FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, England and Wales, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
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SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, Ethical, Social and Cultural (ESC) impacts on sexual reproductive health and rights and HIV.
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PHILIPPINES

AGE OF CONSENT
ETHICAL, SOCIAL AND CULTURAL REVIEW
## ACRONYMS

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<th>Definition</th>
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<tr>
<td>AEP</td>
<td>Adolescent Education Programme</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>GDP</td>
<td>Gross domestic product</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<td>PLWHIV</td>
<td>People living with HIV</td>
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<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
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<td>SRHS</td>
<td>Sexual and Reproductive Healthcare Services</td>
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<td>UNAIDS</td>
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<td>YFC</td>
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Chapter One: Introduction

The world’s attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

Eastern and Southern Africa now has 10.5 million children who have lost one or both parents to AIDS. In 2011, there was an estimated 1.2 million adolescents 10-19 years old living with HIV, more than half of all HIV positive adolescents globally.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15 - 24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15% of young women are HIV positive, compared to 6.5% of young men.

All In To #EndAdolescentAIDS was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides an opportunity for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include 2012 guidance on Pre-exposure oral Prophylaxis (PrEP) for sero-discordant couples, men and transgender women who have sex with men at high risk of HIV as well as the 2013 guidance for HIV testing and counselling and care for adolescents living with HIV and Young Key Population Policy Briefs.

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have therefore explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HTC and to linkages to prevention, treatment and care.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV prevention by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All In To #EndAdolescentAIDS, many agencies and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts at globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review

Several global bodies including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility, acceptability, adherence and quality must inform these services.
SRHR Africa Trust in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. Age of Consent legal review
2. Ethical, Social, Cultural (ESC) desktop review
3. Youth Attitudes Survey

Therefore, the main goal of the project is to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This will entail collecting country experiences to address Age of Consent laws / polices and ESC factors that serve as potential barriers to adolescents accessing sexual and reproductive Health care services, including HIV prevention, care and treatment. This will include exploring implications for expanding SRHR services and HTC in adolescents aged 10 – 19 years.

Objectives and methodology

The aim of this ethical, Economic review is to highlight some of the social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

• Age of Consent for sexual intercourse and sexual debut.
• Homosexuality and transgender expression.
• Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing [HCT] and contraception access.

This report is primarily a desk review of publically accessible sources, including works published by international agencies such as UNICEF, UNESCO, UNDP, and the World Bank, Filipino Government reports, and non-Governmental research outputs.

Country overview

The Philippines comprises 7,107 islands. The country is located in South East Asia in the Western Pacific. The Philippines is the 12th most populated country in the world with approximately 103 million people. It is estimated that 50.4% of the country’s population is male and 49.6% is female. The literacy rates for the youth (15-24 years) is approximately 96.98% for males and 98.94% for females. Approximately 45.3% of the population live in urban areas and 54.7% live in rural areas. Christianity is the most prevalent religion in the Philippines with approximately 80-85% of the population identifying as Roman Catholics. Adherents of Seventh-day Adventists, United Church of Christ, United Methodists, the Episcopal Church in the Philippines, Assemblies of God, The Church of Jesus Christ of Latter-day Saints (Mormons), and Philippine (Southern) Baptists, Iglesia ni Cristo (Church of Christ), Philippine Independent Church (Aglipayan), Members Church of God International, and The Kingdom of Jesus Christ, and the Name Above Every Name cumulatively make up less than 5% of the country’s population. Islam is the largest minority religion, constituting 11% of the population. Ethnically, an estimated 28.10% of the population is Tagalog, 9.00% are Ilocano, 7.60% are Bisaya/Binisaya, 7.50% are Hiligaynon Ilonggo, 6.00% are Bikol, 3.40% are Warray, and 25.30% constitutes other ethnic minorities. The principal languages in the Philippines are Filipino, Tagalog, and English.
Chapter Two: Age of Consent for sex

In the Philippines, the legal Age of Consent to sex is 12 years of age for both males and females. Sex with a child less than 12 years of age is classified as forcible rape. Sex with someone under 18 but over 12 years is permissible as long as the age difference between the two is less than 10 years.

