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Peer Influence in the Promotion of Sexual Health Education among Sangguniang Kabataan Officials

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Abstract

This mixed-methods study examined peer influence in sexual-health-related discussions among youth leaders in Tagbilaran City, Philippines. Specifically, it described the level of peer influence on sexual health awareness, determined differences across selected demographic variables, and explored the lived experiences that contextualize these quantitative findings. A convergent mixed-methods design was employed. Quantitative data were collected from 109 Sangguniang Kabataan (SK) officials using a validated researcher-developed questionnaire, while qualitative data were gathered through focus group discussions and in-depth interviews. Descriptive statistics and one-way ANOVA were used for quantitative analysis, while thematic analysis guided the qualitative phase. Results indicated a generally high level of peer influence on sexual-health-related discussions across domains. Significant differences were found when respondents were grouped according to educational attainment, while no significant differences emerged for sex and age. Qualitative findings revealed that peer discussions served as accessible sources of information but were often constrained by fear of judgment, misinformation, and cultural silence surrounding sexual topics. Integration of findings showed that while peer influence is strong, it does not consistently translate into accurate or comprehensive sexual health understanding. The study underscores the need for guided, context-sensitive peer-based initiatives that strengthen accurate communication while addressing sociocultural barriers.

Keywords: Peer Influence, Sexual Health Awareness, Youth Leaders, Mixed Methods

Rationale

Sexual health education in the Philippines remains insufficiently developed, leaving many adolescents with limited access to accurate and comprehensive information about their sexual and reproductive well-being. Despite existing national policies such as the Responsible Parenthood and Reproductive Health Act and DepEd Order No. 31, s. 2018, the implementation of Comprehensive Sexuality Education (CSE) across schools and communities continues to face cultural, religious, and institutional barriers. As a result, many young people rely on peers and social media platforms for information, which often leads to misinformation, stigma, and unsafe practices.

Globally, the World Health Organization (WHO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) advocate for CSE as a holistic and rights-based approach that equips the youth with accurate knowledge, positive attitudes, and essential life skills. CSE covers nine key areas: (1) relationships, (2) values, rights, culture, and sexuality, (3) understanding gender, (4) violence and staying safe, (5) skills for health and well-being, (6) the human body and development, (7) sexuality and sexual behavior, (8) sexual and reproductive health, and (9) consent and communication. However, in the Philippine context, these areas are rarely taught in their entirety, resulting in fragmented understanding and limited awareness among adolescents.

Peer influence plays a significant role in shaping how SK officials perceive, communicate, and implement health-related programs. Positive peer influence can enhance leadership confidence, encourage responsible communication, and promote collective action, while negative peer pressure or misinformation can hinder advocacy efforts. Understanding the extent and nature of peer influence is therefore crucial in assessing how SK officials navigate their responsibilities and overcome barriers in promoting sexual health awareness.

Given these realities, this study aimed to determine the level of peer influence experienced by SK officials and the challenges they faced in promoting sexual health education. Specifically, it sought to describe their demographic profile in terms of age, sex, and educational attainment; assessed their perceived level of peer influence; identified the challenges they encountered; and determined whether there was a significant difference in the perceived level of peer influence when grouped according to their demographic characteristics. Furthermore, the study looked into the lived experiences of SK officials to contextualize the qualitative relationship between peer influence and sexual health education.

The findings of this study provided valuable insights into how peer dynamics affected the implementation of sexual health education at the grassroots level. It also contributed to developing targeted interventions and capacity-building programs that strengthened the role of SK officials as peer educators and advocates for youth sexual health. Ultimately, the study aimed to support evidence-based and culturally sensitive strategies that empowered local youth leaders to promote informed, responsible, and healthy behaviors among Filipino adolescents.

Theoretical Background

Sex education plays a vital role in the holistic development of young people. It not only provides them with accurate knowledge about human anatomy and reproduction but also fosters an understanding of contraception, prevention of sexually transmitted infections (STIs), consent, and emotional well-being. Comprehensive sex education empowers youth to make informed decisions, develop healthy relationships, and maintain responsible behaviors that support their sexual and reproductive health. By addressing both biological and psychosocial aspects, it serves as a foundation for promoting long-term well-being and reducing health risks among adolescents (UNESCO, 2018).

