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Original article

Barriers to the implementation of sexual and reproductive health programs for adolescents in Eastern Visayas, Philippines: a thematic synthesis of national policies using a qualitative study

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Abstract

Objective: To review the implementation of essential reproductive health services in Eastern Visayas, Philippines.
Materials and Methods: We reviewed four national policies through a qualitative research design using a series of key informant interviews conducted with service providers and focus group discussions with service beneficiaries.
Results: There was a gap between the policies and the implementation of reproductive health services in the Eastern Visayas region. This gap is mainly due to the refusal of service providers to cater to teenagers' needs regarding reproductive health services. This has resulted in teenagers hesitating to seek reproductive health services and related support from primary healthcare facilities. Service beneficiaries have also reported on the unavailability of several reproductive health services in primary healthcare facilities.
Conclusion: The gap between national policies and program implementation must be bridged. This can be achieved by creating culturally-specific policies that can improve the implementation of reproductive health programs in the study areas.

Key words: reproductive health, teenage pregnancy, maternal and child health

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Introduction

Pregnancy in young women, also known as "teenage pregnancy", is a global issue that poses a significant threat to the health and welfare of the population[1)]. Teenage pregnancy is often a consequence of health and education inequality between young parents and their children[2)]. Pregnancy during adolescence poses significant challenges to the affected teenagers, including economic and social status deterioration, partner abandonment, school dropout, and threats of adverse pregnancy outcomes[3–5)].

Annually, an estimated 21 million women between ages of 15–19 years become pregnant in developing regions worldwide[6)]. In the Asia-Pacific region, almost four million teenagers aged 15–19 years were recorded to have given birth in 2019, with India, Bangladesh, Indonesia, Pakistan, China, and the Philippines accounting for over 75% of all such adolescent births[7)]. In the Philippines, preliminary findings of the latest Young Adult Fertility and Sexuality study revealed that the prevalence of adolescent pregnancy declined by half, from 2013 (14%) to 2021 (7%); the Commission on Population and Development attributed the reduction to the improved use of contraceptives and the CO-

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VID-19 pandemic, with the latter having restricted young people from interacting with peers and partners[8].

Despite significant progress in lowering national adolescent pregnancy in the country, more than half of the regions in the Philippines reported numbers higher than the national average[9]. Eastern Visayas, located in east-central Philippines also saw declining teenage pregnancy rates, from 2017 (6.9%) to 2022 (4.9%)[10]. However, this number remains high, according to the Commission on Population and Development Eastern Visayas[11]. In fact, this high prevalence of teenage pregnancy in the region prompted stakeholders, such as the national government, international agencies, and civil society organizations (CSOs), to launch programs aimed at reducing cases[11–13]. Several measures have also been implemented at the national level to address teenage pregnancy. Along with the national policies, the "National Standards for Adolescent Friendly Health Services" renders all government levels in the Philippines responsible for ensuring that adolescents and youth receive the highest attainable standard of health and access to quality health services[14]. Generally, the country does not lack laws, policies, and programs that empower and protect women, but political disagreements, strong religious involvement in reproductive health (RH) legislation, and the Filipinos' ambivalence toward sex and RH negatively affect the implementation of RH programs targeting teenagers[15].

Although teenage pregnancy remains a public health concern in Southeast Asia, healthcare service utilization in the region has been poorly studied[16, 17], and there is a dearth of extensive investigations reviewing the existing policies and legislations regarding healthcare service utilization for teenage pregnancy. Teenage pregnancy has also been amplified by several barriers that teenagers experience in access to healthcare services, including the inaccessibility and unavailability of healthcare facilities, gender relations, sociocultural traditions, and inadequate infrastructure in the healthcare sector[18]. Hence, the present study aimed to review and analyze the existing RH policies focused on teenage pregnancy in Eastern Visayas. The qualitative data was extracted through the key informant interviews and focus group discussions conducted in selected provinces of the region of interest.

Materials and Methods

Research design

A review of four RH-related policies in the Philippines was conducted, focusing on the implementation of RH programs in Eastern Visayas; the final goal was determining the different barriers to RH program implementation that, in turn, have been leading to the consistently high teenage pregnancy rates in the region in recent years. The four policies of interest in this study were the Republic Act (RA) 10354 (Responsible Parenthood and Reproductive Health Act of 2012), Department of Health (DOH) Administrative Order (AO) 2013-0013 (National Policy and Strategic Framework on Adolescent Health and Development), RA 11148 (Kalusugan at Nutrisyon ng Mag-Nanay Act), and Executive Order (EO) 141 series of 2021 (Adopting as a National Priority the Implementation of Measures to Address the Root Causes of the Rising Number of Teenage Pregnancies, and Mobilizing Government Agencies for the Purpose). The selection of these policies was based on the judgment of invested stakeholders that deemed them the most appropriate for the study.

To secure an in-depth investigation as to the current RH policy implementation in the region, qualitative data were collected using a series of key informant interviews and focus group discussions based on a semi-structured interview methodology.

Participants

Respondents were selected through a stakeholder-mapping exercise followed by snowball sampling. To secure participant representativeness and diversity, maximum sampling variation was used to recruit key informants and focus group discussants across four provinces in Eastern Visayas.

Key informant interviews

For key informants, interviews focused on their area of work, engagement with policies, and to what extent their work addressed issues of women or adolescents, including teenage pregnancies. Interviews were conducted by one or two researchers, either through meetings in convenient public settings, telephone, or a videoconferencing app. Although respondents are not identified in this review, where the interview text is used verbatim, it is presented with inverted commas and italics. Every province was represented by one key informant from the education sector, one key informant from the healthcare sector at the regional, provincial, and municipal levels, and one key informant from the service sector at the barangay and/or municipal level. The inclusion criteria for key informants were serving the respective institution/municipality/province and providing basic services related to adolescents and RH for at least a year.

