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STRATEGIES ON TEENAGE PREGNANCY (STEP):

Analysis of Early Pregnancy Situation in the Eastern Visayas as a Basis for Multi-Sectoral Policies to Reduce Teenage Pregnancy in the Region

FINAL REPORT

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EXECUTIVE SUMMARY

Teenage pregnancy is a global health issue which has great implications in the economic development of a nation. Early initiation of pregnancy can affect the growth and development of the infant and risks the mother's life. The Philippines has the second-highest teenage pregnancy rate in East Asia and the Pacific and is the only country showing an upward trend. In 2018, teenage pregnancy was declared a "national emergency" wherein the fertility rate was high at 55 births per 1000 women aged 15–19. Eastern Visayas emerged as one of the regions with rising cases of teenage pregnancy with seven percent of adolescent girls were already mothers. In response, the national government promulgated the Republic Act 10354 (The Responsible Parenthood and Reproductive Health Act of 2012) and Executive Order 14 (Teenage Pregnancy as an Urgent National Priority) to bring down the increasing trend of teenage pregnancy. These policies guarantee all levels of the government be responsible in ensuring that adolescents and youth receive the highest attainable standard of health and access to quality health services which can only achieved if institutions are guided with relevant and valid data that they can use in streamlining their programs and initiatives. Hence, this project aims to have an in-depth analysis of the early pregnancy situation in Eastern Visayas that can serve as a guide for multi-sectoral policies targeting the reduction of teenage pregnancy in the region.

An exploratory study utilizing mixed-method approaches was used to gather information on the impact of teenage pregnancy and to assess the current provision and utilization of services for teenagers. Quantitative research methodologies were utilized to estimate the burden of teenage pregnancy in the study area and recognize the extent and quality of health service delivery aimed at this population. Qualitative research methodologies were also used to address the remaining research questions. A combination of semi-structured interviews, focus group discussions (FGDs), and key informant interviews were administered to the research participants. The target population for the study was made wide and inclusive to obtain information to inform and guide well-designed interventions. Four Focus Group Discussions, comprised of five participants, were conducted in each selected province and six key informants were identified. For the quantitative aspect, records from the regional/local PSA offices were used to achieve the sampling frame of deliveries occurring among women between 13- and 19-year-old. The study was set in select provinces in Eastern Visayas, and its selection was based on an increased emphasis on the socio-clinic-demographic characteristics related to adolescent pregnancies in the region.

Electronic spreadsheets were used to gather data on the prevalence of teenage pregnancy and the socio-demographic characteristics of the study participants. Themes were

recognized and coded in line along with the research question, and FGD/KII topics, while concepts were ranked according to occurrence in the transcribed recordings. The interviews lasted 30–50 minutes. No participants underwent more than one interview, and none withdrew from the study after the interview. Data saturation was reached after interviewing 12 participants. After analyzing the verbatim data using QDA Miner Lite version 2.0.9 as analytic software, we initially extracted 32 codes from the key informant interviews, which were further abstracted into 24 sub-nodes by rephrasing and combining similar statements. The sub-nodes were further re-classified into twelve nodes (indicated in italics below) and were used to generate the three main themes. The focus group discussions conducted typically lasted between 60–90 minutes. No participants underwent more than one FGD participation, and none withdrew from the study. Data saturation was reached after ten focus groups. The verbatim data were analyzed using the same qualitative analysis software. We initially extracted 33 codes from the focus group discussions, which were further abstracted into 26 sub-nodes by rephrasing and combining similar statements. The sub-nodes were further re-classified into six theme nodes and four main themes.

A total of 296 teenage pregnant women participated in the study coming from four provinces in Eastern Visayas. The results showed that most of the respondents were 15 to 19 years old during their first pregnancy, the youngest being 12 years old. In terms of the age of the respondents' children, about a quarter have ages less than one year old and about half of the children are toddlers. It was also revealed that there was a higher proportion of 20 to 25-year-olds responding to the survey among those in GIDA communities which can be attributed to the greater ease in identifying and locating recent teenage pregnancy cases in non-GIDA communities. A notable proportion of women from both communities who were "single with partner" was also observed. In addition, more women use family planning methods in non-GIDA communities, but more women in isolated communities utilize OCPs. Lastly, the results also revealed that women from GIDA communities tend to have a smaller number of sexual partners, longer inter-pregnancy intervals, and a higher proportion of preterm labor.

A higher educational attainment among the respondents' parents and partners in non-GIDA communities was observed. In GIDA communities, unemployment among the respondent's fathers was lower since more of them were self-employed. A similar pattern for self-employed status was observed for the respondents' partners. Meanwhile in non-GIDA communities, a higher proportion of the women's partners were regular or part-time employed which can be attributed to the higher probability of jobs and occupations in non-isolated communities. Furthermore, higher proportions of the participants in both communities live in nuclear and extended family settings. Finally, most of the teenage mothers received a secondary level of education regardless of early pregnancy and motherhood characteristics.