The current study used two established theories to determine our understanding of the ways in which sexual health information proliferates among youth: Social Learning Theory (Bandura, 1977) [2] and Social Norms Theory (Perkins & Berkowitz, 1986) [14]. These theories could also help to explain how young people take in, mirror, and sometimes distort the information they learn from each other, particularly in the context of sexual health education.

Social Learning Theory (SLT) suggests that individuals learn behaviors, values, and norms by observing others within their social environment. In adolescent populations, particularly in low- and middle-income countries, peer modeling and informal information exchange remain common and effective pathways for sexual health learning (Denison *et al*., 2017; Ushie *et al*., 2021) [9, 22].

Review of Related Literature

Peer influence is one of the primary influences that contribute to adolescents' attitudes and practices in relation to sexual health information specifically among youth organizations with developed structure of leadership such as Sangguniang Kabataan (SK) in the Philippines. As an institution charged with the promotion of the welfare of the youth, the SK provides a relevant and topical perspective through which analyses of peer dynamics can be used in the enhancement of a context-specific sexual health education program. Previous studies emphasized the importance of peer relationships for adolescent development. For instance, Agan *et al*. (2019) [1] found in a longitudinal survey of 3,000 American adolescents that greater social integration or popularity (how popular the participant perceived his or herself to be) was linked to increased likelihood of engaging in early sexual onset. This shows that peer endorsement has both a motivating and a risk-inducing effect on sexual decision making of adolescents. Yet, apparently, what is not yet addressed in the literature is how these peer dynamics work in the context of community-based leadership constructs like the SK, nor how it is influenced by cultural considerations indigenous to Southeast Asia a gap that this study seeks to accomplish.

Similarly, Clark *et al*. (2021) [5] analyzed data from the Adolescent Brain Cognitive Development (ABCD) Study and categorized adolescents into peer groups based on prosocial and antisocial behaviors. Their findings indicated that youth associated with antisocial peers were more likely to engage in early and risky sexual behavior, while those with prosocial peers often delayed such behavior. Though this provides insight into the influence of peer group typologies, it lacks attention to structured civic roles and is limited to Western populations. Such limitations highlight the need for context-specific research focusing on how peer influence functions within formal youth-led organizations.

Tolli's (2021) [18] systematic review of peer education programs in Europe and low-income countries further illustrates the potential of peer-led interventions in promoting sexual and reproductive health. Drawing on both randomized controlled trials and qualitative data, Tolli concluded that these programs significantly enhance knowledge and dispel myths. However, a common limitation was identified: many of these initiatives lacked institutional support, rendering them unsustainable. In contrast, the SK, being a formally recognized governmental body, may offer a sustainable and structured setting for peer-led programs, a potential yet underexplored in current research.

Locally, Corciega *et al*. (2018) [6] found that Filipino adolescents demonstrated greater understanding and openness toward sexual health topics when educated by peers, largely because of the relatability and trust built among friends. Supporting this, Casimiro (2018) [4] evaluated a program called RE-YOU, which empowered youth to serve as peer educators on sexuality. The findings showed that peer educators not only changed their personal behaviors but also influenced their peers positively, suggesting the potential for youth-led efforts to create ripple effects within communities. The United Nations Population Fund (UNFPA) Philippines (2021) also reported the effectiveness of youth-led SRH education initiatives in areas like Navotas and Malabon, where SK members acted as facilitators and advocates, helping increase access to accurate information among adolescents.

The influence of peer communication is no longer confined to physical settings. In the digital age, adolescents increasingly turn to peers and online platforms for information about sex and relationships. Byrne *et al*. (2022) [3], in a study of 420 students in Ireland, found that most respondents preferred consulting peers or digital sources over healthcare professionals. However, the study also highlighted widespread misinformation, particularly concerning contraception and STIs. While the research

underscores the importance of digital peer influence, it does not examine how such interactions can be regulated or enhanced within formal organizations like the SK.

Expanding on digital dynamics, Yeo and Chu (2017) [23] conducted a content analysis of a Facebook-based youth peer-discussion space and found extensive advice-seeking and personal storytelling, highlighting how social media can facilitate access to peer-shared sexual health–related discourse Nevertheless, the potential of youth-led structures like the SK to moderate or correct these flows of information remains unaddressed.

