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Filipino Youth's Self-Efficacy in Sexual Health: Implications on Sexuality and Reproductive Health Education and Services

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ABSTRACT
Sexual self-efficacy or one's confidence level, also described as the knowledge, skills, and comfort to carry out different sexual health practices, was explored in this study using a cohort of Filipino youth. Results revealed that among the identified sexual health practices, respondents have a moderate self-efficacy in the following: practicing abstinence and safer sex, observing sexual equality/diversity, and preventing sexual assault and their sexual self-efficacy is low when it comes to sexual health care and sexual relationships. Results also indicate that there are variations as to the sexual self-efficacy level based on age, ethnicity and relationship status. There is a significant difference however as to the respondents' sexual self-efficacy when grouped according sex, sexual orientation and religion. With regard the respondents' perception on the importance of specified sexual and reproductive health programs and services, those that point to prevention of sexual abuse and gender-based violence, management of mental health issues related to sexual health, family planning information, counselling on methods of contraception including emergency contraceptive methods are amongst the top 3. Implications pointed to the need for higher education institutions to strengthen initiatives onward the promotion of sexual self-efficacy and reproductive health and well-being of the Filipino youth, in consonance to the provisions of Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health Act. Hence, the prioritization of university-based sexuality and reproductive health education and services which are gender-inclusive, age-appropriate, and culturally and religiously sensitive becomes an imperative.

Keywords: Sexual self-efficacy, Sexuality and Reproductive Health Education and Services, Filipino youth

INTRODUCTION

Sexual health as one of the indices of individuals' overall health and well-being is defined by the World Health Organization (WHO) as "the state of physical, emotional, mental, and social well-being associated to sexuality; it is not merely the absence of sickness, malfunction, or infirmity", (WHO, 2006a). Holistically, sexual health recognizes all aspects of sexuality which encompasses sexual orientations, gender identities, expressions and roles, sex, sexual relationships, attitudes and values, sexual behaviors, as well as sexual rights and the likelihood of safe sexual experiences, free of threat or coercion, violence, assault and discrimination. Sexual and reproductive health encompasses not only having sex but also the psychological, physical, and social repercussions of one's sexuality on one's overall well-being.

The general health and life quality of individuals and families, as well as the social and economic development of societies at large, depends at a certain extent on their sexual health. In fact, concerns and issues on sexual health such as high-risk sexual activities, increasing cases of sexually transmitted diseases and infections, teenage pregnancies, and exposures to pornographic or sexually explicit content can lead to or exacerbate other issues in the individual, family, and the community as a whole. As such, the Philippine government's commitment to the Global Goals specifically along Good Health and Well-Being continuously calls for the institutionalization and/or strengthening of policies and programs relative to adolescent and youth sexual and reproductive health, development, and wellbeing.

Men and women's ability to achieve sexual health and well-being depends on their access to thorough sexuality information, awareness of the risks they face, susceptibility to negative effects of sexual activity, access to high-quality sexual health care, and a supportive environment. Further, essential to the understanding of sexual behavior and sexual health is the concept of sexual self-efficacy (SSE).

SSE is premised on the Social Cognitive Theory of Psychologist Albert Bandura who expound on the concept of self-efficacy as "the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations." Self-efficacy is the conviction that one can carry out an activity or accomplish a goal. It

includes a person's self-assurance in their ability to manage their conduct, have an impact on their surroundings, and remain motivated in the pursuit of their objective. Self-efficacy is a trait that people might possess in a variety of contexts and domains, including relationships, employment, and other crucial areas. It can also be applied in health promotion. Self-efficacy serves as a behavioral predictor for health and is the key component of personal behavioral change. Additionally, it may work well as a defense mechanism against dangerous sexual practices.

Self-efficacy in sexual health is the conviction that one is capable of making decisions about their sexuality and refraining from high-risk sexual conduct, (Zare, Z., et.al., 2016). SSE focuses on a person's ability to exercise control over their sexual life, their competence and skill as a sexual agent, their capacity to engage in safe sexual activity, their suitability as a sexual partner, and their capacity for sexual satisfaction, (Closson, K., et.al., 2018).