Programs on reproductive health were implemented from the regional to barangay level but low utilization was observed among teenagers which can be attributed to cultural and social influences. The role of different environmental factors to the sustained prevalence of teenage pregnancy was unclear between different groups. Major environmental factors that affect teenage pregnancy include early exposure to social media, influence of peers, lack of education, and abuse. Hesitancy to participate and utilize basic services on reproductive health among teenagers and their parents was noted. Some healthcare providers were observed to be reluctant in discussing and involving young individuals in reproductive health programs which can be explained by the stigma created by cultural taboos in the study areas.

A need to create advocacies targeting the reduction of teenage pregnancy in the region by involving different stakeholders from the regional down to grassroots level is essential. Culture-specific and age-appropriate educational materials must be developed to efficiently deliver reproductive health education to young individuals. Research must be done to determine the effectiveness of the current interventions among adolescents assessing the influence of different factors across varying sociocultural contexts. Teenagers must be engaged in different programs and advocacies which involve open dialogue under the supervision of guidance counselors and healthcare workers. Political leaders, planners and community leaders should formulate and enforce policies to prohibit the acts of cohabiting before the age of 18 to avoid early pregnancy. Collaborative efforts and partnerships must be made between agencies and a special task force unit must be created to oversee activities being implemented.

I. INTRODUCTION

1.1 Background of the Study

Teenage pregnancy is a global health issue which has great implications in the economic development of a nation. Maternal death increases by two folds when pregnancy happens between the ages of 15-19 years compared to 20-24 years. Early initiation of pregnancy can also affect the growth and development of the infant (Rachakonda et al., 2014). Maternal death is mainly due to complications during delivery, obstructed labor, stillbirth, systemic and severe neonatal infections (Ganchimeg et al, 2014; Sawyer et al., 2012). Moreover, the sequential consequences will put these pregnant women at a more significant drawback including limited employment, non-completion of studies, and major health problems in the later part of life (Singh, 1998; WB 2018). Studies suggested that teenage pregnancies are essentially due to sexuality, lack of contraception, age discrepancies between couples, sexual violence, and socio-economic factors (Rachakonda et al 2014).

In the Philippines, teenage pregnancy was declared a “national emergency” wherein the fertility rate was high at 55 births per 1000 women aged 15–19 (NNC 2019 WB 2018). This means that more than 500 Filipino teenage women are getting pregnant and giving birth every day. The Philippines has the second-highest teenage pregnancy rate in East Asia and the Pacific and is the only country showing an upward trend. In contrast, other countries in the region have declining rates of teenage pregnancy (UNFPA; UNESCO; WHO 2015). This problematic issue can be attributed to limited access to sexual education and sexual health services. These services are often against the church teachings’ wherein majority Filipino are Roman Catholic (Rachakonda et al 2014). New technology, particularly the social networking through their smartphones, notebooks and tablets is also considered as one of the major culprits leading to teenage pregnancies (Salvador et al 2016).

Teenage pregnancy was more likely to occur when adolescent women lived with neither parent (aOR = 4.57), who were roughly 19 years old (aOR = 2.17), knew about contraception (aOR = 1.2), and lived in a large family (adjusted OR = 1.14) (Tabei et al, 2017). Higher chance of teenage pregnancy also happens among individuals who lived with neither parent nor belonged to the poorest wealth quintile (aOR = 3.55). Meanwhile, the risk of teenage pregnancy was reduced when a teenage woman reached at least the tertiary level (aOR = 0.08), and those belonging to the wealthiest households (adjusted OR = 0.40) (Tabei et al, 2017). Moreover, adolescent girls residing in both urban and rural areas are equally at risk of early childbearing. Contrary to the findings in the past ten years, higher prevalence of

teenage pregnancies exists in urban areas (14.9%) compared to those in rural (13.2%). Moreover, relative to teenage pregnancies, a higher proportion of adolescent boys in urban areas have someone pregnant (3.7%) compared to rural areas (2%) (PSA and ICF 2018).

Among the regions in the Philippines with a rising concern in terms of teenage pregnancy includes the provinces of Eastern Visayas with seven percent of teenage girls in the region were already mothers. According to a recent report, nearly 10,000 girls (10 to 19 years old) already started bearing a child with most of them impregnated by boys of the same age. Five teenagers get pregnant every day in Eastern Samar, whereas 11% of pregnant mothers in the province are 19 years old and below (UNFPA, 2018).

