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The irony of RH law critics' opposition to comprehensive sex education

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Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas

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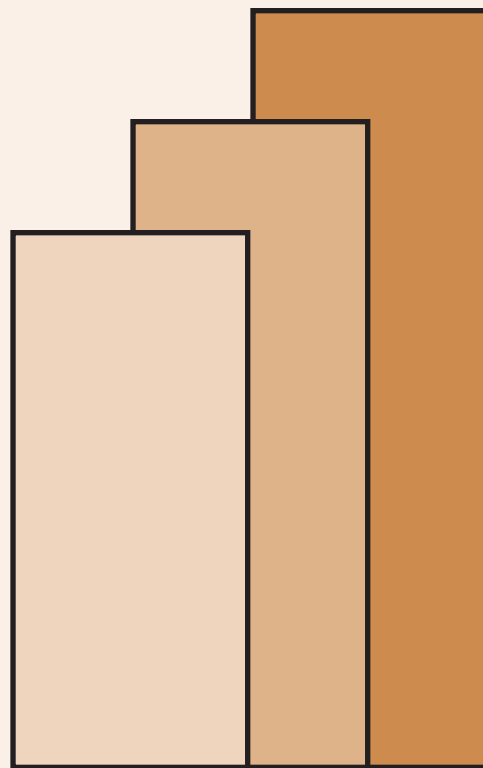
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The Irony of RH Law Critics' Opposition to Comprehensive Sex Education

Michael R.M. Abrigo and Vicente Paqueo

Sex-related risks, early sexual experience and unwanted pregnancies are major concerns of Filipinos. These issues have long been battle grounds for the often rancorous debates about the provisions of the Reproductive Health Law. In December 2012, Congress approved a comprehensive reproductive health law that guarantees universal access to services, including age-appropriate health and sexuality education in schools. Critics then raised a public health concern, saying that exposing children to reproductive health care, especially mandatory sexuality education, leads to earlier sexual initiation and higher rates of sexual activity among them. Using the 2008 National Demographic and Health Surveys, we analyze how sex education relates with the sexual behavior of women 15-24 years old. Our analysis of sexual behaviors by young adult females in recent national surveys does not corroborate this claim. Ultimately, it is ironic that their future is being jeopardized by well-meaning opposition to the Reproductive Health Law, which calls for keeping women better informed about sex-related risks, unwanted pregnancies, their consequences and ways of avoiding them.

Rising sex-related risks, early sexual experience, and unwanted pregnancies are major concerns of Filipinos. Young adults are becoming more sexually active. Among females 15-19 years old, 6.7 percent reported being sexually active in 2003. Ten years later, this number has increased to 7.9 percent. Between 2003 and 2013, the proportion of teen mothers has increased from 6.1 to 7.7 percent. Unfortunately, over the same period, the proportion of them who have never heard about HIV/AIDS almost doubled, increasing from 6.9 percent to 13.2 percent.

Early sexual initiation has lasting impact on life trajectories. Comparing cohabitating female siblings 25-29 years old, siblings who have had their first sexual experience during their teens have two to five years of education less compared to their sisters who have had their sexual debut after they reach 20 years old. This translates to a substantial 20 to 60 percent foregone income for siblings who have had earlier sexual initiation. This ultimately affects not only their personal economic wellbeing, but also the quality and level of investments that they can afford for their children.

The RH law and sexuality education

Although the country has been implementing family planning programs since the 1960s, it was only in 1999 that a comprehensive reproductive health (RH) bill was first filed in Congress to institutionalize various RH services by government. Proponents of the several RH bill versions that have been filed recognized that access to accurate and appropriate reproductive health information and services is important not just in demystifying sex among younger generations, but also in addressing related development issues that arise from less than informed choices. By mandating a national RH program, an RH law would make much-needed RH services available to everyone.

In December 2012, Congress, after years of continuous and often heated debates, finally approved a comprehensive RH law that guarantees universal access to RH services, including age-appropriate RH and sexuality education in schools. It took another sixteen months before the law was implemented however as its implementation was suspended when well-meaning opposition challenged the law's

constitutionality in the Supreme Court. The court eventually ruled RH Law to be “not unconstitutional”, with its key provisions remaining unscathed.