In terms of policy, Executive Order No. 141 (Department of Health, 2021) [10] lays out the Philippine government's strategy for addressing teenage pregnancy, explicitly assigning the SK a role in implementing community-based education. While this offers a robust institutional framework, there is a lack of empirical data on how SK leaders themselves access, understand, and distribute sexual health information, or how their leadership roles are shaped by peer influence and social expectations.

Sociocultural factors further complicate the landscape of adolescent sexual health in the Philippines. Cultural taboos surrounding sexuality and parental discomfort in discussing the topic contribute to a significant information gap. According to the 2024 UNFPA report, only around 11% of Filipino youth consult family members about sexual health, relying instead on peers and community programs. This underscores the need for credible, relatable, and accessible sources of SRH information such as peer educators embedded within youth-led institutions.

Leloambutu (2023) [12] examined how adolescents undergoing Comprehensive Sexuality Education (CSE) became more confident in expressing their thoughts and navigating peer interactions. The study emphasized the importance of fostering supportive peer environments that encourage open dialogue.

Furthermore, the interplay of personal and societal influences shapes adolescent behavior. Factors such as curiosity, denial, misinformation, and peer pressure, combined with a lack of formal sex education and minimal guidance from adults, contribute to confusion and risk-taking. It has been observed that as adolescents strive for autonomy, they increasingly turn to peers and broader social circles rather than parents, making peer-led initiatives especially critical during this developmental stage (Steinberg, 2017) [16].

Despite the growing body of literature exploring adolescent sexual behavior, most studies focus either on general youth populations, Western contexts, or digital communication in isolation. Few have examined how peer influence operates within structured youth leadership organizations such as the SK. This study, Peer Influence in the Promotion of Sexual Health Education Among Sangguniang Kabataan Officials, seeks to fill that gap by providing a localized and culturally sensitive analysis of how SK leaders informally and formally influence SRH education in their communities.

Hence, this studies how peer relationships and digital spaces influence SK leaders as agents of change. It aims to provide practical recommendations to strengthen SK-led initiatives, enhance credibility, and improve the accuracy of sexual health information. Thus, it seeks to support sustainable, youth-centered approaches to sexual and reproductive health education in the Philippines.

Research Methodology

This part provides an overview of the methodology that was employed in this study, covering discussions on the research design, research environment, research participants, research instruments, and research procedures. By examining these key aspects, a deeper understanding of how the study was conducted was gained.

This study utilized an Explanatory Sequential Mixed-Methods Design, which involved collecting and analyzing quantitative data first, followed by qualitative data to explain or expand on the initial findings (Creswell & Plano Clark, 2018) [8].

The use of this design was appropriate for the study as it allows for a comprehensive understanding of the research problem by combining the strengths of both quantitative and qualitative approaches (Ivankova, Creswell, & Stick, 2006) [11]. It did not only measure the extent of peer influence and SK involvement in promoting sex education but also looked at the underlying reasons and contextual factors behind these behaviors. When both numerical data and personal experiences were integrated, the study provided a richer and more nuanced perspective on the role of peer influence in sex education advocacy among youth leaders (Creswell & Creswell, 2018) [7].

The study was focused on selected Sangguniang Kabataan (SK) officials from the 15 barangays of Tagbilaran City, Bohol, aged 18 to 24 years old, in accordance with the age requirement stipulated under Republic Act No. 10742, which mandates that SK officials must be at least 18 years old but not more than 24 years old at the time of election (Republic Act No. 10742, 2015) [15]. Participation in the study was voluntary, and informed consent was obtained from all participants prior to data collection.

A purposive sampling technique was used to ensure that participants were knowledgeable and relevant to the objectives of the study (Palinkas *et al*., 2015) [13]. For the Quantitative Phase, the participants were elected SK officials aged 18–24 years from the 15 barangays. SK officials who are actively involved in community discussions or youth-related initiatives in education and health were prioritized in the selection. Slovin's formula is a widely used method for determining sample size when the population size is known and the margin of error is specified (Tejada & Punzalan, 2012) [17]. Using a margin of error of 5% (0.05), the formula is expressed as:

$$n = \frac{N}{1 + N.e^2}$$

Thus, 109 SK officials were selected to participate in the survey. This sample size ensures a statistically valid representation of the population, allowing for generalizable insights within the accepted margin of error.

