

The Relationship of Religion, Religiosity, and Parental Communication in the Sexual Behaviors of Filipinos Aged 18-25 Years in the United States and the Philippines

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Abstract

This cross-sectional survey research aims to explore and compare the relationship of religion, religiosity, and parental communication to the sexual behaviors of Filipinos aged 18-25 years in the United States and the Philippines. The Duke University Religion Index and Parent-Teen Sexual Risk Communication Scale-III was used to measure religiosity and parental communication. There were 130 participants living in the United States and 247 living in the Philippines included in this study. Among respondents from the Philippines, low levels of parental communication were associated with an increased report for the lack of condom use during the last intercourse. Catholics had a decreased likelihood of alcohol or illicit drug use before intercourse, having had multiple sex partners, and engaging in casual sex. Those who had low levels of religiosity were associated with reports of having had casual sex. Among the United States respondents, those who engaged in alcohol or illicit drug use before sexual intercourse were associated with decreased organizational religious activities. The findings of this study confirmed the need for comprehensive and culturally appropriate approaches to health promotion programs that incorporate religious and familial factors appropriate for Filipinos.

Keywords: Filipinos, HIV/AIDS, parent communication, religion, religiosity, sexual behaviors

Risky sexual behaviors are described as behaviors that increase the risk of contracting sexually transmitted infections and HIV infection (Centers for Disease Control and Prevention [CDC], 2017). In the United States, almost 10 million youths aged 15-24 years are diagnosed with sexually transmitted infections each year. Estimates suggest that this age group acquires half of all new sexually transmitted infection cases costing the U.S. health care system \$16 billion annually (CDC, 2014). In 2015, youths in the United States aged 13-24 years accounted for 22% (8,807) of all new HIV diagnoses – 80% (7,084) of those were among 20-24 year olds. In the same year, 1,489 youths were diagnosed with AIDS accounting for 8% of the total AIDS diagnoses that year. In 2013, of the 60,900 U.S. youths living with HIV, 51% (31,300) were undiagnosed (CDC, 2017).

Filipino Americans comprise the second largest Asian subgroup in the United States. In 2011,

Filipino Americans comprised 1.1% (3.4 million) of the U.S. population, of which, over 1.8 million were born outside the United States (U.S. Census Bureau, 2013). The Philippines continues to be one of the top countries of origin for immigrants in the United States. In 2013, people from the Philippines were the fourth largest immigrant group in the United States after Mexico, China, and India (McNamara & Batalova, 2015).

The Philippines had a total population of more than 100 million in 2015 (Philippines Statistics

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Authority, 2017). The Philippines is one of the ten countries in Asia that account for 95% of new HIV infections in the region. While the majority of the countries continue to make significant progress in decreasing HIV rates, the Philippines is one of the few countries where the rate of HIV infections continues to rise at an alarming rate. The country had a staggering 141% increase in annual new HIV infections from 2010-2016 (United Nations Programme in HIV/AIDS, 2017). The Philippines Department of Health (2016) estimated that among 44,010 people living with HIV in 2016, 27% were aged 15-24 years. The modes of HIV transmission are the same in the United States and the Philippines. About 94% of reported cases are through sexual contacts (Philippines Department of Health, 2016).

Research suggest that religion, religiosity, and open parent-sex communication promote safe sex behaviors among youths (Delgado-Infante & Ofreneo, 2014; Freedman-Doan, Fortunato, Henshaw, & Titus, 2013; Gipson, Gultiano, Avila, & Hindin, 2012; Haglund & Fehring, 2009; Hutchinson, 2007; Landor, Simons, Simons, Brody, & Gibbons, 2011). Family and religion are the two most important social systems in the Filipino culture (Alampay & Jocson, 2011; Chen, Thompson, & Morrison-Beedy, 2010; Nadal, 2009). Roman Catholic, the predominant religion among Filipinos, has shaped the conservative values and belief surrounding sex and sexual practices among families and individuals (Delgado-Infante & Ofreneo, 2014; Nadal 2009). Although there is an abundance of research that has explored the relationship of religion and familial variables to youth's sexual behaviors, studies among Filipinos are limited. Therefore, the purpose of this study was to describe the relationship of religion, religiosity, and parental communication to the sexual behaviors of Filipinos aged 18-25 years in the United States and the Philippines.