Conservative opposition

Of the many points that were raised against the RH Law, one argument, if found to be true, could both be a challenging public health concern and an alarming parenting issue: exposing children to reproductive health care, especially mandatory comprehensive RH and sexuality education, leads to earlier sexual initiation and higher rates of sexual activity among them. Jose Palma, Archbishop of Cebu and President of the Catholic Bishop’s Conference of the Philippines, emphasized this objection in a 2013 pastoral letter¹ where he listed school-based sex education as part of a “long litany of storms”. For Palma and many others, sex education brings “more promiscuity and teenage pregnancy.”

Such sexual curiosity after all seems just natural and to be expected of adolescents with “raging hormones”. By teaching about sexuality and reproductive health as part of a regular class subject, schools may inadvertently be promoting the early sexual awakening of young adults – who would now be armed with information on how to effectively circumvent costly and unwanted pregnancy. Instead of teaching adolescents of being more sexually responsible, many fear that school-based sex education would raise students’ desire for sex. While plausible, evidences from studies here in the Philippines and in other developing countries, however, do not corroborate this claim.

What’s the evidence?

Public health professionals and researchers at Johns Hopkins Bloomberg School of Public Health and at the Medical University of South Carolina² reviewed sixty- three studies on school-based sex education interventions in low- and middle-income countries, including one from the Philippines. They found that students who attended school-based sex education interventions actually delay sexual initiation. In addition, these students generally are less sexually active, have greater HIV/AIDS knowledge, fewer sexual partners, and higher condom-use propensity. The researchers noted that programs that have the most significant effects are those that extended beyond the classroom setting, such as training health care providers to offer youth-friendly services, distributing condoms, and involving teachers, parents and the community in developing the interventions.

In the Philippines, scientists at the Research Institute for Tropical Medicine and at the University of California³ ran a randomized controlled experiment in four demographically similar high schools in Metro Manila in the early 1990s. Together with public high school teachers, local AIDS experts, social scientists and health educators, they developed an AIDS prevention program designed to provide students with accurate information about HIV/AIDS. While the study did not look into actual sexual behavior after the intervention, the researchers found that students in the AIDS prevention program

¹ J.S. Palma (2013). Proclaim the message, In season and out of season: A pastoral statement of the CBCP on certain issues of today. <http://cbcponline.net/v2/?p=9492>

² V.A. Fonner, K.S. Armstrong, C.E. Kennedy, K.R. O’Reilly, and M.D. Sweat (2014). School-based sex education and HIV prevention in low- and middle-income countries: A systematic review and meta-analysis. *PLoS one*, 9(3), e89692.

³ M.R.A. Aplasca, D. Siegel, J.S. Mandel, R.T. Santana-Arciaga, J. Paul, E.S. Hudes, O.T. Monzon, and N. Hears (1995). Results of a model AIDS prevention program for high school students in the Philippines. *AIDS*, 9(Supplement 1), S7–13.

intend to delay their sexual initiation. Also, students in the intervention group have higher HIV/AIDS knowledge and have better attitudes towards people living with HIV/AIDS.

In August and September 2008, enumerators from the Philippine Statistics Authority (PSA, then known as the National Statistics Office) went around the country asking women about their reproductive history, marriage and sexual activity, fertility preferences, and family planning practices and knowledge, among others. PSA conducts this survey, called the National Demographic and Health Survey (NDHS), every five years to gather information on fertility, family planning, and health in the country. Although attendance in sex education classes was not asked in the survey, it did ask several questions probing each survey respondent's knowledge of HIV infection.

How many can you answer correctly? Take some time to answer these Yes/No questions before reading ahead.