Focus group discussions

For discussants, the study sampled representatives from potential direct beneficiaries of healthcare services at the barangay level. Four focus group discussions were conducted in each province until achieving data saturation. Five or six participants were recruited for each group, and the groups comprised teenage girls without children (age 13–19 years), teenage boys (age 13–19 years), teenage mothers (age 13–19 years), and parents of teenage mothers. The inclusion crite-

ria were residing in the study area for at least a year and be willing to participate in the focus group discussion.

Sampling technique and sample size

Due to the exploratory nature of the research, purposive sampling incorporating maximum variation and intensity qualitative sampling was used. This sampling technique intentionally select participants based on specific criteria or characteristics. The goal was to ensure that the sample represents different groups within the population of interest[19]. Furthermore, maximum variation sampling use in qualitative studies serves to capture a wide range of perspectives or experiences within a given population. Instead of focusing on homogeneity, we intentionally selected participants diverse in terms of relevant characteristics[20]. These approaches have been used to explore specific characteristics or variations within large populations, and helped secure a more comprehensive understanding of the phenomenon of interest.

For key informant interviews, data saturation occurred during the fifteenth interview. For discussants, four focus group discussions were conducted with teenage mothers and boys, while three discussions were conducted with teenage girls and the parents of teenage mothers across four provinces. Data collection stopped after reaching data saturation and theme generation was made possible.

Study setting

This study was conducted in low-resource settings in the provinces of Northern Samar, Eastern Samar, Samar, and Leyte in the Philippines to provide an in-depth review of the selected national RH policies concerning teenage pregnancy. Located in the east-central part of the Philippines, the Eastern Visayas region is among the poorest and most typhoon-prone areas in the country[21, 22]. According to the 2022 National Demographic and Health Survey, the region recorded declining teenage pregnancy rates but the rate is still considered high and warrants further reduction and a review of the implementation of the existing teenage pregnancy-related policies in the region. The selection of the study setting was based on an increased emphasis on teenage pregnancies in Eastern Visayas while considering the vulnerabilities of the locality to natural disasters and economic disadvantages.

Research instrument

A validated open-ended questionnaire was used as a guideline for data collectors in conducting the focus group discussions and key informant interviews. The questionnaire was validated by experts in the fields of adolescent health and behavior, fertility, and family development. The questions focused on different topics pertaining to the RH policies and programs in the study region, including barriers to implementation and issues related to teenage pregnancy. The guide was made available in English and in the native tongue of the respondents.

Data analysis

The collected data were transcribed and translated into English after several validations, back-translation of language, and editing to ensure the consistency and coherence of the qualitative information. Thematic analysis was used to identify patterns of meaning across the dataset that answered the study question. Colaizzi's method was used to create themes and patterns from the insights provided by the study participants[23]. An extensive process of data familiarization, coding, and theme creation enabled the researchers to generate the themes and patterns.

After thematic analysis, the patterns were arranged according to the salient provisions of the policies reviewed. The created themes mainly focused on the availability and accessibility of RH services in primary healthcare facilities, the roles of government and non-governmental organizations in RH program implementation, and the gaps in RH policy and program implementation in the study area.

Results

Availability of reproductive health services in primary healthcare facilities

Table 1 summarizes the salient provisions of the four national policies according to the themes created from the narratives of the key informants and focus group discussants. Two national policies, RA 10354 and RA 11148, stipulate that public health facilities should provide the necessary services appropriate to the needs of every sector of the population. These services include providing information on responsible parenthood and RH care to all clients. These policies also mandate national government agencies and partners to establish information and service delivery networks, facilities, and programs that cater to adolescents' needs. Moreover, protection for women and their children is stipulated in RA 11148 to ensure the welfare of this population.

Meanwhile, the DOH AO 2013-0013 stipulates the need to capacitate the youth to engage in policymaking related to adolescents' health. This mandate also recognizes the need to provide age-appropriate competencies for different life skills. In relation to this, EO 141 s. 2021 states that the Sangguniang Kabataan (village youth council) should provide interventions that can address adolescent pregnancies and should reflect in their plan for local youth development and annual investment. These interventions should include education on healthy sexuality among adolescents and other youth-friendly and rights-based services. This directive also promotes assistance for teenage pregnant women to contin-

Table 1 Salient provisions of the four national policies based on the created themes from the key informants and focus group discussants