For the Qualitative Phase, participants for the Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) were drawn from those who completed the survey. The study employed a purposive sampling method to intentionally select participants who are active Sangguniang Kabataan (SK) officials with relevant experience in youth and sexual health-related programs, ensuring that they can provide valuable insights aligned with the study's objectives. Furthermore, maximum variation sampling was applied

within the purposive sampling design to capture diverse perspectives based on barangay location, gender, and degree of involvement in sexual health initiatives.

Out of the fifteen (15) barangays, five (5) groups were formed for the Focus Group Discussion (FGD), with each group composed of three (3) barangays. Two (2) participants were selected from each barangay, resulting in six (6) participants per FGD group. In addition, one (1) participant from each barangay was chosen to take part in the In-Depth Interview (IDI).

This study adopted an explanatory sequential design to determine sexual health information among Sangguniang Kabataan (SK) officials. To ensure a comprehensive and systematic understanding of the phenomenon, three data collection methods were employed: survey questionnaires, focus group discussions (FGDs), and in-depth interviews (IDIs). For the quantitative phase, a researcher-developed survey questionnaire was utilized, consisting of two main sections: the demographic profile of the respondents and a Peer Influence Scale adapted from the nine areas of sexual health education. Responses were measured using a 5-point Likert scale. Prior to data collection, the survey instrument underwent pilot testing, and its internal consistency reliability was established using Cronbach's alpha. The instrument obtained a Cronbach's alpha coefficient of 0.84, indicating good reliability and consistent measurement of the constructs. For the qualitative phase, two instruments were employed: a Focus Group Discussion Guide that focused on peer learning experiences, shared norms, and challenges related to misinformation, and an In-Depth Interview Guide that elicited personal narratives to further explain and contextualize the trends observed in the quantitative findings. All research instruments were subjected to expert validation by professionals in the fields of public health, psychology, and education to ensure clarity, relevance, and content validity prior to final administration.

Presentation, Analysis, and Interpretation of Data

The presentation of the collected data, statistical & thematic analyses, and interpretation of findings. The tables utilized are presented in the sequence of the derived research problems regarding the peer influence in the promotion of sexual health education.

Table 1: Demographic Profile of the Participants

	Frequency (f)	Percentage (%)
Sex		
Male	41	37.61%
Female	68	62.39%
Ages		
18-Year-Old	0	0%
19-Year-Old	0	0%
20-Year-Old	5	4.59%
21-Year-Old	17	15.60%
22-Year-Old	32	29.36%
23-Year-Old	34	31.19%
24-Year-Old	21	19.27%
Educational Attainment		
College Undergraduate	96	88.07%
College Graduate	13	11.93%

The demographic results indicate that the respondents were predominantly female, comprising 68 individuals (62.39%), while males accounted for 41 respondents (37.61%). In terms of age, no respondents were aged 18 or 19, with the majority clustered between 22 and 23 years old, where 32 respondents (29.36%) were 22 years old and 34 respondents (31.19%) were 23 years old; smaller proportions were aged 21 (15.60%), 24 (19.27%), and 20 (4.59%). Regarding educational attainment, most respondents were college undergraduates, totaling 96 individuals (88.07%), while 13 respondents (11.93%) were college graduates. These results show that the sample largely consisted of female respondents in their early twenties who were primarily pursuing undergraduate college education.

Table 2: Peer Influence on Areas of Sexual Health Education

	Weighted Mean	Interpretation
I. Peer Discussion on Relationships		
1. I have learned how to build respectful relationships by observing how my peers interact with others.	4.45	Very High
2. Conversations with friends have helped me understand what a healthy relationship looks like.	4.51	Very High
3. In my peer group, treating others with respect in relationships is considered normal.	4.46	Very High
Composite Mean	**4.47**	**Very High**
II. Peer Discussion on Values, Rights, Culture, and Sexuality	**Weighted Mean**	**Interpretation**
1.I became more aware of different values through stories and discussions with peers.	4.52	Very High
2. Conversations with friends helped me better understand how culture shapes views on sexuality.	4.36	Very High
3. Respecting cultural differences in beliefs about sexuality is important to my peers.	4.47	Very High
Composite Mean	**4.45**	**Very High**
III: Peer Discussion on Understanding Gender		
1.I learned about gender roles by listening to my peers' experiences.	4.44	Very High
2. Observing how my friends express themselves has helped me understand gender better.	4.41	Very High
3. My peer group supports respectful conversations about different gender identities.	4.39	Very High
Composite Mean	**4.41**	**Very High**
IV: Peer Discussion on Violence and Staying Safe		
1. Talking with friends has helped me recognize unsafe or disrespectful behavior.	4.49	Very High
2. My friends believe it is important to speak out against any form of violence.	4.50	Very High
3. In my peer group, it is normal to support one another in staying safe.	4.51	Very High
Composite Mean	**4.50**	**Very High**
V. Peer Discussion on Skills for Health and Well-being		
1.I have learned about self-care and stress management by observing my peers.	4.39	Very High
2. Friends have helped me develop life skills that support my mental health.	4.39	Very High
3.Maintaining personal well-being is valued in my peer group.	4.47	Very High