The average of age of sexual debut in the Philippines is 18 years of age. The Youth Adult Fertility and Sexuality Study (YAFS 4) conducted a study on Pinoy youth between 15-24 years of age which revealed that 1 in 3 Pinoy youth in that age range have had sexual intercourse, of which 16.9% of adolescents in the 15-19 year old age range had sexual intercourse. Approximately 79% of 15-19 year olds did not use any form of protection during first premarital sex. Catholics are prohibited from engaging in premarital sex. The Roman Catholic Church teachings emphases that the main purpose of sexual relations is procreation and hence should be limited to marital unions. This creates tension and prevents young adults who are not married but are sexually active to access SRHS.

Child marriages

Child marriage is also pervasive in the Philippines. Aside from the autonomous region in Muslim Mindanao, where the legal age to marry is 15 years of age, the country’s Family Code of 1987 permits any male or female between 18- 21 years of age to contract marriage with parental consent. The National Statistical Coordination Board reported that in 2011, 58,320 girls under the age of 20 years were married. UNICEF reported that in 2015, an estimated 2% of teenagers are married by 15 years of age and 14% are married by 18 years of age. Studies have also indicated that an estimated 14% of married women 20-24 years of age reported that they were married before 18 years of age. Child marriages mainly occur in poor, rural areas where such norms are tolerated. In Muslim communities, Sharia law allows marriage of females of any age.

Gender roles and expectations

The prevailing gender issues in the Philippines influences the sexual characteristics and identities of Filipino adolescents. Adolescents are faced with double standards and stereotypes which define their roles and behaviours as they form their sexual identity and orientation. Masculinity is an important aspect as sexual characteristics and concepts are held in high regard. The typical rite of passage for male Filipino adolescents entails undergoing key events, namely, circumcision (92.5% of Philippine men are circumcised, with circumcision commonly occurring between 10-14 years of age), first sexual encounter, and courting. Males are expected to pass through these events for them to be classified as ‘real’ men. If a male does not go through these events he reportedly faces negative remarks and is labelled by his peers. Furthermore, it is acceptable for males to respond impulsively to their sexual urges. However, when a girl becomes pregnant she is blamed and labelled as sexually promiscuous.

Social media and technology

There are approximately 38 million Internet users in the Philippines. It is predicted that this will increase due to the falling cost of Internet access and devices. People under 30 years of age account for two thirds of Internet users. It is estimated that approximately 22 million Filipinos accessed their social media via smartphone or tablet. Internet penetration and usage can translate to increased sexual appetite. The YAFS 4 reported that 6 in 10 young people in the age range of 15-24 years of age are regular Internet users. More than half have social network and email accounts and 78% have mobile phones. On average young people in the Philippines spend 6 hours a week online, with some even logging in for 35 hours. Females, younger youth, and those in economically better-off regions show higher social media consumption compared to males, older youth and those in low economic regions. Access to social media and Internet facilitates access to explicit pornographic material. YAFS 4 study reported that 56.5% of respondents had watched pornographic material, 15.5% has visited websites with sexually explicit content, and 35.6% had read sexually explicit material. Males access such material more than women, with 43.1% reading, 75.8 watching, and 26.4% visiting websites with explicit content compared to 28.4%, 38.1% and 5.1%, respectively. Among 15-19 year old adolescents, 29.8% had read, 49.6% had watched, and 13.5% had visited websites with sexually explicit content. Furthermore, studies have reported that 9.8% of adolescents 15-19 years of age had sent or received sex videos through their phone or Internet. Such exposure could heighten an adolescent’s sexual awareness and curiosity, thus catalysing their early sexual debut.
Family and work context

The family context has substantial influence on adolescent sexual behaviour. In Filipino families, talking about sex is taboo or hardly discussed. Parents avoid talking about sex to avoid further ‘complicating the situation’. Some parents are absent in their children’s lives as in the case of Overseas Filipino Workers, which leads to children having flexible morals because they do not have their parents to monitor them. Philippines is the largest provider of workers for business product outsourcing. A substantial number of young Filipinos work in ‘sunshine industries (i.e., new industries with a high growth rate). A study funded by an International Labour Organisation reported risky sexual behaviours among call centre workers such as early sexual activity, promiscuity, and low condom use. Among the 15 to 24 year old age group, 70% of women and 90% men were sexually active. Changes in family structure because of increasing employment opportunities for parents also reduces monitoring of, and social support for, adolescents, which can facilitate their engagement in risky behaviours.