Existing literatures on sexual self-efficacy had consistently pointed out that it plays a fundamental role in sexual decision-making, contributes to a reduced risk-taking behavior, and improves communication with healthcare providers. Enhancing sexual self efficacy is a crucial part of effective behavior change aimed at minimizing or avoiding risky sexual behavior and decreasing or preventing sexually transmitted diseases and infections. High perceived SSE can increase healthy sexual activities, followed by sexual health and eventually health promotion. Also, young individuals who have greater perceived SSE demonstrate less risky sexual behaviour. Teenagers who lack sexual self-efficacy are more likely to engage in dangerous sexual conduct, including unprotected sex, many partners, and early sexual activity. Being sensibly confident and feeling in control of one's sexuality, which is the core of SSE, help individuals to make better decisions regarding their sexual conduct and to more positively express their experiences. (Hajinia A, et.al., 2017; Rosenthal D., et.al., 1991; Lou, JH., et.al., 2011; Khalesi, ZB., et.al., 2018). Indubitably, understanding youth's self-efficacy with regard to sexual health practices is essential for creating effective interventions and programs that can encourage favorable results in sexual health.

Whilst evidence suggests that self-efficacy in sexual health practices is necessary for the promotion of one's general health and well-being, it is a concept less explored using Filipino youth cohort. Further, research literatures in the country on SSE which involved a wide array of sexuality spectrum are scarce and emphasis are more on adolescents. Studies exploring age of sexual debut associated various sexual risk-taking behaviors in adolescence and does not account or assess for age differences, (Bauermeister, Zimmerman, Caldwell, Xue, & Gee, 2010; Moilanen, Crockett, Raffaelli, & Jones, 2010). While issues on sexual and reproductive health may truly be common in the adolescence stage, such are concerns of the Filipino 'youth' in general. Since the term youth as construed under Philippine laws cover the age ranging from 15-30, then this population should have been the subject of studies about SSE but to no avail.

Moreover, with the enactment of Republic Act No. 10354 (RA 10354) otherwise known as the Responsible Parenthood and Reproductive Health Act which stipulates for a comprehensive sex education, it is essential that sexual and reproductive programs and services to be delivered are sourced directly from the concerned youth. Irrespective of sexual orientations, ethnicity, and religion, their perspectives on sexual health must be taken into account.

With these premises, this study primarily embarked on establishing baseline data on the Filipino youth's self-efficacy in sexual health practices. Sexual self-efficacy as used in this study refers to the respondents' confidence (self-efficacy) level, described as their knowledge, skills, and comfort to carry out different sexual health practices including sexual health care, safer sex, sexual relationships, sexual assault, sexual equality/diversity, and abstinence. In particular, this research endeavored to:

1) investigate the respondents' demographic profile in terms of sex, age, sexual orientation, ethnicity, religion, and relationship status;
2) determine the self-efficacy (confidence) level of the youth-respondents on identified sexual health practices;
3) compare the respondents' sexual self-efficacy when grouped according to profile variables;
4) ascertain the extent of importance of sexual and reproductive health programs and services as perceived by respondents; and
5) identify other programs and services recommended by the respondents for the promotion of their reproductive and sexual health.

RESEARCH METHOD

Research Design

This study employed the descriptive quantitative research design. The self-efficacy (confidence) level of the respondents in carrying out specified sexual health practices was established through a standardized questionnaire which yielded into quantitative data. The same was employed in establishing the extent of importance of the different sexual and reproductive programs and services as perceived by the respondents.

Respondents and Sampling Procedure

The sample size which included a total number of 309 youth-respondents, selected through random sampling took part in the study. The respondents are tertiary students of the Cagayan State University – Carig Campus, one of the renowned state-universities in the Philippines located at Cagayan Valley, Region II. The youth-respondents were taken across year levels from the different colleges of the said campus namely: the College of Arts and Sciences, College of Engineering, College of Human Kinetics, College of Information and Computing Science, College of Industrial Technology, College of Public Administration, and College of Veterinary Medicine.

Research Instrument

The primary data collecting instrument for this study is the Sexual Health Practices Self-Efficacy Scale (SHPSES), a standardized tool developed to measure respondents' confidence (self-efficacy), described as their knowledge, skills, and comfort to carry out 20 different sexual health prtactices. The SHPSES consists of 20 items representing a variety of sexual health practices, with identified six sub- scales, including self-efficacy in regard to Sexual Relationships (5 items), Sexual Health Care (4 items), Sexual Assault (3 items), Safer Sex (4 items), Sexual Equality/Diversity (3 items), and Abstinence (1 item). Respondents indicate their confidence in performing these practices (self-efficacy) on a scale from 1 (Not at all Confident) to 5 (Extremely Confident). The Cronbach's alpha coefficient for the entire scale was .89 (Koch, 2009). Subscale reliability coefficients were as follows: Sexual Relationships, .82; Sexual Health Care, .81; Sexual Assault, .78; Safer Sex, .71; Sexual Equality/ Diversity, .73. Abstinence was a single item, so no individual alpha coefficient was calculated.

