Fernando, Pampanga, 29 November 2016
	Two nurses (female) at public sexual health clinic, Angeles City, 30 November 2016
	Midwife (female), Private Clinic (disadvantaged area), Quezon City, 2 December 2016
	Midwife (female), Private Clinic (advantaged area), Quezon City, 2 December 2016
	Midwife (female), public health clinic, Quezon City, 2 December 2016
	Community Health Worker (SGBV focus), Quezon City, 2 December 2016
	School nurse at public school in Quezon City and midwife at FPOP health centre, Quezon City, 2 December 2016
	Pharmacy assistant (female), Quezon City, 2 December 2016
	Sexual Health Nurse (female), FPOP (private health clinic), San Fernando and Angeles, Pampanga, 5 December 2016
	Coordinator (nurse) (male), community-based HIV screening centre, Quezon City, 6 December 2016

International Planned Parenthood Federation
East & South East Asia and Oceania Region
246, Jalan Ampang
50450 Kuala Lumpur
Malaysia
Tel : +60 (3) 425 66 122
+60 (3) 425 66 246
+60 (3) 425 66 308
Fax : +60 (3) 425 66 386
Email : office@ippfseaor.org
Website : www.ippfseaor.org

Sub-Regional Office for the Pacific
BSP Life Centre, Level 4
Thomson Street
Suva, Fiji
Tel : +679 3315 624 / 625
Fax : +679 3315 656
Email : ippf@ippf-srop.org.fj

IPPF Central Office
4, Newhams Row, London SE1 3UZ
United Kingdom
Tel : +44 020 7939 8200
Fax : +44 020 7939 8300
Email : info@ippf.org
Website : www.ippf.org