Religion, Religiosity, and Sexual Behaviors

In the Philippines, 92% of the population are Christians; 81% are Roman Catholics and 11% are numerous Christian groups with the largest being Protestants (Philippines Statistic Authority, 2015). Among Filipino Americans, 65% are Roman Catholics. Catholicism has a major influence on Filipinos' conservative views on social issues surrounding sex where the majority view homosexuality, sex and pregnancy outside marriage, and cohabitation as sinful. In general, Filipinos believe that the only morally and legally acceptable sexual behavior is heterosexual intercourse within a monogamous marriage. Sexual abstinence is intensely promoted for those who are not married (de Irala et al., 2009; Delgado-Infante & Ofreneo, 2014; Gipson et al., 2012).

In the Philippines, HIV/AIDS has been associated with homosexuality, promiscuity, and sub-

stance abuse. The epidemic of HIV/AIDS in the Philippines has been stigmatized and avoided in personal and societal levels resulting in lack of sex and HIV education in households, schools, and the health care system (de Irala et al., 2009; Nadal, 2009). For a long time, the Catholic Church and conservative politicians opposed and delayed the passage of the Responsible Parenthood and Reproductive Health Act of 2012. This act not only guarantees access to medically safe, effective, and quality reproductive health care services but also mandates public awareness and sex education in public schools (Urada, 2014).

Parental Communication

Parental sexual communication has one of the strongest influences in promoting safe sex behaviors including an increase in condom use, delay in sexual initiation, and decrease in the number of sexual partners. Parent-teen sexual communication leads to the development of a child's sexual values and norms that are similar to the parents (Foster, Byers, & Sears, 2011; Hutchinson, 2007; Trinh, Ward, Day, Thomas, & Levin, 2014). However, among Filipinos in the United States and the Philippines, open discussions about sex are generally uncomfortable and avoided. Additionally, the influence of Catholicism leads parents to believe that it is unlikely for children to engage in premarital sex. Therefore, discussions of safe sex practices are not necessary (Nadal, 2009).

There is little research on sexual communication patterns of Filipinos in the United States and the Philippines. Nadal (2009) reported that only 25% of Filipino American adolescents regularly discussed sex with their parents. A community-based participatory research project that explored sex communication in Filipino American families suggested that parents believe that school should be the primary source of facts about sex. Filipino American parents have difficulty addressing emotions and feelings regarding sex. As a result, adolescents turn to sexually experienced peers to tackle feelings and for emotional support (Chung et al., 2005).

In the Philippines, a survey of 3,726 high school and college students indicated that friends were the major source of sexual information. Participants reported having inadequate information regarding biological and emotional aspects of sexuality and desired more information about the emotional aspects of sex from their parents (de Irala et al., 2009).

Method

Design and Sample

We conducted a cross-sectional survey using a convenience sample of participants who were (a) self-reported Filipino aged 18-25 years and (b) able

to write and read in English. In the United States, we recruited participants from university student clubs and Filipino youth community organizations in Los Angeles, California and its surrounding areas. In the Philippines, we established a collaboration with a university located in Manila. Manila is the capital and most urbanized city in the Philippines with a population of over 12 million where majority speak English (Philippines Statistics Authority, 2015). We recruited participants in the Philippines through advertisements in student/school newsletters and student clubs.

Instruments

Religion and Religiosity

We asked participants about their religion. Choices included *Catholic*, *Christian/Protestant*, *Muslim*, *None*, and *Atheist*. If these choices were not applicable, the participant could write in their religion under *Other*. Catholic is Roman Catholic, Christian/Protestant is all other Christian faiths outside Roman Catholic. Muslim is someone who follows the religion of Islam. The participants checked none when they did not affiliate with any religion and checked Atheist when they did not believe in God (Philippines Statistics Authority, 2015).

We used the Duke University Religion Index (DUREL) to measure religiosity. The tool is a widely-used brief measure of religiosity to examine the relationships between religiosity and health outcomes. The tool is a 5-item instrument with three dimensions of religiosity. The first dimension, organizational religious activity, involves religious activities done in public, including church attendance and religious group (i.e., bible study). The second dimension, non-organizational religious activity, are activities performed privately (i.e., prayer, watching religious TV). The third dimension, intrinsic religiosity, is the degree of personal religious commitment or motivation. The psychometric properties of DUREL were established with acceptable internal consistency ($\alpha = 0.78-0.91$) and convergent validity with other measures of religiosity ($r = 0.71-0.86$). The reliability of the tool was established using a 2-week, test-retest method, with an intra-class correlation coefficient of 0.91 (Koenig & Büssing, 2010).