Composite Mean	**4.42**	**Very High**
VI: Peer Discussion on Human Body and Development		
1.I became more informed about physical changes during adolescence through conversations with peers.	4.48	Very High
2. My understanding of how the body develops was influenced by peer discussions.	4.46	Very High
3. Among my friends, talking about body changes is considered normal.	4.43	Very High
Composite Mean	**4.46**	**Very High**
VII: Peer Discussion on Sexuality and Sexual Behavior		
1.I have gained awareness of responsible sexual behavior through stories shared by peers.	4.39	Very High
2.My understanding of sexuality has been shaped by what I observe and hear from my friends.	4.35	Very High
3. Among my peers, making informed choices about sexual behavior is encouraged.	4.42	Very High
Composite Mean	**4.39**	**Very High**
VIII: Peer Discussion on Sexual and Reproductive Health		
1.I have learned about pregnancy prevention through peer conversations.	4.20	High
2. My awareness of STIs has increased because of discussions with friends.	4.19	High
3. Most of my peers believe that learning about STI prevention is essential.	4.31	Very High
Composite Mean	**4.24**	**High**
IX: Peer Discussion on Consent and Communication		
1.I have learned to respect boundaries by observing how my peers communicate.	4.43	Very High
2. Conversations with friends helped me understand the importance of mutual consent.	4.25	Very High
3. In my peer group, consent practices are encouraged.	4.31	Very High
Composite Mean	**4.33**	**Very High**

Scale interpretation: 4.21–5.00 = Very High Influence | 3.41–4.20 = High Influence | 2.61–3.40 = Moderate | 1.81–2.60 = Low | 1.00–1.80 = Very Low

Table 2 shows that peer discussions across all areas of sexual health education generally obtained Very High composite mean ratings, indicating consistently strong peer influence in these domains. The highest composite mean was observed in peer discussions on violence and staying safe ($\bar{x}$ = 4.50), followed by relationships ($\bar{x}$ = 4.47) and human body and development ($\bar{x}$ = 4.46). Peer discussions on sexuality and sexual behavior, skills for health and well-being, values, rights, culture, and understanding gender likewise yielded Very High ratings, with composite means ranging from 4.39 to 4.45. In contrast, sexual and reproductive health registered a High composite mean ($\bar{x}$ = 4.24), indicating comparatively lower but still favorable peer discussion levels in this area.

Table 3: Significant Difference in the occurrence of Peer Influence in the Promotion of Sexual Health Education when Grouped by Demographic Profile

Variables	P-value	Decision on Ho	Interpretation
Peer Influence when grouped by Sex	0.252	Accept Ho	Not Significant
Peer Influence when grouped by Age	0.267	Accept Ho	Not Significant
Peer Influence when grouped by Educational Attainment	0.000	**Reject Ho**	**Significant**

Table 3 shows that there was no significant difference in the occurrence of peer influence in the promotion of sexual health education when respondents were grouped according to sex (F = 1.325, p = 0.252) and age (F = 1.307, p = 0.267), as the null hypotheses for these variables were accepted. In contrast, a significant difference was observed when respondents were grouped by educational attainment (F = 17.986, p = 0.000), leading to the rejection of the null hypothesis. This indicates that peer influence in the promotion of sexual health education varied based on respondents' level of educational attainment, while remaining comparable across sex and age groups.

Thematic Analysis

Qualitative data from the Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) were analyzed thematically to identify recurring patterns in participants' experiences and perceptions regarding peer interaction and sexual health discussions. Five major themes emerged, reflecting shared social dynamics, communication patterns, and contextual constraints influencing engagement.