1. Can people reduce their chance of getting the AIDS virus by having just one uninfected sex partner who has no other sex partners?
2. Can people get the AIDS virus from mosquito bites?
3. Can people reduce their chance of getting the AIDS virus by using a condom every time they have sex?
4. Can people get the AIDS virus by sharing food with a person who has AIDS?
5. Can people reduce their chance of getting the AIDS virus by not having sexual intercourse at all?
6. Can people get the AIDS virus by hugging or shaking hands with a person who is infected?
7. Is it possible for a healthy-looking person to have the AIDS virus?

If you answered "Yes" to odd-numbered questions and "No" to the rest, congratulations, you got a perfect score! Young adult women 15-29 years old in 2008 were not as knowledgeable however. Among those between 15-19 years old, only 14.5 percent of the 2,766 surveyed correctly answered all seven questions. One in every three received failing marks. One in every ten has not gotten any answer correct! Tossing a fair coin would have gotten them correct answers half of the time. Scores improve with age group, but the pattern persists. A plurality of young adults has limited HIV/AIDS knowledge.

Although 92 percent of women 15-29 years old have heard about HIV/AIDS, about three in twenty do not know any of the three major methods of preventing HIV transmission, i.e. A – abstaining from sexual intercourse, B – Being faithful to your partner, and C – consistently using condom during intercourse. Three of every five young adult females still believe that HIV may be transmitted by sharing food, hugging or shaking hands, or being bitten by mosquitoes.

How does your score make you feel... sexually? It turns out sex education – which we proxy by HIV/AIDS knowledge score – is indeed related to young adults' sexual behavior. But the relationship is not in the way suggested by groups opposing school-based sex education.

Among all female respondents, those who correctly answered four of the seven HIV/AIDS questions generally have their first sexual experience later than those who did poorly on the same set of questions. Among females age twenty, for instance, only 44 percent of those with failing marks never had any sexual experience, while a larger 55 percent of those with passing marks have been able to abstain from sex up to this age. On average, women who did better on these HIV/AIDS knowledge questions delay their sexual initiation by twenty-six months.

Who voted for RH Bill?

In 2008, Albay Representative Edcel Lagman filed House Bill 5043, a.k.a. the 2008 Reproductive Health Bill, and was supported by 46 other district and party-list representatives. Although Lagman, then of Lakas-KAMPI-CMD, was the primary author of the RH Bill, then President Gloria Macapagal-Arroyo, who was also chairman of the party, did not support the bill. Interestingly no Liberal party member in the House of Representatives supported the 2008 RH Bill, although a revised version in 2012 was widely supported, when fellow member President Benigno Aquino III certified the bill as urgent. Between the 2008 and the 2012 versions, population-weighted odds of voting for the RH Bill among district representatives jumped from 0.09 to 0.25. The president's leadership in rallying support appears to be crucial in making RH Bill gain traction in Congress.

Representatives who were in their last term, i.e., those who were more likely to leave their incumbency to run for another, presumptively local, office, were 7.4 percentage points less likely to vote for the 2008 RH Bill relative to first termers.⁴ Those who were from more Catholic-concentrated districts were also less likely to vote for the bill. On the other hand, past HIV/AIDS knowledge and access to reproductive health services at the district level, lo and behold, are not as predictive⁵ of representatives' RH Bill vote.

Those who supported the 2008 RH Bill in Congress practically voted despite the president's opposition. This reveals the representatives' thrusts. On average, RH Bill supporter-lawmakers represent districts with lower HIV/AIDS knowledge. Between 2008 and 2013, average HIV/AIDS knowledge among females 15-29 years old declined, but the fall is significantly larger among those who live in districts where their representatives voted against the RH Bill in 2008.⁶ During the same period, access to family planning services, which we proxy by accessibility of condoms, fell in districts of representatives who were sympathetic to the RH Bill, although the slight drop was not enough to cancel the upward trend since 2003. Taken together, this suggests that lawmakers' support of the RH Bill was able to raise awareness despite the over-all drop in HIV/AIDS knowledge, although this does not necessarily translate to provision of other RH services at the district level.