Parental Communication

The Parent-Teen Sexual Risk Communication Scale (PTSRC-III) is an eight-item self-report instrument for measuring the amount of communication about sexual risk and sexual risk reduction occurring between parents and their adolescent children, as reported by the adolescent. The instrument focuses on sexual risk, avoidance, and risk reduction communication. The instrument uses a 5-point response choice format, 1 to 5 for *none*, *a little*, *some*, *a lot*,

and *extensive* amounts of communication to allow respondents to quantify the amount of sexual-risk-related communication (Hutchinson, 2007).

The PTSRC-III's content validity was established using a panel of experts with acceptable ratings. Construct and criterion validity were established using Pearson's r . Test-retest reliability was acceptable at $r = 0.88$ for PTSRC-III with mothers and $r = 0.79$ with fathers. Cronbach's alpha indicated high internal reliability at 0.94 with mothers and 0.88 with fathers (Hutchinson, 2007).

Sexual Behaviors

Sexual behaviors were determined by answering five questions. Risky sexual behaviors were defined by answering "no" to the following questions, "The last time you had sexual intercourse, did you or your partner use a condom" and "In the past six months, did you or your partner use condom consistently?" Risky sexual behaviors were also defined by answering "yes" to three of the questions: "Have you ever had alcohol and/or high (used illicit drugs) before sexual intercourse," "Have you ever had more than one sex partner or multiple sex partners," and "Did you ever have casual sex (one-night stands or hook-ups)?" (CDC, 2014; Hahm, Lee, Rough, & Strathdee, 2012; Huang, Wong, De Leon, & Park, 2008; So, Wong, & De Leon, 2005; Takahashi, Magalong, DeBell, & Fasudhani, 2006). The sexual behavior questions were finalized after a pilot survey administered to seven adolescents living in the United States and five living in the Philippines was completed and verified for comprehensibility, appropriateness, and clarity.

Data Collection

The Institutional Review Board of Azusa Pacific University in the United States and Polytechnic University of the Philippines' Research and Extension Management Office in the Philippines approved this study. We formatted the instruments and demographics as self-administered questionnaires that could be completed in a pencil-paper format or via the Internet through Survey Monkey, a customizable online survey platform. A hard copy of the informed consent form was provided to and signed by participants before completing the paper-and-pencil self-administered questionnaires. The completion of the online survey implied consent to participate in the study; we did not gather a separate consent from the participants. We explicitly explained the procedures in the disclosure given at the beginning of the survey.

In the United States, we distributed a pencil-paper format of the self-administered questionnaires and provided Internet access information to the survey to interested participants during scheduled club

Table 1. Demographics for United States and Philippines

	<u>Combined</u> (n = 377)		<u>USA</u> (n = 130)		<u>Philippines</u> (n = 247)	
Were you born in the U.S.? *						
No	32	24.6%	32	24.6%		
Yes	98	75.4%	98	75.4%		
Were your parents born in the U.S.? *						
No	123	94.6%	123	94.6%		
Yes	7	5.4%	7	5.4%		
Gender						
Male	213	57.3%	70	53.8%	143	59.1%
Female	159	42.7%	60	46.2%	99	40.9%
	Missing = 5				Missing = 5	
Education						
High school diploma	27	7.3%	13	10.1%	14	5.7%
Enrolled in college	206	55.4%	68	52.7%	138	56.8%
College Degree	139	37.3%	48	37.2%	91	37.5%
	Missing = 5		Missing = 1		Missing = 4	
Employment status						
Not employed/student	26	7%	5	3.9%	21	8.7%
Student	176	47.6%	41	31.8%	135	56%
Part time employment	66	17.8%	48	37.2%	18	7.5%
Full time employment	102	27.6%	35	27.1%	67	27.8%
	Missing = 7		Missing = 1		Missing = 6	
Living situation						
Alone	27	7.3%	4	3.1%	23	9.5%
With husband/wife/BF/GF	14	3.8%	4	3.1%	10	4.1%
With parent/relative	260	70.3%	92	71.9%	168	69.4%
With students/roommates	69	18.7%	28	21.9%	41	16.9%
	Missing = 7		Missing = 2		Missing = 5	
Marital or relationship status						
Cohabiting	6	1.6%	1	0.8%	5	2.1%
In a relationship (BF/GF)	147	39.7%	62	48.1%	85	35.3%
Married	4	1.1%	0	0%	4	1.7%
Single	213	57.6%	66	51.2%	147	61%
	Missing = 7		Missing = 1		Missing = 6	
Religion						
Atheist	21	5.8%	1	0.8%	20	8.6%
Catholic	241	66.9%	97	77%	144	61.5%
Protestant	68	18.9%	19	15.1%	49	20.9%
None	30	8.3%	9	7.1%	21	8.8%
	Missing = 17		Missing = 4		Missing = 13	
Income						
High income	74	21.2%	32	26.4%	42	18.4%
Low income	93	26.7%	22	18.2%	71	31.1%
Middle income	182	52.2%	67	55.4%	115	50.4%
	Missing = 28		Missing = 9		Missing = 19	