A. Focus Group Discussion

Theme 1: Silence, Fear of Judgment, and Limited Openness in Peer Discussions

8 FGD participants shared that "Dili tanan open-minded, maong lisod kaayo maghisgot ani."
(Not everyone is open-minded, that's why it's very difficult to talk about this.)

"Kung lahi imong hunahuna, hilom na lang ka." (FGD-P7)
(*If your opinion is different, you just stay quiet.)*

5 FGD participants mentioned "Mas maayo nang maghilom kaysa ma-judge."
(*It's better to stay quiet than be judged.)*

13 FGD participants mentioned "Makaulaw kaayo maghisgot ana." (FGD-P3)
(*It's really embarrassing to talk about that.)*

Participants repeatedly described peer discussions on sexual health as constrained by discomfort, embarrassment, and fear of negative reactions. Many stated that openness depended on individual personalities rather than shared group practices. When differing opinions were expressed, discussions were often interrupted or discontinued, resulting in reduced participation. Several participants indicated that silence was a common response when they felt their views might not be accepted or might invite ridicule. Even participants who felt confident in their knowledge reported hesitation due to concerns about being misunderstood or laughed at. Across both FGDs and interviews, silence was consistently described as a safer option than active participation. These accounts reflect Social Norms Theory, where avoidance and silence function as accepted responses

within the group, and Social Learning Theory, where observing negative reactions discourages participation.

Theme 2: Peer-Centered Information Exchange and Reinforcement of Peer Norms

21 FGD participants shared "Sa among kauban ra mi mangutana."
(*We only ask our group members.)*

6 FGD participants mentioned "Mas sayon makigstorya og kaedad kaysa sa adults." (FGD-P5)
(*It's easier to talk to someone of the same age than to an adult.)*

13 FGD participants shared "Usahay sakto ra, pero usahay mali ang info." (FGD-P19)
(*Sometimes the information is correct, but sometimes it's wrong.)*

Participants identified peers as their primary source of sexual health information. Peer discussions were described as more accessible and less intimidating than conversations with adults or formal authorities. However, participants acknowledged that information exchanged within the group was sometimes incomplete or inaccurate. Despite this, peer advice remained influential because it was perceived as relatable and non-judgmental. Peer reactions also shaped which topics were considered acceptable to discuss and which were avoided. This reflects Social Learning Theory, where peers serve as primary models for learning, and Social Norms Theory, where group acceptance influences what information is shared and retained.

Theme 3: External Disapproval

17 FGD participants said "Bastos daw ni."
(They say this is rude.)

5 FGD participants shared "Dili angay hisgutan sa among edad."
(They say it's not appropriate for our age.)

Participants reported resistance from family members, community adults. Sexual health topics were frequently labeled as inappropriate or taboo, which discouraged further discussion or advocacy. In addition, interviewees noted leading to feelings of uncertainty and isolation. This lack of external support increased reliance on peers, despite acknowledged limitations in peer-provided information. These experiences reflect broader social norms reinforced by family and community, and social learning processes where avoidance and silence are modeled and sustained.

A. In-depth Interview

Theme 4: Conformity, Suppressed Questions, and Emotional Self-Protection

"Musunod na lang ko bisan sayop." (IDI-01)
(*I will just follow even if it is wrong.)*

"Mahadlok ko mu-question. Bisan ganahan ko mangutana, dili nalang ko modayun kay basin ingnon ko nga walay alam. Usahay naglisod ko pero dili ko musulti kay maulaw ko." (IDI-05)

(I am afraid to question. Even if I want to ask, I stop because they might say I do not know anything. Sometimes I struggle but I do not speak up because I feel embarrassed.)

"Dali ko maapektuhan kung naay musaway." (IDI-09)
(*I get easily affected when someone criticizes me.)*

Theme 5: Institutional Neglect and Perceived Lack of Support

"Walay tabang. Murag kami-kami ra. Walay seminar, walay klarong guidance, ug usahay walay motubag kung mangayo mig help." (IDI-13)

(There is no help. It feels like we are on our own. No seminars, no clear guidance, and sometimes no one responds when we ask for help.)