Themes	RA 10354	DOH AO 2013-0013	RA 11148	EO 141 s. 2021
Availability of RH services in PHC facilities	All public health facilities shall provide full, age-and development-appropriate information on responsible parenthood and RH care to all clients, regardless of age, sex, disability, marital status, or background (Section 4.03).	Adolescents (10 to 19 years old), the primary target of AHD program, shall be provided with resources and interventions to prevent early pregnancies (Section VI.2). To promote equity and inclusion, specific AHD program strategies for marginalized and vulnerable groups shall be established (Section VI.5).	Counseling and support for early childhood development shall be rendered to parents and caregivers (Rule 8. Section 2.k). Protection against child abuse, violence against women and children, injuries, and accidents shall be in place (Rule 8. Section 2.m).	The Sangguniang Kabataan is encouraged to identify and implement localized programs addressing teenage pregnancies and promoting ASRH (Section 3).
Accessibility of RH services in PHC Facilities	Any minor who consults at healthcare facilities shall be given age-appropriate counseling on responsible parenthood and RH. Healthcare facilities shall dispense products and perform procedures for family planning (Section 4.07).	Improving access to quality and adolescent-friendly healthcare services and information for adolescents (Section VI.6b). Guided by the UNCRC, AHD program shall provide adolescents with access to information and life-saving interventions (Section VII.3).	Counseling on, and utilization of, modern methods of family planning and access to RH care services shall be rendered (Rule 8. Section 2.q).	Initiatives for adolescent pregnancy prevention shall be included in the country's annual national budget (Section 6). The funding to implement this Order shall be sourced from the concerned agencies' budget for GAD (Section 8).
Role of government agencies in the implementation of RH services among adolescents	Local healthcare systems shall carry out measures to reduce the unmet need and/or gaps for RH care (Section 4.10). DOH and LGUs shall conduct nationwide multimedia awareness campaigns on responsible parenthood and RH (Section 10.01). Public schools shall provide young people a supportive environment to tackle teenage problems (Section 11.03). LGUs shall ensure that all skilled healthcare professionals have appropriate training to provide the full range of RH services (Section 12.02).	DOH-attached agencies shall lead planning, management, monitoring, and evaluation shall be the responsibility (Section IX.1). Education agencies, with DOH, DSWD, CPD, and NAPC, shall create RH and sex education curriculum (Section IX.3). CHR shall uphold adolescents' rights (Section IX.6). PSA shall provide age-disaggregated data for monitoring and evaluation (Section IX.7). PhilHealth should cover teens, especially those from the marginalized sector (Section IX.8). The academia, youth groups, and other CSOs are expected to participate with RH programs (Section IX.9). The provision of RH programs shall be the joint responsibility of the national and local governments (Section IX.12)	Integrating maternal and child health and nutrition programs in LNAPs and investment plans for health are LGU's responsibility (Section 7). To ensure the delivery of health and nutrition services and interventions, different stakeholders, such as government agencies and CSOs, shall collaborate (Section 8). To upgrade the competence of BNSs and BHWs for the implementation of health and nutrition programs for women and children, training courses shall be provided by DOH, NNC, and LGU (Section 12).	Mobilize mechanisms related to the prevention of teenage pregnancy and ensure adolescents' access to CSE and RH services (Section 1). The government shall identify and implement interventions to prevent teenage pregnancies (Section 2). CPD shall continue to educate community members on strategies to reduce teenage pregnancy and improve adolescent RH. CPD shall submit an action plan on adolescent pregnancy prevention (Section 5).
Role of the private sector and CSOs in the implementation of RH programs	CSOs and the private sector are encouraged to participate in the promotion and communication of responsible parenthood and reproductive health and rights (Section 10.07).	NGOs shall implement programs and services, assist in policy formulation, contribute to research, and generate resources for AHD (Section IX.10).	To ensure the delivery of health and nutrition services and interventions, different stakeholders, such as government agencies and CSOs, shall collaborate (Section 8).	

AHD: adolescent health and development; AO: Administrative Order; ASRH: Adolescent Sexual & Reproductive Health; CHR: Commission in Human Rights; CPD: Commission on Population and Development; CSE: comprehensive sexuality education; CSO: civil society organization; DOH: Department of Health; DSWD: Department of Social Welfare and Development; EO: Executive Order; GAD: gender and development; LGU: local government unit; LNAP: local nutrition action plan; NAPC: National Anti-Poverty Commission; NGO: non-governmental organization; NNC: National Nutrition Council; PHC: public health care; PhilHealth: Philippine Health Insurance Corporation; PSA: Philippine Statistics Authority; RA: Republic Act; RH: reproductive health; s.: series; UNCRC: United Nations Convention on the Rights of the Child.

ue their education through targeted outreach support programs. The details are presented in Table 1.

Service providers (key informants) indicated that while basic (RH) services are available at their centers, there are typically few teenagers seeking consultations. This lack of utilization may be attributed to adolescent embarrassment and hesitation. However, it is important to consider other potential factors influencing this lack of use, such as the possibility that some teenagers who need assistance, particularly those experiencing abuse that may lead to early pregnancy, may not feel safe or comfortable seeking help at these centers. Moreover, some participants shared their grievances about the insufficiency of contraceptives and the capacity of facilities to handle the needs of adolescents seeking RH services.

Service beneficiaries (focus group discussants) reported experiencing difficulties accessing RH services at primary healthcare facilities. These difficulties included encountering negative attitudes from healthcare providers, denial of specific RH products and services, and a general lack of service availability. The discussants specifically mentioned being reprimanded by service providers for seeking the services at such a young age. Additionally, dissatisfaction was expressed regarding the unavailability of certain RH products, such as oral contraceptive pills, condoms, and intrauterine devices.

Accessibility of reproductive health services in public healthcare facilities

The RA 10354 mandates health systems in all local government units (LGU) to provide interventions that can reduce gaps in RH care. It is also mandatory to ensure that essential RH services have high-impact strategies and accessible management approaches. As cited in the National Objectives for Health, the RA 10354 states that modern contraceptives should be accessible to all including adolescents and sexually-active unmarried women with an unmet need for family planning, and should not cater only to married women.

In support of the latter, the AO 2013-0013 directs LGUs to improve access to high-quality and adolescent-friendly healthcare services and information. It is also stipulated that adolescent access to information and all essential RH services is to be insured.

The RA 11148 supports the AO 2013-0013, ordering the provision of accessible counseling and modern RH methods for all adolescents. To support the aforementioned policies, EO 141 s 2021 stipulates that the state should provide adequate funds to make services accessible by ensuring that the National Expenditure Program includes funds for the prevention of teenage pregnancies in the annual budget priority framework. The details are presented in Table 1.

To support the initiatives of the government to make the programs accessible, service providers (key informants) expressed their eagerness to improve their facilities to be adolescent-friendly and acknowledged the problematic teenage pregnancy in the study areas They also expressed that they wanted to support teenage parents who wanted to go back to study, and offered them help in availing themselves of the services necessary for them as young parents, but the lack of support and funding that informants faced hindered this process. They also stated that they should be provided with proper training and assistance for conducting related works.