Note. BF/GF = boyfriend/girlfriend; U.S. = United States; * = U.S. participants only.

and organization meetings. We provided an incentive of \$5.00 (coffee shop gift card), on the spot, to participants who completed the self-administered questionnaires.

In the Philippines and the United States, emails were sent to officers of clubs and organizations with the hyperlink to access the survey through Survey Monkey. The officers were encouraged to forward the email to prospective participants; this resulted in snowball sampling where emails were forwarded to friends, relatives, and co-workers. Re-

minder emails were sent 7 and 14 days after the initial email. Because there was no tracking mechanism to identify participants who completed the online survey, we did not provide incentives. Data collection occurred during August to November 2015.

Analysis

First, univariate, descriptive statistics were used to describe the sample characteristics. The DUREL has five questions with three subscales: subscale

Table 2. Association Between Religion, Religiosity, Parental Communication, and Sexual Behaviors

	USA		<i>p</i> -value	Philippines		<i>p</i> -value
	Non-Risky	Risky		Non-Risky	Risky	
	<i>N</i> (%)	<i>N</i> (%)		<i>N</i> (%)	<i>N</i> (%)	
	<i>M</i> ± <i>SD</i>	<i>M</i> ± <i>SD</i>		<i>M</i> ± <i>SD</i>	<i>M</i> ± <i>SD</i>	
Condom use During the Last Intercourse						
Religion			0.23			0.96
Atheist	1 (100%)	0 (0%)		5 (25%)	15 (75%)	
Catholic	31 (38.3%)	50 (61.7%)		36 (29.8%)	85 (70.3%)	
Christian/Protestant	7 (41.2%)	10 (58.8%)		13 (30.2%)	30 (69.8%)	
None	5 (71.4%)	2 (28.6%)		5 (26.3%)	14 (73.7%)	
DUREL Subscale 1	3.71 ± 1.35	3.8 ± 1	0.62	3.65 ± 1.51	3.61 ± 1.56	0.88
DUREL Subscale 2	3.17 ± 2.35	2.92 ± 1	0.58	3.17 ± 2.44	3.05 ± 2.42	0.79
DUREL Subscale 3	11 ± 2.59	10.32 ± 2.93	0.23	9.29 ± 3.48	9.5 ± 3.81	0.75
PTSRC-III	17.15 ± 7.51	14.89 ± 8	0.13	18.91 ± 9.67	15.44 ± 7.16	0.02
Consistency of Condom use in the Past 6 Months						
Religion			0.06			0.17
Atheist	0 (0%)	1 (100%)		3 (15%)	17 (85%)	
Catholic	20 (25%)	60 (75%)		37 (31.1%)	82 (68.9%)	
Christian/Protestant	6 (35.3%)	11 (64.7%)		6 (14.3%)	36 (85.7%)	
None	3 (42.9%)	4 (57.1%)		5 (26.3%)	14 (73.7%)	
DUREL Subscale 1	4.11 ± 1.29	3.62 ± 1	0.09	3.76 ± 1.43	3.57 ± 1.57	0.49
DUREL Subscale 2	3.14 ± 2.3	3 ± 1	0.78	3.1 ± 2.35	3.08 ± 2.45	0.96
DUREL Subscale 3	10.79 ± 2.82	10.5 ± 2.81	0.65	9.4 ± 3.39	9.46 ± 3.83	0.93
PTSRC-III	17.42 ± 8.12	15.28 ± 8	0.20	16.45 ± 7.89	16.46 ± 7.9	0.58
Alcohol or Illicit Drug use Before Intercourse						