"Ganahan unta ko nga sige naay programa sa sexual health kaso maglisod mi kay dili kaayo supportado ning mga ingon ana kay para sa uban nga dako-dako masulbad raning mga problemaha og naay libre nga contraception" (IDI-15)

(I would like to see a sexual health program in place, but we are having a hard time because there is not much support for these things, because for some, these big problems can be solved with just free contraception.)

Participants consistently described the absence of institutional support as a key factor influencing their limited engagement in sexual health initiatives. They reported a lack of formal capacity-building activities, such as seminars or structured training, as well as unclear or nonexistent guidelines to aid program planning and implementation. Requests for assistance were often met with delayed or no responses, which fostered feelings of isolation, uncertainty, and inadequacy. Consequently, participants relied heavily on peers for guidance and information, even while acknowledging that their peers were similarly underprepared. This perceived lack of visible institutional involvement weakened participants' confidence, reduced program consistency, and limited their ability to respond effectively to sexual health concerns. These findings align with Social Learning Theory, which emphasizes the role of credible models and guidance in shaping learning, and Social Norms Theory, wherein the absence of institutional reinforcement allows silence, inaction, and minimal intervention to become normalized responses to sexual health issues.

B. Integration of Quantitative and Qualitative Results

Table 4: Joint Display depicting Peer Influence on Sexual Health Information

Quantitative Results	Qualitative Results	Mixed Meta-Inferences
Peer influence rated Very High in 8 of 9 domains	Peers identified as primary source of information	Peers are the dominant learning agents among SK officials
Very high ratings in relationships and values	Respect and values reinforced through peers	Peer interactions shape moral and relational development
Very high influence in gender understanding	Gender norms learned socially	Peer culture regulates identity
Very high scores in consent and communication	Fear limits open discussion	Awareness exists without practice
Very high influence in violence and safety	Harmful acts discouraged yet rarely confronted	Safety norms are known but not enforced
Sexual and reproductive health rated only High	Misinformation common	High dependence with weak accuracy
Very high influence in emotional well-being	Shame, anxiety, and avoidance	Peer learning is emotionally taxing
No significant difference by sex	Shared fear across groups	Peer culture outweighs gender differences
No significant difference by age	Similar experience across ages	Peer influence consistent across age groups
Significant difference by education	Education improves awareness	Education enhances interpretation

The integrated quantitative and qualitative findings affirm that peer influence is the central mechanism shaping sexual health information among SK officials, consistent with Social Learning Theory and Social Norms Theory. Quantitatively, peer influence was rated *Very High* in eight of nine domains, with no significant differences by sex or age, indicating that peer-driven processes are stable across demographic groups. Qualitative data reinforce this pattern by identifying peers as the primary sources of information and reinforcement, particularly in relationships, values, gender understanding, and emotional well-being. In line with Social Learning Theory, peers act as salient models through which behaviors, attitudes, and expectations are observed, imitated, and sustained. Simultaneously, Social Norms Theory explains how shared peer beliefs define what is considered acceptable, shaping moral reasoning, gender norms, and relational conduct through collective regulation rather than formal instruction.

Despite this strong convergence, the integration reveals limitations inherent in peer-based learning systems. While very high quantitative ratings were observed in consent, communication, violence prevention, and safety, qualitative findings highlight fear, silence, and avoidance, indicating that norms are recognized but weakly enforced. Sexual and reproductive health information, rated only *High*, further reflects heavy peer reliance accompanied by misinformation and uneven accuracy, suggesting norm transmission without sufficient validation. Emotional well-being emerged as highly influenced yet emotionally taxing, as shame and anxiety are reproduced within peer interactions. The significant difference by educational attainment supports both theories by showing that education refines how peer-modeled information is interpreted without diminishing peer influence itself. Overall, the findings demonstrate that peers strongly shape knowledge and norms, but without institutional reinforcement, peer cultures tend to normalize awareness while constraining openness, accuracy, and consistent practice.

Summary of Findings

The findings are organized and reported in direct alignment with the research problems of the study.

1. Demographic Profile of the Respondents

In terms of demographic characteristics, none of the respondents were aged 18 or 19. The largest proportion of respondents fell within the 22–23 age group, followed by those aged 24, 21, and 20. Regarding sex, the majority of the respondents were female, while males constituted a smaller proportion of the sample. In terms of educational attainment, most respondents were college undergraduates, with only a limited number identified as college graduates.