This has resulted in the inaccessibility and insufficiency of RH products, services, and facilities for teenagers. Service providers (key informants) shared that they lacked resources to guide them in understanding and interpreting the national policies concerning teenage pregnancy and other RH issues among youth resulting in less accessible interventions. Informants also shared their hesitation to promote the use of modern contraceptive methods among adolescents because they believed that this would promote and normalize early sexual activity among teenagers. To support their claims, they cited the provision of RA 10354 stating that consent was needed before providing essential RH services to teenagers. The details are presented in Table 2.

In relation to the responses of key informants (service providers), discussants (service beneficiaries) expressed their dissatisfaction with the unavailability of RH care services for adolescents. This dissatisfaction stemmed from the negative attitudes of healthcare workers toward providing essential RH services when teenagers attempted to avail of family planning. Alarmingly, some discussants claimed being unaware of the existence of programs and services addressing teenage pregnancy. The details are listed in Table 2.

Role of government agencies in the implementation of reproductive health programs for adolescents

The RA 10354 and AO 2013-0013 include the mandate for all governmental organizations to implement different RH programs. These two national policies stipulate the role of the DOH and LGUs in spearheading RH activities. The AO 2013-0013 also provides special provisions on the roles of other government agencies in the country. These policies also require the continuous provision of training for healthcare workers to ensure that they are adequately capable of performing their tasks. The details are presented in Table 1.

In addition, the RA 11148 suggests that maternal and child health programs should be reflected in the local nutritional actions and investment plans of all LGUs. This includes the provision of integrated maternal counseling and support regarding early childhood development for parents and caregivers. The law also provides protection against child abuse and violence against women and children. To

Table 2 Insights from the key informants and focus group discussants arranged according to their respective narratives

Policy	Insights from KII and FGD	Narratives
Availability of RH services in PHC facilities	Key informants shared that no teenager has ever requested information on RH from their facility, citing reasons of embarrassment and hesitation. Focus group discussants said that they had difficulties in availing services in PHC facilities due to negative attitudes by some healthcare providers, denial of RH products and services, and the lack of services in general.	*"No, they don't really ask us. Ever since I was assigned here it seems like I have not encountered teenagers asking things regarding reproductive health because they are embarrassed. The adolescents are hesitant to approach or open-up to us."* [ID 8, Female, 27 years in the health sector] *"There is a lack of information about sexual activities that is why this becomes a problem."* [ID 9, 12 years old, teenage boy] *"Our parents do guide and teach us, but sometimes they are busy or not around. It is difficult to look for someone who will guide and teach us without giving angry comments."* [ID 5, 17 years old, teenage mother] *"The government says that there are services available, but at times, these are not what we really need."* [ID 38, 51 years old, mother of a teenage parent] *"I don't think there are enough services for teenage couples. The barangay, the health center, the school, and the church did not offer any kind of help."* [ID 50, 15 years old, teenage boy] *"When we ask for information about family planning or prenatal services, they get angry and tell us to just wait or settle with what is available."* [ID 1, 17 years old, teenage mother] *"I know someone who is a rape victim and asked for abortion because she did not want it. People at the health center told her that it should not be the mindset."* [ID 13, 17 years old, teenage mother]
	A focus group discussant shared her concern over the unavailability of services intended for the early development of the children of teenage mothers. RA 11148 states that new mothers must be given support and counseling sessions on early childhood development.	*"There are services not available for teenage mothers like a daycare center where our child will be taken care of while we are studying, or support for rape victims who get pregnant."* [ID 13, 17 years old, teenage mother]
	The key informants shared several cases of abuse and violence that involved their teenage partners. RA 11148 states that women and their children should be protected against abuse and violence, and be provided with first aid, counseling, and proper referrals.	*"The teenage couple tend to quarrel frequently and leading to physical abuse at times, the female would live temporarily with her mother and would later be wooed by the partner to live together again later."* [ID 3, Female, 5 years in the health sector] *"Teenage mothers might become victims of violence."* [ID 7, Female, 4 years in the health & education sector] *"There was a case of a teenager who was pregnant and was locked up and beaten by her partner - but no complaint was done since the process takes a long time - and they do not have a choice but settle for him."* [ID 1, Female, 1 year as health sector supervisor] *"In one of our severe domestic abuse cases, the boy was able to flee. Since there is a complex process in court, he cannot be arrested immediately."* [ID 2, Female, 34 years in the health sector] *"When we have cases like VAWC, that is not under our responsibility. The Rural Health Unit might manage it but still then there are only specific personnel in charge, you cannot meddle with things beyond your responsibility."* [ID 12, Female, 21 years in the health sector]
	The key informants shared their grievances about the insufficiency of RH products, services, and facilities available. Focus group discussants also expressed their dissatisfaction on the unavailability of RH care services for adolescents. The RA 10354 states that all levels of the health system should address the gaps in the delivery of RH care	*"There is a need for a separate room, not like here where there is no privacy, these teenagers will not approach us since they are embarrassed and not confident, so they will not really open-up."* [ID 8, Female, 27 years in the health sector] *"The Local Health Unit does not withhold [contraceptives] because they don't like to give out among adolescents but because we do not have supplies."* [ID 12, Female, 21 years in the health sector] *"There is no [sufficient] support like that coming to us. Maybe the government has a budget for it [adolescent targeted programs] but maybe not just reach the local units."* [ID 12, Female, 21 years in the health sector] *"Maybe that problem [teenage pregnancy] is being overlooked because of a really big problem already [COVID-19 pandemic]."* [ID 9, Female, 22 years in the health sector] *"It is important for those people in position to hear the things we need and suggest improvements to understand the struggles that come with teenage pregnancy."* [ID 38, 51 years old, mother of a teenage parent] *"I don't think there are enough services for teenage couples. The barangay, the health center, the school, and the church did not offer any kind of help."* [ID 50, 15 years old, teenage boy]