Religion			0.83			0.02
Atheist	0 (0%)	1 (100%)		14 (70%)	6 (30%)	
Catholics	37 (45%)	45 (54.9%)		87 (72.5%)	33 (27.5%)	
Christian/Protestant	8 (47.1%)	9 (52.9%)		29 (67.4%)	14 (32.6%)	
None	3 (42.9%)	4 (57.1%)		7 (36.8%)	12 (63.2%)	
DUREL Subscale 1	4.06 ± 1.26	3.55 ± 1	0.05	3.76 ± 1.52	3.35 ± 1.56	0.11
DUREL Subscale 2	3.04 ± 2.35	3.13 ± 1	0.85	3.24 ± 2.49	2.76 ± 2.29	0.25
DUREL Subscale 3	10.87 ± 2.8	10.51 ± 2.89	0.53	9.61 ± 3.65	8.88 ± 3.89	0.06
PTSRC-III	17 ± 7.72	14.96 ± 8	0.17	16.16 ± 8.11	17.72 ± 8.34	0.32
Multiple Sex Partners						
Religion			0.19			< 0.01
Atheist	0 (0%)	1 (100%)		8 (40%)	12 (60%)	
Catholic	37 (45.1%)	45 (54.9%)		84 (71.2%)	34 (28.8%)	
Christian/Protestant	12 (70.6%)	5 (29.4%)		19 (44.2%)	24 (55.8%)	
None	5 (55.6%)	4 (44.4%)		8 (42.1%)	11 (57.9%)	
DUREL Subscale 1	3.93 ± 1.29	3.59 ± 1	0.19	3.89 ± 1.47	3.19 ± 1.56	0.01
DUREL Subscale 2	3.24 ± 2.37	2.84 ± 1	0.37	3.3 ± 2.5	2.71 ± 2.26	0.13
DUREL Subscale 3	10.57 ± 2.88	10.55 ± 3.02	0.97	9.75 ± 3.74	8.75 ± 3.69	0.1
PTSRC-III	15.2 ± 6.86	16.55 ± 8	0.35	16.77 ± 8.12	16.26 ± 8.39	0.73
Casual Sex/One-Night Stand						
Religion			0.55			0.02
Atheist	1 (100%)	0 (0%)		9 (45%)	11 (55%)	
Catholic	45 (56.3%)	35 (43.8%)		78 (64.5%)	43 (35.5%)	
Christian/Protestant	12 (70.6%)	5 (29.4%)		21 (48.8%)	22 (51.2%)	
None	6 (66.7%)	3 (33.3%)		6 (31.6%)	13 (68.4%)	
DUREL Subscale 1	3.9 ± 1.34	3.54 ± 1	0.17	3.91 ± 1.43	3.23 ± 1.6	0.01
DUREL Subscale 2	3.17 ± 2.3	2.93 ± 1	0.60	3.12 ± 2.49	3.03 ± 2.35	0.82
DUREL Subscale 3	10.36 ± 3.14	10.68 ± 2.64	0.60	9.96 ± 3.62	8.55 ± 3.73	0.02
PTSRC-III	15.52 ± 7.35	16.36 ± 8	0.58	16.6 ± 8	16.51 ± 8.46	0.95

Note. DUREL = Duke University Religion Index; PTRSC-III = Parent-Teen Risk Sexual Communication III scale; Risky = report of lack of condom use, inconsistent condom use in the past six months, use of alcohol or illicit drugs during the last intercourse, report of having had multiple partners, and report of having had casual sex or a one night-stand; Subscale 1= organizational religiosity; Subscale 2 = non-organizational religiosity; Subscale 3 = intrinsic religiosity.

1 has one question that measures organizational religious activity, subscale 2 has one question that measures non-organizational religious activity, and subscale 3 has three questions that measure intrinsic religiosity. As recommended by its authors, each subscale was analyzed separately; a single analysis has the potential to result in subscale scores canceling out the effects of each other (Koenig & Büssing, 2010).