Ethical implications and recommendations

Philippine authorities should also take the lead in challenging stereotypes in regard to gender roles and expectations. The country’s Age of Consent for sex (12 years of age) is low compared to most countries. Furthermore, the country’s permissibility of sex between individuals 12-18 years of age, as long as the age difference between the two is less than 10 years, may facilitate early sexual debut and complicate disclosure obligations in instances of abuse. Authorities should give thought to how provide social and emotional support of adolescents who have absentee parents due to their work responsibilities. Given the relatively high Internet usage rate amongst Philippine adolescents, the Philippine Government, international agencies, and NGOs working in the field of adolescent health should consider mounting online SRHS campaigns targeted to adolescents, in a non-judgemental manner. Such campaigns and information provision should include information on SRHS and where adolescents can access SRHS.

Country experiences in addressing the barriers

Philippine law contains provisions aimed at protecting children against exposure to pornography. For instance, Article 95 of the country’s Special Protection of Children Against Child Abuse, Exploitation and Discrimination Abuse Act states that “it shall be the duty of all civic associations and youth associations to bring to the attention of the proper authorities their exhibition of indecent shows and the publication, sale, or circulation of pornographic materials.” Moreover, the Act also instructs families and the community to “cooperate with each other in counteracting and eliminating such influence as may be exerted upon children by useless and harmful amusements and activities, obscene exhibitions and programmes, and establishments inimical to health and morals.”

The State is obligated “to provide special protection to children from all forms of abuse, neglect, cruelty, exploitation and discrimination, and other conditions prejudicial to their development; provide sanctions for their commissions and carry out a programme from prevention and deterrence of and crisis intervention in situations of child abuse, exploitation and discrimination.” Although the state is trying to curb adolescents’ access to pornographic material these efforts have had limited success. For instance, one can merely type ‘porn’ on a search engine in the Philippines and the results will yield a number of porn sites. Some porn sites have a pornographic variety of animation known as Hentai, which are easily accessible to adolescents. Free pornographic websites are also easily accessible to Filipino adolescents.
Chapter Three: Homosexuality and transgender expression

The Philippines is one of a few countries globally where homosexual acts were never explicitly criminalised. It is estimated that MSM make up 3% of the population, which equates to approximately 730,917 people. Adolescents between 15-19 years of age make up one fifth of MSM aged between 15 and 49 years. In the local Tagalog language, there is only one term, bakla, to describe MSM. A survey conducted by the Pew Research Centre in 2013 reported that 73% of Filipino respondents indicated that homosexuality was acceptable, although this claim has been disputed by Philippine LGBTI. Young respondents (18-29 years group) demonstrated a higher percentage (78%) in support of acceptability of homosexuality.

Despite claimed tolerance, LGBTI-related crimes are still prevalent in the country. In the first half of 2011, 28 LGBTI-related killings were documented. The LGBTI community in the Philippines is marginalised, stigmatised and discriminated against. Transgender adolescents often face abuse in schools. Studies indicate that some transgender students were made to leave the classroom or threatened with being barred from graduating because of their gender expression. The church opposes LGBTI Filipinos being afforded legal protection. The Roman Catholic Church is against same-sex relationships and same sex unions, regarding them as unacceptable. The Media Office of the Catholic Bishops Conference of the Philippines believes that being homosexual is a choice and is changeable.

Ethical implications and recommendations

Philippine authorities need to do more to deter discriminatory, judgemental, and stigmatising attitudes and behaviour towards LGBTI on the part of society and health professionals. Healthcare workers should be given sensitivity-training and reminded that they have an ethical (and legal) duty to provide care to any person in need and that this duty supersedes their personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, that health professionals (and officials) have a legal and ethical obligation to always act in the best interests of a child, regardless of that child’s sexual orientation.