To establish data on the extent of importance of sexual and reproductive programs and services as perceived by the respondents, a self-made questionnaire was employed integrating related and common programs and services culled from research literatures online. Further, open-ended questionnaire personally crafted by the researcher was utilized to substantiate the quantitative data gathered.

Data Analysis

Frequency and percentage, weighted mean and standard deviation (SD) were the statistical tools used to treat the data. These statistics were utilized to determine the youth-respondents' self-efficacy level on identified sexual health practices and to ascertain the extent of importance of sexual and reproductive health programs and services as perceived by respondents. The t-test for independent sample means was used to compare the sexual health self-efficacy level when the samples were divided into separate groups based on sex and religion. On the other hand, the analysis of variance (ANOVA) was applied to compare the sexual health self-efficacy level when the participants were categorized according to age, sexual orientations, ethnicity, and relationship status.

Ethical Considerations

Permission to reach out to the respondents were secured through the respective University/College Deans. Respondents were duly informed about what the study is about and of the voluntary nature of their participation, and that their permission were sought thru an informed consent. Participants were assured that data collected will be treated with utmost anonymity and confidentiality.

RESULTS AND DISCUSSION

Respondents' Demographic Profile

The demographic profile of the university students inclusive of sex, age, sexual orientation, ethnicity, religion and relationship status. Data in Table 1 manifests that the sample size is male-dominated with 161 or 52.1% and of the age range 18-20 years old or 275 (89%), with the mean age of 19.006. In terms of sexual orientation, almost half or 41.7% of the respondents are heterosexual which means they are sexually attracted to the opposite gender. Moreover, data shows that majority are Ilokano (192 or 62.1%); Roman Catholic (225 or 72.8%) and single as to relationship status with 305 or 98.7%.

Table 1:Distribution of respondents according to demographic profile

Variables	Frequency (n=309)	Percent (%)
Sex		
Male	161	52.1
Female	148	47.9
Age		
18-20 years old	275	89.0
21-23 years old	29	9.4
24 and above	5	1.6
Mean Age = 19.006		
Sexual Orientation		
Aromantic	39	12.6

Asexual	71	23.0
Bisexual	41	13.3
Heterosexual	129	41.7
Homosexual	14	4.5
Pansexual	5	1.6
Queer	8	2.6
Transition	2	.6
Ethnicity		
Ibanag	21	6.8
Ilokano	192	62.1
Itawes	91	29.4
Ivatan	1	.3
Malaueg	4	1.3
Religion		
Roman Catholic	225	72.8
Non-Roman Catholic	84	27.2
Relationship Status		
Single	305	98.7
Living in	3	1.0
Married	1	.3

Respondents' Self-Efficacy in Sexual Health Practices

The self-efficacy of the respondents as determined by their confidence level in carrying out identified sexual health practices is shown in Table 2. As can be gleaned from the data, among the specified sexual health practices, abstinence having the highest mean of 2.95 renders to a moderate level of sexual self-efficacy. This denotes that the respondents are moderately confident in making a conscious choice to refrain from any desired behavior, including sexual activity, for a predetermined amount of time or indefinitely. Abstinence having been consistently cited as the best strategy for preventing STIs and unintended pregnancies, is a decision that people make on a personal level and is frequently motivated by moral, religious, or health considerations, (Zhang, et.al., 2013).

Other sexual health practices to which the respondents carry out at a moderate self-efficacy level are: sexual equality/diversity with a mean of 2.91; sexual assault with 2.86 as mean; and safer sex with 2.71. These suggest that the respondents are moderately confident in ensuring that people of different genders and sexual orientations are given the same opportunities and rights in the society, without discrimination or prejudice. They somehow encourage tolerance for diversity and affirm that everyone, regardless of gender or sexual orientation, deserves respect and consideration. Also, they are somewhat confident of their capability to deal with and/or prevent or help their friends in case sexual assault or coercion occurs. It was further noted that the respondents have moderate confidence when deciding about sexual behaviors; though not absolutely, they somehow proceed with consideration and wisdom when engaging into sexual activity. These probably accounts into the decrease as to the percentage of youth engaged in potentially high-risk sexual activities, (University of the Philippines Population Institute, 2022).