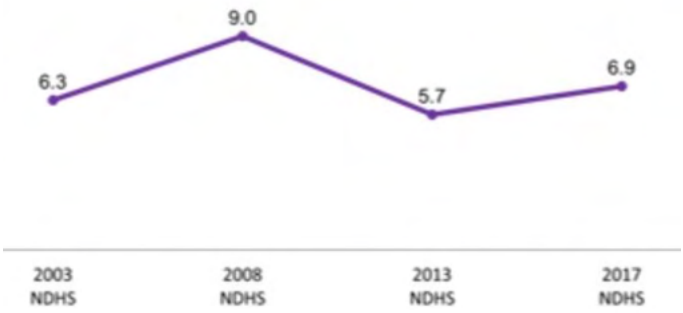

Figure 1. Trends of teenage pregnancy in Eastern Visayas from 2003 to 2017 (PSA, 2018)

Figure 1 shows that 6.9 percent of teenage women aged 15 -19 years in the region have begun childbearing, of which in 2017. Prevalence of teenage pregnancy in the region was at peak in 2008 at 9.0 percent and eventually declined to 5.7 percent in 2013. However, it has again a sharp increase up to 6.9 percent in 2017 (PSA 2018).

In response to this national emergency, the national government promulgated the Republic Act 10354 (The Responsible Parenthood and Reproductive Health Act of 2012) and Executive Order 14 (Teenage Pregnancy as an Urgent National Priority) to bring down the increasing trend of teenage pregnancy. Aside from the national policies, it must ensure that all levels of the government must be responsible in ensuring that adolescents and youth receive the highest attainable standard of health and access to quality health services. Adolescents and youth deserve to enjoy the full extent of their rights and the 'triple dividend' of improving their health now, their lives in the future, and the next generation by investing in their health (UNESCO 2013). This can be only achieved if these different agencies must be guided with relevant and valid data that they can use in streamlining their programs and initiatives to reduce the prevalence of teenage pregnancies in the study areas. Hence, this project aims to have an in-depth analysis of the early pregnancy situation in the Eastern

Visayas that can serve as a guide for multi-sectoral policies targeting the reduction of teenage pregnancy in the region.

1. 2 Research Objectives

Generally, this study aims to identify and develop effective strategies (e.g., interventions, advocacies, policies) to reduce the risks associated with teenage pregnancy in the Eastern Visayas region. Specifically, this study aims to:

1. Determine the prevalence and trends of teenage pregnancy (less than 18 years old during first delivery) in the Eastern Visayas Region (Northern, Eastern and Western Samar, and Leyte).
2. Determine the underlying causes of teenage pregnancy in selected areas in Eastern Visayas region.
3. Assess the delivery of programs, projects, and activities of local and national government/private agencies targeting teenage pregnancy.
4. Explore the perceptions of grassroot health workers (e.g., BHWs, midwives, nurses), teenage women and their parents/guardians regarding factors predisposing pregnancy among teenagers, and its impact on the health and well-being of the young parent and their children.
5. Explore and identify perceived barriers and facilitators in the delivery of these health care services.
6. Provide sound and feasible recommendations that can be used for advocacy, policy, research, and programs/projects/activities to address the causes of teenage pregnancy aligned to the plan of the relevant national government agencies/local government units in the study areas.

1. 3 Significance of the Study

The increased risks to both mother and child of too early childbearing have been regarded throughout different constructs. Hence, there is a need to understand the situation on teenage pregnancy in a specific study area to design appropriate interventions based on reliable and valid data for analysis (Natividad, 2013). The scarcity of evidence related to teenage pregnancy in developing countries has led to a lack of programs targeting this societal and health issue. Thus, this study will investigate the situation of teenage pregnancy in Eastern Visayas using mixed method design to provide findings that can augment the need of program

planners and implementers working in adolescent health to understand the risk and protective factors as well as the high-risk population related to teenage pregnancy (Tabei et al. 2021).

In the Philippines, this may be one of the more recent studies that will explore teenage pregnancy using mixed-method study design to understand the phenomenon. At this time in the Philippines, teenage pregnancy was declared a “National Emergency” wherein the fertility rate was high at 55 births per 1000 women aged 15–19 (NNC 2019 WB 2018). Hence, the information derived from this study will be very useful to provide empirical evidence towards the situation of teenage pregnancy measured at the local level. Moreover, it will also provide valuable evidence for policy makers and the health sector to address the problem that can be used in planning and strategizing interventions and programs. This study can be eventually used as a model for other local government units and other researchers to explore the multifactorial issues of teenage pregnancy for better targeting. The methodology of this study can be also used by future researchers to understand the facets of teenage pregnancy across different agro-ecological settings and culture in the country considering regional variations. Thus, it will help to gain insight into observed variations in pregnancy rates and ensure that new public health and sexual health interventions are better designed and implemented. Funders of future research should also consider supporting longitudinal studies to be able to explore changes over time.