Country experiences in addressing the barriers

In order to address bullying in Filipino schools, the Anti-Bullying Act of 2013 was developed to protect students from all the different forms of bullying and abuse in schools. Intervention programmes for victims and engagement with the families and community at large are also included in the Act. However, schools need to be monitored to make sure that they are implementing the policy. Furthermore, a regional programme in Asia called ‘Being LGBT in Asia’ was established in order to address inequality, violence, and discrimination on the basis of gender identity, sexual orientation or intersex status. The formation of partnerships between LGBTI groups such as TLF Sexuality, Health and Rights Educators Collective Inc. (TFL SHARE) and the Commission on Human Rights of the Philippines (CHRP) to support the Anti-Discrimination Bill has made some progress in addressing stigma and discrimination against the LGBTI community. In an attempt to address stigma and discrimination against the LGBTI community, Amnesty International-Pilipinas and the Lesbian and Gay Legislative Advocacy Network (LAGALAB) launched the ‘Stop Discrimination Now’ campaign. The campaign addresses and opposes discrimination against the LGBTI community in the Philippines. The International Gay and Lesbian Human Right Commission (IGLHRC) and LADLAD LGBT Party partnered with the Philippines National Police Human Rights Affairs Office to conduct a nation Gender and Sexuality training programme to sensitive police officers when engaging with LGBTI people.
Chapter Four: Access to sexual and reproductive health services (SRHS)

There is a high prevalence of teenage pregnancy in the Philippines. The National Statistics Authority reports that 1 in 10 adolescent Filipino females aged 15 to 19 years of age is already a mother or pregnant with first child. Reports have highlighted that between 2000 and 2010 there was an increase of 65% in teenage pregnancy. In some instances, adolescents as young as 10 years of age have a baby as soon as menstruation occurs. In 2013, adolescent Filipino women had heard an average of 4.5 modern contraceptive methods. In the same year two-thirds of women 15-24 years of age knew where to obtain a condom, and 35% indicated that they could obtain condoms on their own. SRHS in the Philippines lacks political support, both at local and national levels. The national approach to SRHS remains unclear and is not well integrated with the response to HIV/AIDS.

The law surrounding consent for HCT is a barrier to adolescents accessing HCT. In the Philippines for one to access HCT without parental consent he/she needs to be 18 years of age, Adolescents at a higher risk of contracting HIV can access HCT at 15 years of age. The higher age for individual consent is restrictive and detrimental to adolescents who need to access these services. Philippine laws have been criticised to run counter and non-responsive to sexual health needs of adolescents.

The dominant sexual ideologies prescribe condom use in particular sexual contexts like during casual sex but not in committed relationships. Due to the various sociological and structural factors, the Philippines has the lowest reported condom use in Asia.

Legislative barriers

The Revised Philippine HIV and AIDS Policy and Program Act of 2012 stipulates that HIV testing and counselling shall be made available to a child only under the following conditions:

1. The child, who is above the age of fifteen (15) years but under eighteen (18) years, expresses the intention to submit to HIV testing and counselling and other related services;
2. Reasonable efforts were undertaken to locate, provide counselling to, and to obtain the consent of, the parents, but the parents are absent or cannot be located, or otherwise refuse to give their consent;
3. Proper counselling shall be conducted by a social worker, healthcare provider or other healthcare professional, accredited by the DOH or DSWD; and
4. The licensed social worker, health care provider or other health care professional shall determine that the child is “at higher risk of HIV exposure,” as defined in Section 3 (O) of this Act, and that the conduct of the testing and counselling is in the child’s best interest and welfare.

Similarly, the country’s Responsible Parenthood and Reproductive Health Act of 2012 stipulates that: “No person shall be denied information and access to family planning services, whether natural or artificial: Provided, That minors will not be allowed access to modern methods of family planning without written consent from their parents or guardian/s except when the minor is already a parent or has had a miscarriage.”