Table 2 Continud

Policy	Insights from KII and FGD	Narratives
Accessibility of RH services in PHC Facilities	Most of the key informants opposed the idea of providing family planning products and services to teenagers. Focus group discussants shared that healthcare workers showed negative attitudes when teenagers attempted to avail of family planning products and services.	*"We only give contraceptives to married couples, we don't give it to those who have no partners."* [ID 2, Female, 34 years in the health sector] *"If we give them education about use of condoms, we are encouraging them to do the act. It should be limited to married couples only."* [ID 14, Male, 19 years as church pastor] *"They will be more complacent and will not be careful anymore in avoiding sexual intercourse because of the contraceptives."* [ID 7, Female, 4 years in the education sector] *"There were situations when the doctors refused to give family planning advice on teenage parents. The nurses were even judgmental in tone and attitude to them."* [ID 21, 52 years old, mother of a teenage parent] *"I know someone who is 20 years old and asked for condoms in the health center, but he was scolded since he is not yet married but asking for these things."* [ID 9, 12 years old, teenage boy]
	The key informants expressed their eagerness to improve their facilities towards being adolescent-friendly, but the lack of support and funding hinders it. A national policy states that improvements in adolescent-friendly healthcare facilities should be made.	*"We are trying to reach a Level 1 Adolescent Friendly facility however we [local health unit personnel] are still lacking training. It is only when we reach it [Level 1] where you will see concrete support and funding for programs targeting adolescents."* [ID 12, Female, 21 years in the health sector]
	The focus group discussants shared their negative experiences when they attempted to avail of family planning services. A key informant said teenagers find it difficult to access RH services due to a national policy. Women should gain access to family planning and other RH care services, in consideration with the regulations set by RA 10354.	*"When we ask for information about family planning or prenatal services, they get angry and tell us to just wait or settle with what is available."* [ID 1, 17 years old, teenage mother] *"There were situations when the doctors refused to give family planning advice on teenage parents."* [ID 21, 52 years old, mother of a teenage parent] *"If you're not yet of legal age, there must be consent from your parents or guardian. The said policy is a hindrance in the family planning program for our teenagers because even if they want to use it, they still need to ask for their mother's or their guardian's signature and sometimes they refuse to consent."* [ID 8, Female, 27 years in the health sector]
Role of government agencies in the implementation of RH services among adolescents	The key informants shared that they lacked resources that will guide them in understanding and interpreting national policies on teenage pregnancy and other RH issues among the youth. The focus group discussants claimed that they are not aware of existing programs and services dedicated to tackle teenage pregnancy. The RA 10354 mandates the DOH and LGUs to be responsible for the public dissemination of information regarding RH.	*"We do not have defined policies, we deal with whatever [notice] comes in whatever form, and whatever way we can interpret it [the national policy] (laughs with researcher)."* [ID 12, Female, 21 years in the health sector] *"In schools, there is no written policy on how to handle [absences or tardiness] among students who are teenage pregnancy cases, we just handle it in our own ways but there is no rule so far."* [ID 4, Female, 13 years in the education sector] *"Training or learning activities are needed for teenagers to become involved and understand the impact and how to avoid teenage pregnancy."* [ID 11, Female, 4 years in the education sector] *"There are no announcements for services made for teenage pregnancy or I am just not familiar or have heard of anything."* [ID 18, 45 years old, mother of a teenage parent]
	The key informants expressed their support to teenage parents who wanted to go back to studying and offered them help in availing services necessary for them as young parents. This is conforming to RA 10354 which states that educational facilities should be an encouraging and nurturing place for the youth while providing them with appropriate services.	*"Pregnant students must be allowed to continue with the modular because they will really get shy to go to school."* [ID 11, Female, 4 years in the education sector] *"They are encouraged to continue with their studies because if they stop studying and not finish schooling, what job will they do to address the needs of their kids in the future."* [ID 8, Female, 27 years in the health sector] *"While they are still pregnant, I always monitor and advise them to go to their prenatal visits. After birth, I regularly ask about the health and well-being of their children."* [ID 7, Female, 4 years in the health & education sector]

Table 2 Continud

Policy	Insights from KII and FGD	Narratives
	The key informants suggested that as healthcare workers, they should be provided with proper training and assistance in maintaining their professional licenses active. The RA 10354 mandates that LGUs should guarantee that appropriate training is provided for healthcare professionals designated in PHC facilities that offer RH services.	*"It is only when we reach it [Level 1] where you will see concrete support and funding for programs targeting adolescents.*" [ID 12, Female, 21 years in the health sector] *"We really need training on adolescent targeted programs."* [ID 5, Male, 3 years in the health sector as supervisor] *"We are having difficulty giving access to birthing services since our license to practice was not renewed."* [ID 2, Female, 34 years in the health sector]
	The key informants shared that healthcare services rendered to teenage parents are very limited. The AO 2013-0013 directs LGUs, in coordination with the national government, to have the full responsibility in ensuring the delivery of adolescent RH care services and programs. The EO 141 s. 2021 also orders the local youth council to identify and implement localized programs addressing teenage pregnancies and promoting ASRH.	*"It is important for those people in position to hear the things we need and suggest improvements to understand the struggles that come with teenage pregnancy."* [ID 38, 51 years old, mother of a teenage parent] *"The barangay, the health center, the school, and the church did not offer any kind of help."* [ID 50, 15 years old, teenage boy] *"When we ask for information about family planning or prenatal services, they get angry and tell us to just wait or settle with what is available."* [ID 1, 17 years old, teenage mother]
Role of the private sector and CSOs in the implementation of RH programs	The focus group discussants revealed that several CSOs have provided them with RH services that benefit the adolescents. The RA 10354 and AO 2013-0013 state that alongside government interventions, NGOs are highly encouraged to take part in providing RH programs and services benefitting adolescents.	*"In the health center, they only conduct seminars for teenage pregnancy, unlike Marie Stopes which offered seminars, free pap smears, and other family planning activities."* [ID 17, 45 years old, mother of a teenage parent] *"KOICA. First is the infrastructure and maternal kits, so the adolescents here benefit from it... when we have programs related to pregnancy, the KOICA is there to support."* [ID 18, 45 years old, mother of a teenage parent]