Bivariate analysis using Chi-square was conducted to examine the relationship of religion. We used *t*-tests to examine the relationship of the DUREL subscales 1, 2, and 3; and PTSRC-III variables to condom use, consistency of condom use in the past six months, alcohol or illicit drug use before intercourse, having multiple sex partners, and casual sex or a one-night stand. The data from the United States and the Philippines were separated and analyzed individually. We used SPSS, version 22.0 and Statistical Analysis System version 9.4 for Windows for statistical analysis.

Results

There were 377 respondents, 130 were from the United States and 247 were from the Philippines. Among the United States respondents, 75.4% were born in the United States although only 7% of United States respondents' parents were born in the United States. The demographics of participants in both countries were comparable regarding education, employment status, and relationship status. There was only one respondent who reported religion as Muslim. This response was removed from the analysis because the number was too small to yield accurate and meaningful results. Most respondents were college educated and enrolled in school, and were either single without boyfriend/girlfriend or currently in a relationship. While over half of the respondents were in the middle-income category, 31.1% of the respondents from the Philippines had a low income compared to 18.2% from the United States. Table 1 summarizes the characteristics of the study population.

Religion, Religiosity, Parental Communication, and Sexual Behaviors

To examine the relationship between religion, religiosity, parental communication, and sexual behaviors (risky vs. non-risky), we individually examined five types of sexual behaviors (Table 2). First, regarding condom use during the last sexual intercourse, respondents from the Philippines with this risky behavior had signifi-

cantly lower PTSRC-III scores than those without this particular risky behavior (risky: $M = 18.91$, $SD \pm 9.67$; non-risky: $M = 15.44$, $SD \pm 7.15$, $p = .02$). No other differences were detected for this behavior. Also, no significant findings were associated with consistency of condom use in the past six months.

Second, regarding the use of alcohol/illicit drug use before intercourse, United States participants with this risky behavior had lower DUREL subscale 1 scores than their counterpart (risky: $M = 3.55$, $SD \pm 1$; non-risky: $M = 4.06$, $SD \pm 1.26$, $p = .05$). Among respondents from the Philippines, Catholics were less likely to engage in alcohol or use of illicit drug before intercourse as compared to participants who reported as no religion, atheists, or Christians/Protestants ($p = .02$). No other differences were detected for this behavior.

Third, regarding having multiple sex partners, among respondents from the Philippines, Catholics had a decreased likelihood of engaging in this risky behavior compared to participants who reported as no religion, atheists, and Christians/Protestants ($p < .01$). Additionally, participants from the Philippines who engaged in this risky behavior had a lower DUREL subscale 1 score (risky: $M = 3.19$, $SD \pm 1.56$; non-risky: $M = 3.89$, $SD \pm 1.47$, $p = .01$). No other differences were detected for this behavior.

Last, regarding having ever had casual sex or a one-night stand, among respondents from the Philippines, Catholics had fewer reports of a one-night stand compared to participants who reported as no religion, atheists, or Christians/Protestants ($p = .02$). Additionally, respondents from the Philippines with this risky behavior had lower DUREL subscale 1 scores (risky: $M = 3.23$, $SD \pm 1.6$; non-risky: $M = 3.91$, $SD \pm 1.43$, $p = .01$) and lower DUREL subscale 3 scores (risky: $M = 8.55$, $SD \pm 3.73$; non-risky: $M = 9.96$, $SD \pm 3.62$, $p = .02$). No other differences were detected for this behavior.

Discussion and Implications

This study investigated the relationship of religion, religiosity, and parental communication to the sexual behaviors of Filipinos living in the United States and the Philippines. The findings of this study are consistent with previous studies and suggest an association between risky sex behaviors and religion, religiosity, and parental communication (Delgado-Infante & Ofreño, 2014; Freedman-Doan et al., 2013; Gipson et al., 2012; Haglund & Fehring, 2009; Hutchinson, 2007; Landor, et al., 2011). The associations found in this study are statistically

stronger among respondents from the Philippines than those from the United States.

There was only one significant association found among United States respondents, those who engaged in alcohol or illicit drug use before intercourse had reports of low attendance and involvement with the church. Previous studies support the finding that attendance to religious services not only leads to increased adherence to religious teachings of avoiding risky sex behaviors but also exposes them to social support from peers who have similar practices and beliefs. The group norms, such as religious teachings that support rejection of risky behaviors, influence the individual to do the same (Haglund & Fehring, 2009; Landor et al., 2011).