Such provisions are arguably unethical as the denial of autonomy rights to adolescents in respect to their sexual and reproductive health effectively deprives them of access to SRHS. Such an outcome is not in their best interest.
Structural barriers

Adolescents have difficulty accessing HIV testing and condoms due to the high costs. Condoms cost 12 Philippine Pesos, equivalent to $0.24USD, for a 3-pack. In the Philippines, free condoms are scarce and there is restricted condom supply. Due to Government ordinances prohibiting condom distribution, USAID’s withdrawal of support and supply of free condoms for distribution in 2002, and the Filipino Government’s withdrawal of funding for contraceptives in 2003, many health clinics no longer offer free condoms. Condoms can, however, be purchased in pharmacies. One village council in the Philippines required a prescription for individual to be able to buy condoms. Reports have indicated that women living with HIV face difficulties in accessing ART and other HIV testing and treatment due to economic hardship.

Distance and commuting time impose significant costs. Lower socio-economic groups easily access condoms at smaller pharmacies. Pharmacies are often crowded with people from the neighbourhoods in which they are located, and the condoms are usually behind the counter, which necessitates asking the clerk for them, thus signalling that one intends on having sex. Cultural norms stigmatize condom use. Overtly conveying that one is intending to engage in sexual relations is seen as shameful. There is lack of privacy and anonymity in accessing condoms. Studies have highlighted that some adolescents, both male and female, indicated that they would never purchase condoms because doing so is embarrassing.

Filipino adolescents are also faced with unfriendly services in healthcare facilities. Most Heathcare providers have conservative attitudes. For example, they believe that young people, especially unmarried females, have no right to seek services relating to sex. Filipino cultural norms allow males to control females’ access to contraceptives, condoms and HIV testing. Despite substantial training for adult HCT, there is a substantial gap in providing adolescent-specific training. Filipino providers have reported problems with effective communication between themselves and adolescents. Some have problems in providing counselling to seemingly inattentive or unreceptive adolescents. Furthermore, most clinics in the Philippines open at inconvenient times when most adolescents are in school or at work. The clinics are also situated in uninviting locations that are inconvenient for adolescents or in locations that are well-known for specifically catering to sex workers. There are no specific testing centres for adolescents.

The Roman Catholic Church in the Philippines is against the provision of artificial contraceptives. In 2003, the country’s Catholic Church successfully blocked the implementation of a national reproductive health policy. The policy would have helped in facilitating access to condoms and HIV/AIDS information at the local level. The Catholic Bishops Conference of the Philippines issued a pastoral letter which was to be read at every Sunday mass in the country. The letter was intended to give an impression that the majority of people were against reproductive health services.

The letter was used to exert the church’s strategy of using its institutional influence to block reproductive health legislation. Attempts to pass a reproductive health bill in the local legislature were met with widespread protest, including threats to excommunicate the country’s President. Provisions for comprehensive sexuality education are stipulated in the country’s law on reproductive health. However, this law has a clause which mandates that such education “not be used as an excuse to propagate birth control or the sale or distribution of birth control devices”. This clause was inserted because religious people feared that the law would encourage artificial contraception and abortion. Due to such clauses, adolescents are faced with many barriers in accessing these services and commodities. Hence, there is minimal impact on the prevention of sexually transmitted infections and pregnancy in the country.

HIV testing is met with discrimination and stigma in Filipino communities. Young people are stigmatized as irresponsible risk-takers, but are locked in passive and dependent roles. Such contradictory messages have a negative impact on their access to SRHS.
Lack of information

Filipino communities lack awareness about HIV because the majority of the population has not received basic HIV information. This lack of information translates to lack of understanding, causing adolescents and parents to be misinformed about HCT, the seriousness of HIV, and its consequences. This prevents adolescents from seeking testing or parents encouraging their children to get tested. Furthermore, word of mouth and mainstream media pass on misinformation alluding to the functional problems and pitfalls of condoms deters adolescents from using condoms. Beliefs that condoms are ineffective as birth control and disease prevention also act as barriers to their use. Condoms are also viewed as inhibitors to the pleasurable aspect of sex.