The data also revealed that the respondents' sexual self-efficacy is low when it comes to sexual health care and sexual relationships, with a mean of 2.51 and 2.42 respectively. This implies that the respondents are slightly confident in accessing medical information and services relative to the maintenance of sexual health and relationships, which include but are not limited to: self-examining the breasts or testicles; getting tested for a sexually transmitted infection (STI); getting an HIV test; discussing a sexual health concern, such as a STI, with a partner and/or a medical professional; forming a satisfying sexual connection; discussing sexual histories with a potential partner; discussing a relationship issue with a sexual partner; and overcoming difficulties with sexual function, such as ejaculating too soon or having trouble achieving orgasm. These findings recognize the need for strengthening sex education advocacies.

Table 2:Respondents' self-Efficacy level in sexual health practices

Sexual Health Practices	Mean	Qualitative Description
Sexual Health Care	2.51	Low
Safer Sex	2.71	Moderate
Sexual Relationships	2.42	Low
Sexual Assault	2.86	Moderate
Sexual Equality/Diversity	2.91	Moderate
Abstinence	2.95	Moderate

Legend
4.2 - 5 = Very High
3.40 – 4.19 = High
2.60 – 3.39 = Moderate
1.80 – 2.59 = Low
1 – 1.79 = Very Low

Comparison on the Respondents' Sexual Self-Efficacy Level according to Demographic Profile

Table 3 gives a view of the differences between the respondents' sexual self-efficacy level when grouped according to demographic profile specifically sex, age, sexual orientation, ethnicity, religion, and relationship status.

In terms of sex differences on the respondents' self-efficacy in the identified sexual health practices, data in Table 3.a. reveals that there is no significant difference in the respondents' responses with respect to sexual health care, sexual assault, sexual equality/diversity, and abstinence. The finding suggests that both male and female respondents have similar self-efficacy (confidence) level and perspectives in carrying out the aforementioned sexual health practices. As regards the remaining practices, safer sex and sexual relationships, the data illustrate a significant difference in the respondents' sexual self-efficacy level, with males being more self-efficacious/confident than females in the practices of safer sex and sexual relationships. These could probably be attributed to social norms which allow males to be generally more sexually uninhibited than females. In fact, according to Boislard M.A., et.al., (2016), this comes as a result of the peer milieu that men are exposed to, which is marked by more acceptance of sex and increasing pressure to engage in sexual activity.

Table 3.a. Differences on the respondents' sexual self-efficacy when grouped according to sex

Variable	Sex	Mean	Std. Deviation	t-value	Probability
Sexual Health Care	Male	2.64	1.33	1.653	0.099^{ns}
	Female	2.38	1.36		
Safer Sex	Male	2.93	1.24	3.216	0.001*
	Female	2.46	1.30		
Sexual Relationships	Male	2.68	1.23	4.003	0.000*
	Female	2.14	1.16		
Sexual Assault	Male	2.95	1.27	1.357	0.176^{ns}
	Female	2.75	1.41		
Sexual Equality/Diversity	Male	3.00	1.32	1.283	0.200^{ns}
	Female	2.80	1.42		
Abstinence	Male	2.97	1.46	0.243	0.808^{ns}
	Female	2.93	1.67		

With regard the comparison of the youth-respondents' sexual self-efficacy when grouped according to age, it can be gleaned from the data in Table 3.b. that there is no significant difference in the respondents' confidence in engaging into the identified sexual health practices based on age. This means that age is not a factor in determining the self-efficacy level of the respondents' in carrying out the sexual health practices. The respondents, irrespective of age are likely to be comparably the same in terms of practices along sexual health. Adolescents and young adults alike are similarly exposed to sexual risk behaviors; sexually transmitted diseases (STDs) and infections affect people of all ages.

This result however is in contrary to the findings of Sales, J., et.al., (2011) who found younger adolescents of age 14-17 having significantly higher rates of STDs than older adolescents of age 18-20; older adolescents however had significantly higher levels of STD-associated risk behavior.