AO: Administrative Order; ASRH: Adolescent Sexual & Reproductive Health; COVID-19: corona virus disease 2019; DOH: Department of Health; EO: Executive Order; KOICA: Korea International Cooperation Agency; LGU: local government unit; NGO: non-governmental organization; PHC: public health care; RA: Republic Act; RH: reproductive health; s.: series; VAWC: violence against women and their children.

support these policies, the EO 141 s 2021 provides a mechanism to mobilize existing interventions and strategies to improve the accessibility of these programs to adolescents, with special provisions on the capacity building of healthcare workers to create action plans addressing teenage pregnancy.

However, despite the provisions of the abovementioned national policies, key informants (service providers) expressed concerns about the limitedness of the teenage programs and about the lack of support for program implementation. They cited a lack of resources to interpret and harmonize national policies to create ordinances specific to the region's culture. Consequently, the key informants suggested that they should be better capacitated to guarantee the provision of adequate and appropriate RH services to their clients.

Meanwhile, discussants (service beneficiaries) shared their concerns about their lack of knowledge regarding the services that their primary healthcare facilities could offer to address early pregnancy. They still had to acknowledge the pivotal role of government organizations in addressing early pregnancy in the study area. The details are presented in Table 2.

The role of the private sector and Civil Society Organizations in the implementation of reproductive health programs for adolescents

In addition to the role of government institutions, RA 10354 and AO 2013-0013 state the important role of the private sector and CSOs in promoting responsible parenthood and RH. These two documents particularly focus on the delivery and provision of demand-generation activities for RH. Furthermore, RA 11148 and EO 141 s. 2021 highlight the importance of collaborating with several CSOs and

international agencies to address teenage pregnancy in the country. The details are presented in Table 1.

The active role of private organizations and CSOs in addressing teenage pregnancy was also explored by focus group discussants in the study area. They revealed that several CSOs provided RH services that benefited adolescents (Table 2).

Gaps in the implementation of national policies targeting reproductive health of teenagers in Eastern Visayas

These four national policies have clear provisions addressing the problematic concerns regarding teenage pregnancy in the study area. They serve as a clear manifestation of the country's vested interest in eradicating teenage pregnancies. The policies direct different agencies and LGUs to perform their necessary functions to cater to the needs of the youth particularly in sexual health. They also establish a clear link between the roles of the government institutions with private organizations and CSOs, as their collaboration is essential in the context of initiatives addressing teenage pregnancy.

Despite clear guidelines and provisions in the national policies, several gaps and barriers have been observed in essential RH service implementation in the study areas. The most important concern suggested was the refusal of the service providers to cater to adolescents' needs regarding essential RH services. This hesitancy stemmed from several factors, including a lack of resources and capacity and having a disposition that educating the youth about sexuality normalizes intimacy acts among teenagers.

The provisions in the RA 10354 toward the need for consent from parents for service providers to grant teenagers access to RH services was also identified as a barrier because they created fear among service providers, resulting in refusal to provide oral contraceptives. The focus of the educational sector on abstinence-only sex education also created a norm where educating the youth about sexuality is inappropriate.

These identified gaps and barriers resulted in teenagers having low access to essential RH services. The refusal of service providers regarding the provision of such services was also reportedly leading adolescents to be hesitant about seeking advice on essential RH services. Adolescents feared being intimidated once they voluntarily submitted themselves for consultation and secured different services, including requests for oral contraceptives. The stigma created among teenage pregnant mothers also increased the gap between service providers and beneficiaries.

Discussion

Availability of reproductive health services in primary healthcare facilities

The availability of RH and contraceptive information and services in primary healthcare facilities in the Philippines varies by several factors, including location, funding, and staffing[24]. These institutions are expected to provide various RH services, including family planning counseling and contraceptives, to underserved communities in rural areas[25]. However, challenges such as limited funding, staffing shortages, and cultural barriers can affect the availability of these services.

The observations in the current study underpinned RH service availability in rural health units and barangay health stations. Still, teenagers were quietly hesitant to seek RH services local facilities because of embarrassment due to healthcare providers' negative observations toward adolescents (once the latter sought the services), the denial of RH products and services, and the lack of services in general. This hesitancy can be attributed to the limited availability of trained healthcare workers in these facilities. Many rural health units and barangay health stations are understaffed, with only one or two healthcare workers serving a large community; this can lead to long waiting times, limited services, and reduced quality of care[26]. Another challenge is the limited availability of contraceptive supplies and equipment[27]. Primary healthcare facilities may not have the necessary resources to provide various contraceptive options, and some rural areas may have limited access to pharmacies or stores that sell contraceptives[28]. In the present study, discussants (service beneficiaries) shared their negative experiences when they attempted to avail of family planning services. They also expressed dissatisfaction regarding RH care service unavailability for adolescents although the existing law states that the healthcare system must address gaps in RH care delivery.

In addition to the previously mentioned concerns pertaining to RH information and service availability, religion was also a point of concern for some key informants and discussants as it affected people's moral values and beliefs. The religious teachings cited by participants described that premarital sex is morally wrong, leading teenage mothers to be viewed as immoral or sinful, which can result in social ostracism and discrimination. This concern has also been cited in prior research[29], and couple with our findings, it suggests that cultural barriers be one of the factors limiting RH availability and contraceptive services in some rural areas. Some communities may have cultural or religious beliefs that discourage contraception or family planning service use, making it difficult for healthcare workers to provide information and services to those who need it[30].