Unlike the Philippines, the influences of Catholicism in the United States were limited in personal, familial, and church levels (Nadal, 2009). Further, the majority of the U.S. respondents were second-generation immigrants. It is likely that acculturation patterns have led them to accept and adapt the more liberal views of sex in the United States. The acculturation process not only changes familial structure, gender roles, and peer group selection, it also leads to economic advancement, lifestyle changes, and risky behaviors (Agbayani-Siewert, 2004; Serafica, 2011; Shim & Schwartz, 2007).

Studies have linked the relationship between acculturation and sexual behaviors. So et al., (2005) found an association between high rates of acculturation and increased alcohol use that led to risky sexual behaviors in Asian Americans. Tong (2013) also examined the influences of acculturation in sexual behaviors among Asian Pacific Islander adolescents. The results suggested that high acculturation increases the likelihood of early sexual intercourse and number of sexual partners. Both studies had a small number of Filipino Americans in the sample, but Filipino Americans' data were not analyzed separately.

Known protective factors of children's safe sex behaviors include parental sex communication, open sex discussions before initiation of sex, explicit parental disapproval of sexual practices, and parental monitoring (Foster et al., 2011; Hutchinson, 2007; Trinh et al., 2014). We found an association between high levels of parental communication and an increased use of condoms among respondents from the Philippines. However, parental communication was not found to be associated with any other sexual behaviors and was not a significant factor among U.S. respondents.

Among Filipinos, family is the most important social group, and children are expected to obey parental authority (Alampay & Jocson, 2011; Nadal, 2009). The association of parental sex communication to reports of condom use may very well be related to parents' conservative teachings that pregnancy outside of marriage is shameful and a disgrace to the entire family. Filipino daughters are expected to follow the "ideal" female virtues, including maintaining virginity until after marriage (Alampay & Jocson, 2011; Chen et al., 2010; Nadal, 2009). In the Philippines, unmarried couples, in general, use condoms for contraception rather than disease prevention (Luca, Hindin, Gultiano, Kub, & Rose, 2013). Unmarried couples often hide sexual relationships from their parents (Luca et al., 2013).

The parent-teen sex communication was low among respondents, an expected finding among Filipinos in the United States and in the Philippines whose cultural and religious norms prevent open parent-child sex communication. In general, Filipino values view sex as a private matter. As a result, parents do not openly speak about many aspects of sex (Chung et al., 2005; de Irala et al., 2009; Nadal, 2009).

Limitations and Recommendations for Future Research

Although this is one of the few studies to investigate the sexual behaviors of Filipinos, limitations exist. The first limitation was the nature of self-report in survey research. The accuracy and honesty of answers are always a concern in self-reported surveys especially with sensitive topics such as sex. The second limitation was the demographics of the participants. This was limited to those educated young adults living in urban settings; therefore, the generalizability of the findings is limited. The third limitation is the sexual behavior questionnaires. The sexual behavior questionnaires were developed using sources from the United States; there may be an additional description of risky sexual behaviors in the Philippines that we did not capture.

Parental influence in this study was limited to parental-teen sex communication described by teenagers. The inclusion of parental monitoring, parental discipline, and disapproval of premarital sex could provide a comprehensive approach to determining parental influence in a child's sexual behaviors (Chen et al., 2010; Levine, 2011). Health promotion interventions should focus on parental training to promote ongoing open conversations about sexuality and

the parental role in educating their children regarding sex. Finally, we did not evaluate acculturation in the survey. Ahrold and Meston (2010) discussed two layers of acculturation that minority groups need to incorporate: their heritage culture and the mainstream culture. Future research should focus on determining to what degree Filipino Americans retain heritage culture of conservative values and religious traditions while adapting the mainstream liberal views regarding sex. There is also a need to investigate parental acculturation and its impact on parents' transfer of traditional values and beliefs to their children.

Conclusions

The results of this study suggest that there is a need for culturally appropriate safe sex health promotion programs that integrate familial and religious factors. Filipinos have unique values and beliefs that affect their health and health care decisions, one of the largest ethnic minorities and foreign-born immigrant groups in the United States. It is critical that health promotion and intervention activities are tailored to address the needs of this group.

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