Table 3.b. Differences on the respondents' sexual self-efficacy when grouped according to age

Variable	Age	Mean	Std. Deviation	F value	Probability
Sexual Health Care	18-20 years old	2.47	1.32	1.373	0.255^{ns}
	21-23 years old	2.87	1.46		
	24 and above	2.90	1.95		
	Total	2.51	1.35		
Safer Sex	18-20 years old	2.66	1.26	1.336	0.264^{ns}
	21-23 years old	3.05	1.38		
	24 and above	3.00	1.88		

	Total	2.70	1.29		
Sexual Relationships	18-20 years old	2.39	1.20	1.175	0.310 ns
	21-23 years old	2.70	1.36		
	24 and above	2.84	1.99		
	Total	2.42	1.23		
Sexual Assault	18-20 years old	2.83	1.30	0.670	0.513 ns
	21-23 years old	3.13	1.63		
	24 and above	2.93	1.92		
	Total	2.86	1.34		
Sexual Equality/Diversity	18-20 years old	2.89	1.34	0.477	0.621 ns
	21-23 years old	2.98	1.62		
	24 and above	3.47	1.85		
	Total	2.91	1.37		
Abstinence	18-20 years old	2.95	1.55	0.067	0.935 ns
	21-23 years old	2.93	1.67		
	24 and above	3.20	1.79		
	Total	2.95	1.56		

As presented in Table 3.c. which compares the respondents' sexual self-efficacy based on sexual orientation, result reveals that there are significant differences in the self-efficacy/confidence level of the respondents in carrying out all the identified sexual health practices. Among the specified sexual orientations, pansexual emerged being more self-efficacious/confident in all the sexual health practices. Though there were very few researches that have been conducted to define and characterize pansexuality, the word 'pansexual' etymologically refers to those who believe they are sexually, emotionally, and spiritually capable of being attracted to anyone, regardless of gender or sex, (Palermo, 2013). Being attracted to all genders and sexual orientations, pansexual are more likely to have diverse experiences and exposures considering that they are open to sexual relationships with anyone across the sexuality spectrum.

This result runs in contrary to the findings of Blanc, A.,et.al., (2023) whose study explored on the relationship between sexual orientation and specific sexual risk behaviors and found that among the sexual orientations, bisexuals and homosexuals had more positive attitudes toward sexual behaviors and are engaged in a greater number of sexual acts/practices. These data suggest for policies and programs that work toward a more inclusive sex education in schools, going beyond the typical heterosexual and homosexual identities and relationships, in order to cater to students who, identify themselves as pansexual, and also to broaden awareness and acceptance of various sexual and gender identities.

Table 3.c. Differences on the respondents' sexual self-efficacy when grouped according to sexual orientation

Variable	Sexual Orientation	Mean	Std. Deviation	F value	Probability
Sexual Health Care	Aromatic	2.03	1.35	4.6333	0.000*
	Asexual	2.18	1.35		
	Bisexual	2.14	1.04		
	Heterosexual	2.82	1.35		
	Homosexual	3.23	1.05		
	Pansexual	4.10	0.84		
	Queer	2.66	1.48		
	Transition	2.38	0.53		
	Total	2.51	1.35		
Safer Sex	Aromatic	2.39	1.48	3.952	0.000*
	Asexual	2.37	1.28		
	Bisexual	2.37	1.15		
	Heterosexual	2.94	1.21		
	Homosexual	3.39	0.95		
	Pansexual	4.25	0.64		
	Queer	2.81	1.53		
	Transition	3.13	0.53		
	Total	2.70	1.29		
Sexual Relationships	Aromatic	2.10	1.31	4.064	0.000*