Child labour

An estimated 2.1-2.3 million children 5-17 years of age (approximately 8% of this age group) in the Philippines are child labourers. Age, sex, and residence impact on child labour prevalence in the Philippines. To this end, involvement in child labour increases with the age, from 4% prevalence for children aged 5-14 years, to 20% prevalence for children aged 15-17 years. Boys face a much greater risk of child labour than girls with those 5-17 years of age being twice as likely to be involved in child labour as their female peers (10% versus 5%). Child labour is much more common among rural children than urban children (10% versus 5%).

Ethical implications and recommendations

When the Philippine legislature revised the country’s laws on HIV testing and access to SRHS, the country lost an opportunity to grant its adolescents greater autonomy in respect to reproductive health decision-making. Barring a few exceptions (such as the minor already being married), the requirement of parental or guardian consent for HIV testing, treatment, and contraception access is counter-intuitive and will likely deter adolescents from accessing such services. Such restrictions raise ethical concerns and are not in the best interests of adolescents.

To address stigma and discrimination, which deters some Filipino adolescents from accessing SRHS, authorities should sensitise health workers on an ongoing basis regarding the harmful impact of stigma and discrimination, and how these prejudices impact on adolescent health. Health professionals should be reminded that they have a duty to provide care to any person in need and that this duty supersedes their personal moral biases. If adolescents are engaged in labour practices, it follows that they will likely be unable to access SRHS, especially if their working hours and the operating hours of SRHS correspond. The Philippine's prevalence of child labour may accordingly serve as a major barrier to adolescents accessing SRHS. Authorities should consider ways to facilitate access to SRHS for adolescent labourers. This may include the provision of community-based youth friendly SRHS mobile clinics with extended operating hours to cater for adolescent labourers. Such provision should extend to rural areas where child labour prevalence is higher.

Country experiences in addressing the barriers

Several initiatives are underway in the Philippines in-order to address and promote women's access to SRHS. For instance, The Magna Carta of Women (Republic Act 9710) is a comprehensive women's human rights law that seeks to eliminate discrimination against women. It seeks to provide comprehensive, culture-sensitive and gender responsive health services to women. The National Policy and Strategic Framework on Adolescent Health and Development of 2013 outlines guidance intended to ensure that young people have access to SRHS. Further, the National Policy and Strategic Framework is also in support of the use of an age and development appropriate Reproductive Health and Sexuality Education Curriculum. In April 2014, the Responsive Parenthood and Reproductive Health Act was implemented after a decade of resistance. This Act guarantees universal access to family planning. The Court struck down the exception that enabled minors to obtain reproductive health services without parental approval. The Philippines DOH launched the Adolescent Health Programme which seeks to provide all-inclusive guidelines for youth-friendly comprehensive Heathcare and services on numerous levels. In 2009, UNICEF and the Department of Education launched The Power of You campaign to help young people learn about risky behaviors, STIs, HIV and AIDS. The campaign was aimed at high school students.
Chapter Five: Conclusion

Philippine lawmakers should consider revising current laws to enable adolescents to autonomously access SRHS, including HIV testing. Authorities should take the lead in challenging stereotypes in regard to gender roles and expectations as such notions impact on adolescent health. The country’s Age of Consent for sex (12 years of age) is low compared to most countries and may facilitate early sexual debut and complicate disclosure obligations in instances of abuse. To discourage discriminatory behaviour against adolescents accessing SRHS, health professionals should be reminded they have a duty to provide care to any person in need and that this duty supersedes their personal moral biases.

Given the relatively high Internet usage rate amongst Philippine adolescents, the Philippine Government, international agencies, and NGOs working in the field of adolescent health should consider mounting online SRHS campaigns targeted to adolescents, in a non-judgemental manner. Such campaigns and information provision should include information on SRHS and where adolescents can access SRHS. Authorities should consider ways to facilitate access to SRHS for adolescent labourers. Addressing these issues will help address the sexual and reproductive health needs of adolescents in the country.

A limitation of this work is that data sources were limited to publically-accessible documents in English, and not based on original qualitative or quantitative research. Relevant studies may have been overlooked if they were not included in the databases reviewed for this report.
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Annex

KEY QUESTIONS FOR THE LEGAL REVIEW

1. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents males and females).

2. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

3. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

4. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

5. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

6. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.