More evidences

How district representatives voted in the 2008 RH Bill presents us with a natural experiment. District representatives may be seen as aggregators of information. That their voting behavior does not respond to past RH services available at their districts provides indication that their 2008 RH Bill votes are independent of local electorate demands. By comparing the HIV/AIDS knowledge, and the sexual behaviors of young adults based on how their district representatives acted on the plenary, we can estimate the direct impact of raising RH knowledge on sexual behavior. Unfortunately, data from NDHS only allows us to estimate the impact for females.

Over-all, we find that increasing HIV/AIDS knowledge lowers sexual activity, delays sexual transition, and increases condom-use, although the impact masks the heterogeneity across age groups, and across

⁴ Ronald U. Mendoza provides an excellent analysis of how representatives had voted in the 2012 RH Bill version, House Bill 4244. See <http://www.rappler.com/thought-leaders/19566-dissecting-the-vote-on-the-rh-bill>

⁵ After purging the contribution of district-level characteristics, as well as of district representative attributes

⁶ Based on Questions 1-4, which are common to the 2003, 2008 and 2013 rounds of NDHS

economic status.⁷ In any case, this suggests that reproductive health and sexuality education does not raise our adolescent population's sexual desires, but actually inhibits them. In addition, sex education also makes adolescents more sexually responsible by using condoms, which lowers the risks of spreading sexually transmitted infections (STI).

Conclusion

Filipinos especially teenagers and young adults are not well-informed about sex-related issues that could intimately and personally affect them. Addressing this information deficiency with appropriately designed sex education can be beneficial. Contrary to critics' expectations, less informed women tend to have earlier sexual initiation and higher rate of sexual activity among young adults. The evidence further indicates that those consequences will likely lead subsequently to reduced human capital, as manifested by lower level of educational attainment. It is ironic, therefore, that their future is being jeopardized by well-meaning opposition to the RH Law, which calls for keeping women better informed about sex-related risks, unwanted pregnancies, their consequences and ways of avoiding them.

It is true that there are risks in providing the youth with comprehensive sexuality education in public schools. But depriving them of government-mandated opportunities to learn about human sexuality and ways of dealing with sex-related issues also carries with it its own risks. It is not uncommon for the young to grow up without having quality time with parents and their surrogates about sex-related issues. Often, they get false information and bad advice from peers who also need proper sex education. In light of the evidence discussed above, it seems more prudent for the government to ensure that the youth get age-appropriate sex education than keep them ignorant.

There are ways of dealing with concerns of premature and improper exposure to inappropriate materials. For example, school officials can work together with parents, community leaders, teachers, local experts, social scientists and health educators to develop a sex education program that is designed to provide students with accurate information about HIV/AIDS and other sex-related issues that are important for them to learn about. Additionally, a regular review by a group of eminent persons supported by data produced by an independent research group can be established to ensure sex education programs are appropriate and effective. On this suggestion, impact evaluation of sex education programs in schools coupled with good monitoring would be valuable in ensuring that legitimate concerns about the implementation of the RH Law comprehensive education mandate are addressed opportunistically.

Arguably, it is better to develop a sex education program based on a deep consultative process with key stakeholders and evaluate its impact than preventing government from providing students opportunities to learn from professionally developed sex education programs solely on pre-conceived ideas of their consequences. Moral beliefs and good intentions alone are not enough to determine whether a policy position is beneficial or detrimental to the well-being of the country's citizens. Empirical evidence is necessary to protect them against the unintended consequences of well-meaning but misinformed policy stance. On this score, rigorous evaluation of the impact of sexuality education is valuable.

⁷ For a detailed discussion, see M.R.M. Abrigo (2016). HIV/AIDS knowledge and sexual behavior of young adults in the Philippines. In, *Health over the lifecycle: Essays on Health and Family*. Doctoral dissertation. University of Hawai'i at Manoa, USA.