	Asexual	2.11	1.24		
	Bisexual	2.15	1.05		
	Heterosexual	2.63	1.19		
	Homosexual	3.30	0.74		
	Pansexual	3.80	0.73		
	Queer	2.43	1.35		
	Transition	2.30	0.14		
	Total	2.42	1.23		
Sexual Assault	Aromatic	2.20	1.48	3.115	0.003*
	Asexual	2.71	1.36		
	Bisexual	2.73	1.16		
	Heterosexual	3.07	1.32		
	Homosexual	3.52	0.78		
	Pansexual	3.80	0.87		
	Queer	3.04	1.46		
	Transition	2.00	0.47		
	Total	2.86	1.34		
Sexual Equality/Diversity	Aromatic	2.10	1.40	5.846	0.000*
	Asexual	2.50	1.42		
	Bisexual	2.98	1.22		
	Heterosexual	3.16	1.25		
	Homosexual	3.81	0.86		
	Pansexual	4.40	0.60		
	Queer	3.25	1.81		
	Transition	3.33	0.94		
	Total	2.91	1.37		
Abstinence	Aromatic	2.28	1.65	3.947	0.000*
	Asexual	2.66	1.68		
	Bisexual	2.54	1.36		
	Heterosexual	3.32	1.48		
	Homosexual	3.50	0.86		
	Pansexual	4.40	0.89		
	Queer	3.13	1.64		
	Transition	2.50	0.71		
	Total	2.95	1.56		

Presented in Table 3.d. is the differences on the respondents' sexual self-efficacy when grouped according to ethnicity. The result manifests that there are no significant variations in the respondents' confidence in engaging into the identified sexual health practices based on ethnicity. Thus, ethnicity is not considered a determinant in the respondents' sexual self-efficacy. This may be accounted somewhat to the similarity in the norms of the identified ethnic groups which comes as a result of shared social and cultural experiences of Filipinos.

Table 3.d. Differences on the respondents' sexual self-efficacy when grouped according to ethnicity

		Mean	Std. Deviation	F value	Probability
Sexual Health Care	Ibanag	2.92	1.44	0.532	0.712 ns
	Ilokano	2.49	1.31		
	Itawes	2.47	1.42		
	Ivatan	2.25	.		
	Malaueg	2.69	1.09		
	Total	2.51	1.35		
Safer Sex	Ibanag	3.23	1.24	0.976	0.421 ns
	Ilokano	2.66	1.28		
	Itawes	2.69	1.33		
	Ivatan	2.25	.		
	Malaueg	2.50	0.71		
	Total	2.70	1.29		
Sexual Relationships	Ibanag	2.77	1.23	0.463	0.763 ns

	Ilokano	2.40	1.23		
	Itawes	2.39	1.25		
	Ivatan	2.20	.		
	Malaueg	2.45	0.44		
	Total	2.42	1.23		
Sexual Assault	Ibanag	3.43	1.20	1.077	0.368 ns
	Ilokano	2.81	1.36		
	Itawes	2.82	1.34		
	Ivatan	3.33	.		
	Malaueg	2.92	0.74		
	Total	2.86	1.34		
Sexual Equality/Diversity	Ibanag	3.65	1.35	2.003	0.094 ns
	Ilokano	2.79	1.35		
	Itawes	2.99	1.43		
	Ivatan	2.67	.		
	Malaueg	2.83	0.19		
	Total	2.91	1.37		
Abstinence	Ibanag	3.71	1.27	1.497	0.203 ns
	Ilokano	2.89	1.58		
	Itawes	2.89	1.57		
	Ivatan	4.00	0.00		
	Malaueg	3.00	1.16		
	Total	2.95	1.56		

Data in Table 3.e illustrates the variations on the respondents' sexual self-efficacy based on religion. The result reveals that among the sexual health practices, only in sexual assault and abstinence were there are differences on the respondents' sexual self-efficacy, with non-Catholics being more self-efficacious/confident than Catholics. This implies that religious factors may contribute to differences in sexual and reproductive health practices. Religion may offer a sexual compass or a moral rule of conduct on acceptable sexual behaviors. Religious doctrines reinforce self-control, sexual morality and chastity which are potentially contributory to the youths' sexual self-efficacy. Different religious sects have different sexual mores.

This finding corroborates to the result of some researches which found adolescents/youths who belong to conservative religious movements such as Mormons, Evangelicals, etc. being more likely to put off having sex or abstain from sexual acts than their mainline or unaffiliated peers, Beck et al. (1991); Brewster et al. (1998) as cited in Burdette, A., et.al., (2015).