2. Perceived Level of Peer Influence Experienced by SK Officials

The perceived level of peer influence was rated Very High in eight out of nine areas of sexual health education, including relationships; values, rights, culture, and sexuality; understanding gender; violence and staying safe; skills for health and well-being; human body and development; sexuality and sexual behavior; and consent and communication. Peer influence in sexual and reproductive health was rated High, making it the lowest among the domains assessed.

3. Challenges Encountered by SK Officials in Promoting Sexual Health Education

The challenges identified through FGDs and IDIs included silence and limited openness during peer discussions, fear of judgment, embarrassment, and reluctance to express differing opinions. Respondents also reported reliance on peers as primary sources of information, experiences of external disapproval from family and community members, conformity to group opinions, suppressed questions, emotional discomfort, and perceived lack of institutional support such as seminars, guidance, and responsive assistance.

4. Significant Difference in the Perceived Level of Peer Influence

There was no significant difference in the perceived level of peer influence when respondents were grouped according to sex and age. A significant difference was found when respondents were grouped according to educational attainment.

5. Contextualization of Peer Influence Through SK Officials' Experiences

The qualitative experiences of SK officials showed that peer influence occurred within peer-centered interactions characterized by both active information exchange and constrained participation. These experiences aligned with the quantitative results indicating high levels of peer influence across most areas of sexual health education.

Conclusion

The findings of this study indicate that peer influence is a prevalent and consistent contextual factor in relation to sexual health knowledge, attitudes, and norms among SK officials. High reported levels across most domains suggest that peer interactions are a common source of exposure and reference for topics related to relationships, values, gender, consent, safety, and well-being. The absence of significant differences by sex and age implies that peer-related processes are similarly experienced across these groups, reflecting shared social environments rather than differential influence. However, the significant variation by educational attainment suggests that education contributes to a greater capacity to critically evaluate and interpret peer-shared information, rather than diminishing the presence of peer influence itself.

Despite the prominence of peers within sexual health–related contexts, the study also highlights important structural and social limitations. Qualitative findings reveal that fear, silence, conformity, and misinformation remain within peer spaces, restricting the depth and accuracy of dialogue. Awareness of sexual health concepts did not consistently translate into open communication or sustained practice, particularly in matters related to sexual and reproductive health. The absence of clear institutional guidance allows these conditions to persist, positioning peers as accessible but limited sources of information rather than comprehensive or authoritative educators. Overall, the study concludes that peer influence alone is insufficient to ensure meaningful sexual health engagement and requires formal educational and institutional support to address gaps in accuracy, confidence, and application.

Recommendations

Based on the findings of this study, the following recommendations are proposed to strengthen sexual health education among Sangguniang Kabataan officials in Tagbilaran City. These recommendations introduce new, feasible policy directions that are not currently institutionalized within SK programs but are necessary to address the documented gaps in peer-based sexual health education.

Pilot Structured Peer-Led Sexual Health Learning Circles: Given the strong reliance on peers, structured peer-led sexual health learning circles may be piloted within SK councils. These sessions may formalize peer discussions by providing clear objectives, prepared learning materials, and rotating peer facilitators. This approach builds on existing peer influence while ensuring discussions are intentional, focused, and aligned with youth development goals.

Pilot a Safe and Respectful Discussion Framework in SK Activities: To address limited openness, a safe and respectful discussion framework may be piloted during SK meetings, training, and sexual health-related activities. This framework may include agreed-upon rules on confidentiality, respectful language, and non-ridicule policies. Establishing clear discussion norms may reduce fear-based silence and encourage more active participation

Reflective Peer Climate Check-Ins: In response, reflective peer climate check-ins may be piloted at the end of sexual health discussions or programs. These brief, anonymous reflections may allow SK officials to express discomfort, confusion, or unmet learning needs without fear of exposure. This mechanism may help identify unspoken barriers and guide improvements in future peer activities.

Pilot an Institutional Sexual Health Capacity-Building Program: An institutional sexual health capacity-building program may be piloted at the city or barangay level. This program may include regular training sessions, standardized learning modules, and designated support personnel. Strengthening institutional involvement may reduce overreliance on peers alone and ensure continuity, quality, and accountability in sexual health education initiatives.

Pilot a Peer Resource Corner: It is recommended to set up a simple, accessible space (physical or digital) where SK officials can post verified articles, pamphlets, or links related to sexual health.

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