Figure 1. Age at sexual initiation by HIV/AIDS knowledge score: NDHS, 2008

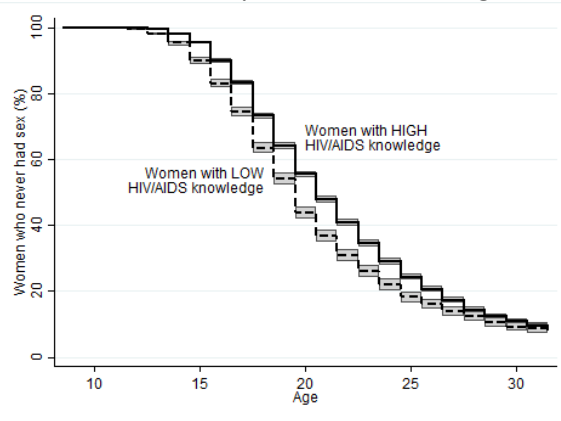
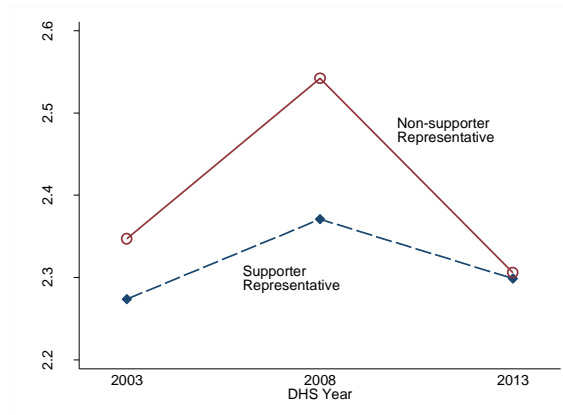


Figure 2. HIV/AIDS knowledge* of females aged 15-29 by district representative's 2008 RH Bill vote



* Based on Questions 1-4, which are common to the 2003, 2008, and 2013 rounds of NDHS.

Figure 3. Access to condoms of females aged 15-29 by district representative's 2008 RH Bill vote

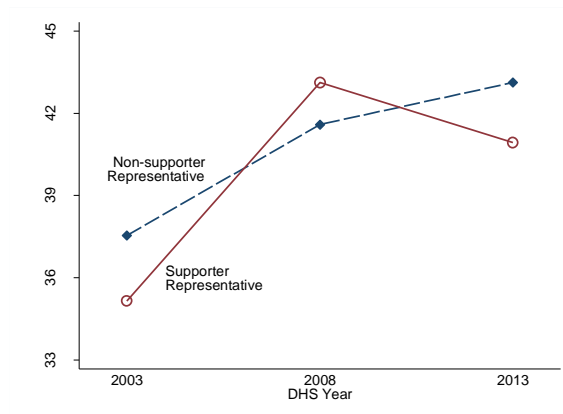


Table 1. HIV/AIDS knowledge score: NDHS, 2008

| | Age group | | |
|--------------|-----------|-------|-------|
| | 15-19 | 20-24 | 24-29 |
| Respondents | 2,766 | 2,143 | 2,067 |
| % with score | | | |
| 0 | 12.3 | 6.3 | 6.8 |
| 1-3 | 19.3 | 16.7 | 14.8 |
| 4-6 | 53.9 | 58.5 | 61.3 |
| 7 | 14.5 | 18.5 | 17.1 |

Table 2. Impact of HIV/AIDS knowledge on sexual behavior of females aged 15-29

| How representative voted on 2008 RH Bill | HIV/AIDS knowledge | Sexually Active (Percent) | Age at first sexual initiation (Years)* | Condom-use (Percent)* |
|---|-----------------------|------------------------------|--|--------------------------|
| Aye (Yes) | 3.7 | 34.9 | 19.0 | 0.7 |
| Nay (No) | 4.0 | 32.3 | 19.1 | 3.1 |
| Knowledge effects** | | -9.8 | 0.5 | 8.8 |

* Conditional on being sexually active

** Change in sexual behavior with respect to a unit increase in HIV/AIDS knowledge. Knowledge effects on propensities of sexual activity and condom-use are in percentage points; those for age at sexual transition are in years. Estimates are based on the 2008 NDHS by PSA. HIV/AIDS knowledge scores are calculated based on the sum of seven (7) Yes/No questions related to HIV/AIDS transmission. Knowledge effect estimates do not control for individual characteristics. See Abrigo (2016) for estimation details, and further refinements.