Table 3.e. Differences on the respondents' sexual self-efficacy when grouped according to religion

	Religion	Mean	Std. Deviation	t-value	Probability
Sexual Health Care	Roman Catholic	2.42	1.32	-1.960	0.051 ns
	Non Roman Catholic	2.76	1.41		
Safer Sex	Roman Catholic	2.63	1.27	-1.650	0.100 ns
	Non Roman Catholic	2.90	1.31		
Sexual Relationships	Roman Catholic	2.37	1.18	-1.321	0.187 ns
	Non Roman Catholic	2.57	1.33		
Sexual Assault	Roman Catholic	2.73	1.31	-2.616	0.009 *
	Non Roman Catholic	3.18	1.38		
Sexual Equality/Diversity	Roman Catholic	2.82	1.36	-1.797	0.073 ns
	Non Roman Catholic	3.13	1.39		
Abstinence	Roman Catholic	2.79	1.50	-2.930	0.004 *
	Non Roman Catholic	3.37	1.66		

As to the comparison of youth-respondents' sexual self-efficacy based on relationship status, the data in Table 3.f. renders a finding of no significant difference. This implies that relationship status is not a factor that brings about variation in the self-efficacy of respondents in carrying out the specified sexual health practices. Regardless of whether one is single, married or in a living in set-up, their sexual self-efficacy is comparably the same. Being in a relationship is not required for one to be knowledgeable or confident about sexual health care, safer sex, sexual relationships, sexual assault, sexual equality/diversity, and abstinence. Neither being single a reason for one to be ignorant of these sexual health practices.

Table 3.f. Differences on the respondents' sexual self-efficacy when grouped according to relationship status

		Mean	Std. Deviation	F value	Probability
Sexual Health Care	Single	2.52	1.35	0.457	0.634 ns
	Living in	2.67	1.04		
	Married	1.25	.		
	Total	2.51	1.35		
Safer Sex	Single	2.70	1.28	1.456	0.235 ns
	Living in	3.50	1.32		
	Married	1.00	.		
	Total	2.70	1.29		
Sexual Relationships	Single	2.42	1.22	1.637	0.196 ns
	Living in	3.40	1.11		
	Married	1.00	.		
	Total	2.42	1.23		
Sexual Assault	Single	2.86	1.34	1.152	0.317 ns
	Living in	3.33	1.53		
	Married	1.00	.		
	Total	2.86	1.34		
Sexual Equality/Diversity	Single	2.91	1.37	1.304	0.273 ns
	Living in	3.56	1.26		
	Married	1.00	.		
	Total	2.91	1.37		
Abstinence	Single	2.95	1.56	1.096	0.335 ns
	Living in	3.67	1.16		
	Married	1.00	.		
	Total	2.95	1.56		

Respondents' Perception on the Importance of Sexual and Reproductive Health Programs and Services

The perception of the youth-respondents on the importance of sexual and reproductive health programs and services is illustrated in Table 4. All of the identified programs and services relative to sexual and reproductive health were perceived by the respondents as very important. Among the specified programs and services however, those that point to prevention of sexual abuse and gender-based violence, management of mental health issues related to sexual health, family planning information, counselling and methods of contraception (including emergency contraceptive methods) are amongst the top 3, with a corresponding mean of 4.06, 4.05, and 4.01 respectively.

These suggest that the youth-respondents are fully aware and/or may have witnessed or experienced gender-based violence and sexual abuse. Based on the result of the 2021 Young Adult Fertility and Sexuality Study, sexual abuse and gender-based violence like bullying were one of the common reasons for suicide attempt of the Filipino youth, (University of the Philippines Population Institute, 2022). This may justify why services along management of mental health issues related to sexual health was also perceived as very important and in fact, ranked 2 among the enumerated services. Family planning information, counselling on reproductive and sexual health issues and methods of contraception, including emergency contraceptive methods were also pointed out as very important by the respondents. Implications are on the emphasis of a comprehensive sexuality education as mandated by the provisions of RA 10354. These call for the integration of sexual and reproductive health information in the degree and non-degree education programs of higher education institutions (HEIs) in the country. Also, this could be considered an input in the development of instructional and informative materials intended to raise awareness of the academic community on matters regarding sexual and reproductive health and well-being of the youth.

Other programs and services deemed very important for the respondents include: fertility awareness education, information and counseling on sexual reproductive health rights, HIV-AIDS and other STIs prevention and management. These have indications as to what activities to prioritize when crafting for a school-based sexuality education.