Accessibility of reproductive health services in primary healthcare facilities

In the Philippines, minors under 18 years are legally allowed access to family planning services with parental consent. However, minors' accessibility to family planning services in rural primary healthcare facilities is limited by several factors[31]. For example, the lack of information and education regarding family planning and RH among minors makes it difficult for them to seek and access related services[32]. This is particularly true in rural areas where there may be limited access to information and education on RH and family planning[33].

Another challenge is the stigma associated with teenage pregnancy and family planning services. As aforementioned, some communities may have cultural or religious beliefs that discourage the use of contraception or family planning services among minors, rendering information and service provision by healthcare workers to those who need it is a difficult task[34]. There may also be a limited availability of trained healthcare workers in rural health units and barangay health stations to provide family planning services, particularly for minors. Past research indeed remarks that healthcare workers may lack the necessary skills and training to provide confidential and age-appropriate family planning services to minors[35].

As cited by our key informants, the RH law in the country envisions the inclusion of adolescents in RH programs mainly through education and counseling, but is silent on contraception for adolescents[36]. The Department of Education Order 031 series of 2018 mandates basic education institutions to provide comprehensive sexuality education to all students. The policy also states that the comprehensive sexuality education curriculum should be grade-level, age- and development-appropriate. This comprehensive and developmental approach would correct the old practice of conducting isolated lessons in specific grades, such as teaching contraceptive methods in Grade 10. The law also identifies critical subjects that should be taught but does not explicitly include sexuality and contraception. It advises flexibility in deciding topics and methodology based on consultations with stakeholders like parents and other “interest” groups. Despite these efforts, the Department of Education stopped implementation of this law because of the appeal of the opposing sector[31].

It was also observed that some service providers were hesitant to provide RH services to adolescents including dispensing pills and condoms because it might provide the impression that sex is permissible if it is protected. Discounting the specific life conditions of teenagers, most guidance materials for contraceptive services and information recommend abstinence as the best behavior for preventing adolescent pregnancy. This situation reflects a government policy equivocation. The guidance also fails to consider pertinent issues including age, marital status, sexual assault experiences, and the ability to make mature decisions. Instead, the related guides promote abstinence-only or abstinence-centered values and practices[31].

In addition to the previously mentioned concerns, the devolved RH service implementation throughout the country and restructuring of program allowed LGUs to spearhead their health functions including financing and budgeting, operating facilities from healthcare posts to provincial hospitals, hiring and managing healthcare personnel, and creating local healthcare policies and programs[37]. With such spearheading also comes the possibility of local officials to cooperate with other local officials because of political and personal differences. This situation can result in a disparate, poorly-integrated healthcare system, which perhaps may also account for the country's stagnating performance in areas such as tuberculosis control, immunization, family planning and maternal mortality reduction.

Role of government agencies in the implementation of reproductive health programs for adolescents

LGUs play a pivotal role in implementing RH services among adolescents, being responsible for providing adolescents with access to family planning, counseling, and education. This, one of their primary roles is to ensure adolescents have access to information and education on RH, including on contraception, sexually transmitted infections, and safe sex practices. LGUs should also ensure that schools and other educational institutions have comprehensive sexuality education programs that cover RH-related topics.

In addition to providing education, LGUs should ensure that adolescents have access to RH services, encompassing contraception and testing and treatment for sexually transmitted infections. Counseling services for adolescents who may experience RH issues, including unplanned pregnancies[38], are also a part of the work of LGUs. Based on the results of the present study, informants were very eager to improve their facilities to be adolescent-friendly but a lack of support and funding for these purposes hindered their efforts. Some of the healthcare workers were also reportedly hesitant to dispense contraceptives for adolescents because to the possibility of misimpression.

LGUs should work to remove barriers to the access to RH products and services for adolescents. This may include providing services in schools or other community-based locations and outside regular business hours. These facilities are also responsible for reducing the stigma surrounding RH services, particularly in relation to adolescent access to such services, to encourage more young people to seek the care they need.

Role of the private sector and Civil Society Organizations in the implementation of reproductive health programs for adolescents

Despite the aforementioned challenges, efforts have been made to improve the RH and contraceptive service availability in rural health units and barangay health stations in the Philippines. These efforts include increasing funding and staffing for these facilities, providing training and resources for healthcare workers, and addressing cultural barriers through community education and outreach programs[39]. Some in rural health units and barangay health stations also partnered with non-governmental organization and other stakeholders to expand their range of services and reach more people in need[40].

Indeed, law implementation involves different sectors of society, including the private sector and CSOs. Private sector involvement in RH Law implementation can take different forms, with an example being private companies delivering funding, technical expertise, and resources to support RH program implementation. Some companies have also partnered with the government to provide free or subsidized family planning services to their employees. In this study, the discussants suggested that various CSOs provided RH services for the benefit of adolescents.

The private sector can also play a role in raising awareness about RH issues, using private companies' marketing and communication channels to promote the family planning and RH and their importance. For instance, companies can use their advertising resources to create public service announcements and campaigns to educate people on family planning.

CSOs can also assist in RH law implementation. These organizations can provide advocacy, technical support, and capacity building to government agencies and other stakeholders. They can work directly with communities to provide RH-related information, education, and services, help monitor RH law implementation, and hold the government accountable for its commitments. Furthermore, CSOs can conduct research and gather data to assess the impact of RH programs on different communities, as well as deliver feedback to the government on the effectiveness and efficiency of RH programs and policies.