Table 4:Extent of importance of sexual and reproductive health programs and services as perceived by respondents

Indicators	Mean	Qualitative Description
Fertility Awareness Education	4.00	Very Important
Counseling and support for sexual relationship problems	3.85	Very Important
Information and counselling on sexual and reproductive health issues	3.87	Very Important
Preventing sexual abuse and gender-based violence	4.06	Very Important
Testing and counselling services for pregnancy, HIV and other STIs	3.87	Very Important
HIV-AIDS and other STIs Prevention and Management	3.92	Very Important
Information and counseling on Sexual Reproductive Health Rights	3.95	Very Important
Family planning information, counselling on methods of contraception (including emergency contraceptive methods)	4.01	Very Important
Managing mental health issues related to sexual health	4.05	Very Important
Counselling and education on the impact of physical disabilities and chronic illnesses on sexual well-being	3.94	Very Important
Promotion of safe and satisfying sexual experiences.	3.80	Very Important

Legend
4.2 - 5 = Extremely Important
1 – 1.79 = Not Important at All
2.60 – 3.39 = Moderately Important
1.80 – 2.59 = Somewhat Important
3.40 – 4.19 = Very Important

Other Programs or Services Recommended by Youth-Respondents for the Promotion of their Sexual and Reproductive Health

When respondents were asked to recommend other programs and services which can be implemented for the promotion of their sexual and reproductive health and well-being, 193 out of 309 or 62.46% of them responded. Responses were clustered and the following top 3 emerged: garnering the most, with 121 or 62.69% is sex education which can be given thru orientation/seminar/symposium about adolescent sexuality and reproductive health and inclusion in the curriculum; this was followed by contraceptive distribution/access to and promotion on the use of contraceptives, with 21 or 10.88%, third on the list is Family Planning, with 17 or 8.81%.

Other recommended programs or services as can be gleaned in Table 5 are: counseling re: sexual and reproductive health issues; mobile health clinic providing free check-ups (i.e. HIV/AIDS/STI free testing); establish support groups/peer education programs and maternal and child health care/prenatal care. These may appear like a reiteration of some of the programs and services cited in Table 4 but the fact that respondents emphasized on it probably expresses their need to access or avail of such. Hence, implications point on the sexual and reproductive health-related programs and services delivered specially by the following core offices: the Campus Clinic, the Campus Gender and Development Office, and the Campus Counseling and Career Services Office.

Table 5:Other programs or services recommended by respondents

Other recommended programs or services	Frequency (n = 193)	Percent (%)
Contraceptive distribution/access to and promotion on the use of contraceptives (i.e. condom, provision of adolescent-friendly contraceptive services.)	21	10.88%
Counseling (re: sexual and reproductive health issues)	11	5.70%
Sex Education: Orientation/Seminar/Symposium about adolescent sexuality and reproductive health and inclusion in the curriculum	121	62.69%
Family Planning	17	8.81%

Establish support groups/Peer Education Programs	9	4.66%
Maternal and Child Health Care/Prenatal Care	3	1.55%
Mobile health clinic providing free check-ups (i.e. HIV/AIDS/STI free testing)	11	5.70%

IMPLICATIONS

Results of the study highlights the need for HEIs to strengthen initiatives onward the promotion of sexual self-efficacy and reproductive health and well-being of the Filipino youth, in consonance to the provisions of Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health Act.

This entails the prioritization of university-based sexuality and reproductive health education and services which are gender-inclusive, age-appropriate, and culturally and religiously sensitive. Such may comprehensively include but is not limited to: prevention and elimination of sexual abuse and gender-based violence, management of mental health issues related to sexual health care, family planning information, counselling on methods of contraception including emergency contraceptive methods, fertility awareness education, information and counseling on sexual reproductive health rights and issues, HIV-AIDS and other STIs prevention and management, provision of a mobile health clinic offering free check-ups/testing for HIV/AIDS/STI; establishment of support groups/peer education programs and maternal and child health care/prenatal care.

These programs and services can be concretized thru the concerted efforts of all stakeholders in the academic community - from the educational leaders who lay down the policies, to the curriculum developers whose role is vital in the integration of the abovementioned in the curricula, the program implementers such as the teachers and the concerned offices who are directly in-charge of the delivery of the services, and the student-recipients whose cooperation is essential in ensuring an effective program implementation.

Accordingly, resources and efforts should focus on facility improvement, engagement of health professionals, in-service training and capacity building for educators, gender and development focal persons and guidance counselors. Ultimately, ensuring a supportive school environment through the active involvement of all stakeholders is critical in the delivery of appropriate reproductive health education and services.

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