Gaps in the implementation of national policies targeting reproductive health of teenagers in Eastern Visayas

The Philippine government has implemented several initiatives aimed at improving RH, but much work remains to be done to ensure that all young people in Eastern Visayas have access to the information and services they need to make informed decisions about their sex and RH. This study found that the perceived burden of teenage pregnancy was high in the study area, particularly among the parents and teenagers. Hence, it is necessary to improve the accessibility of contraceptives, RH service quality and availability, sexuality education in schools, and reduce the stigma surrounding premarital sex[41]. This cited study also suggested that the utilization rates of contraceptives in the Eastern Visayas region were low as evidenced by the low use of contraceptives among pregnant teenagers.

The limited access to contraceptives among young people in Eastern Visayas may be attributed to cultural and religious beliefs, limited availability of contraceptives in rural areas, and financial barriers[42]. Moreover, adequate RH education is not widely taught in educational institutions in the Philippines—including schools in our study setting, because teachers and parents are uncomfortable discussing sex with their children and adolescents. This can leave young people without the knowledge needed to make informed decisions regarding sex and RH.

There is also a stigma around premarital sex in the region since most of the population is Catholic, resulting in significant concerns about premarital sex. Stigma around abortion and contraception can prevent individuals from accessing the required services[43], which in turn can cause young people to fear seeking sexual and RH information and services[44]. These factors lead to a lack of comprehensiveness in the RH services, and suggest that even those young people who seek out RH services may encounter challenges such as long wait times, lack of confidentiality, and insufficient information about service availability. In addition to the stigma surrounding premarital sex, these cultural beliefs and practices may discourage individuals from seeking family planning services or using contraceptives[45].

This study also depicts a limited access to family planning services in many remote and disadvantaged communities in Eastern Visayas, which is a concern in the context of early pregnancy in the region. There also seems to be a shortage of trained healthcare professionals who can provide family planning counseling and services. This lack of access can lead to unintended pregnancies, maternal and infant mortality, and other RH issues[46].

The region also faces a lack of comprehensive RH education, particularly among young people. Sex education is not widely taught in schools, and many families are reluctant to discuss this topic at home. This lack of education can lead to misconceptions and stigma surrounding RH, which can negatively affect individuals' health-seeking behavior[47]. Regarding poor coverage and accessibility, the region faces challenges in providing adequate maternal and childcare services. There is a shortage of healthcare facilities, equipment, and supplies, particularly in rural areas. This lack of resources can lead to poor maternal and child health outcomes, including maternal and infant mortality[48].

This lack of access to comprehensive RH education and services owing to gaps in policy implementation can result

in a range of negative outcomes. Examples of such outcomes include early pregnancy, health risks for both mothers and their children, interrupted education, and economic challenges for families and communities[49]. The gaps between sex and RH policies and program implementation can also contribute to higher rates of sexually transmitted infections among teenagers which can have long-term health consequences[50].

Early pregnancy and sexually transmitted infections are often accompanied by social stigma and discrimination, particularly in conservative cultures in the region and in the country[51]. Thus, the aforementioned gaps in RH policies may perpetuate misconceptions and negative attitudes toward adolescent RH, leading to increased stigma toward affected individuals and barriers to seeking care and support. These concerns can place a strain on the current healthcare systems in resource-constrained settings in Eastern Visayas resulting in inadequate provision of RH services, longer wait times, and limited availability of contraceptives and other essential resources[52].

Additionally, early pregnancy can disrupt educational attainment and limit future employment opportunities for young mothers and fathers, and the coupling of this inadequate support services and policies may exacerbate the related challenges. A potential outcome here is the perpetuation of a cycle of poverty and inequality in affected communities. The study findings hence suggest that a cycle of poverty and early pregnancy may occur in the region of interest, as children born to teenage mothers are more likely to experience poor health outcomes and limited opportunities for socioeconomic advancement[53–55]. Indeed, gaps in RH policy implementation can exacerbate existing health inequities, particularly for marginalized populations including rural communities and low-income families[56]. These groups may face additional barriers to accessing RH education and services, further widening the disparities in healthcare outcomes. It appears that addressing gaps in RH policy implementation is essential for breaking the aforementioned cycle and promoting the well-being of future generations.

Limitations

The review and thematic analyses of the qualitative data focused only on four policies, namely the RA 10354, DOH AO 2013-0013, RA 11148, and EO 141 s. 2021. Accordingly, the resulting themes primarily focused on the salient provisions of these policies, potentially overlooking insights relevant to a broader range of policies. The use of qualitative data from key informant interviews and focus group discussions is also inherently susceptible to biases, such as social desirability and social acceptability. To mitigate this, the interviewers underwent intensive training before data collection to ensure effective probing techniques for enhancing data quality. Finally, the generalizability of the results is limited to the current state of RH program delivery in the study area. Therefore, further local studies employing targeted lenses based on community characteristics are highly recommended.

Conclusion

RH programs were implemented from the regional to the barangay levels in the study areas, but teenagers seemed to make low use of these programs, which in turn could be attributed to cultural and social influences. These influences were dictated by current societal norms in the province. The role of different environmental factors in the sustained prevalence of teenage pregnancy in the region across different groups remains unclear. To some extent, the major environmental factors affecting teenage pregnancy in the region include early exposure to social media, peer influence, lack of education, and abuse. Hesitancy to participate in and utilize basic RH services among teenagers and their parents was also observed in the study areas. Some healthcare providers were reluctant to discuss RH programs with young individuals and get the latter involved in these programs, which could be explained by the stigma created by cultural taboos in the study areas.

This study generally showcases a need to create advocacies targeting the reduction of teenage pregnancy in the region by involving different stakeholders from the regional to the grassroots levels. Culture-specific and age-appropriate educational materials must be developed to efficiently deliver RH education to young individuals. Finally, political leaders, program planners and community leaders should formulate and enforce policies and local ordinances to prohibit acts of cohabitation before the age of 18 years to avoid early pregnancy. Collaborative efforts and partnerships must be made between agencies and a special task force must be created to oversee the activities being implemented.

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