II. REVIEW OF RELATED LITERATURE

Global Issues on Teenage Pregnancy

Pregnancy among young women or also known as “teenage pregnancy” is a global issue that carries significant threat to the health and welfare of the population (Mezmur, Assefa and Alemayehu, 2021). Teenage pregnancy is defined as the occurrence of gestation among girls ages 13-19 (UNICEF, 2008). Teenage pregnancy is a consequence of health and education inequality for young parents and their children (Hadley, 2018).

Pregnancy during adolescence poses significant challenges which includes abandonment of partners, dropout from school, and threats of adverse pregnancy outcomes. Maternal and neonatal deaths among teenage mothers are higher in less developed countries. Hence, the birth of a child from a teenage mother who has only entered the adolescence period poses significant concern across cultures and countries. (Cherry et al, 2009).

Teenage pregnancy tends to be a global health problem across all the continents. Although there has been a decline among developed countries, the United States recorded the highest rates of teenage pregnancy (67.8 per 1000) followed by the UK with 30.9 per 1000 (Allan Guttmacher Institute, 2012; Malawi National Statistics Office, 2013). Teenage pregnancy remains to be a pressing concern among adolescents in the United States, wherein about 31% of American women become pregnant before the age of 20. Meanwhile, about 13% of the sexually active American men between the ages of 15 and 19 report that they have fathered a pregnancy (Suellentrop and Flanigan 2006).

The problematic issue of teenage pregnancy has the worst outcome among the less developed countries compared to the first world countries. This can be attributed to poverty which has dual dynamics in teenage pregnancy. Poverty seems to be both a determinant and a consequence of teenage pregnancy wherein, many of the individual and environmental risk factors of teenage pregnancy are also linked to poverty (Oke, 2010). Among the less developed countries, the sub-Saharan Africa in particular has the highest rate of teenage pregnancy at the global level with an average of 143 per 1000 (Magadi, 2004; Treffers, 2003).The highest prevalence of teenage pregnancy was recorded in Sub-Saharan Africa, wherein half of all the births were accounted for among young women aged 15 to 19 (Odimegwu and Mkwananzi, 2016; Loaiza and Liang, 2013). One of the countries with the highest rate of teenage pregnancy is Ethiopia, recording a prevalence of 16%. The prevalence was higher in rural compared to urban areas (15% and 5%, respectively). It was evident that most teenage pregnancy in rural areas happened outside marriage. It was also observed that teenage pregnancy was also higher among those without any education (CSA 2016; Taffa and Obare, 2004).

In the South-East Asia region, an estimated 6 million adolescents are giving birth each year which is on an average 16% of all births, though it varies markedly by countries in the region. However, the largest declines in the last decade are observed in India, Bangladesh, Myanmar, Maldives, and Timor-Leste. The decline in teenage pregnancy over the years varies from country to country which can be attributed to increasing age at marriage, higher educational attainments and greater career opportunities for women, urbanization, and increased rates of contraceptive use. Infant mortality rates (IMRs) are also significantly higher for babies born to adolescent mothers than for infants born to women in their twenties or thirties. In Indonesia, the Infant Mortality Rate for younger women is higher than those for women in the age group 20-29 years by as much as 75% (WHO 2015). Although teenage pregnancy remains to be a public health concern in the Southeast Asia region, health service utilization has been poorly studied. There are only very few studies that show the utilization of health services which tends to be directly linked to socio-economic deprivation. Moreover, there are also several barriers leading to poor access towards health services including gender relations, socio-cultural traditions, access and availability of health facilities and inadequate health sector infrastructure (Santhya et al 2007).

Teenage Pregnancy in the Philippines

Consistent with other countries in the Southeast Asia region and other developing nations, the Philippines recorded increasing rates of teenage pregnancy for the last two decades. In 2008, a total 1,784,316 births were registered; of these 10.4%, (186,527 births) were born to mothers under 20 years of age (Natividad, 2013). Generally, the country is not lacking in laws nor policies and programs that empower and protect women. However, political disagreement, strong religious involvement in reproductive health legislations, and the ambivalence of Filipinos towards sex and reproductive health negatively affects the implementation of programs related to adolescent reproductive health (Serquina-Ramiro, 2014).

Substantially, the Philippines has a young population with an estimated median age of 22.9 years wherein, almost 20 million Filipinos aged 15–24 were also noted. This comprised 21% of the total population (NYC 2010). In a qualitative study done by Acaba (2006), young Filipino men and women consider the time of the first manifestation of changes in their bodies as the start of adolescence. Among Filipino young women, initial manifestations include the onset of menarche and relative increase in the size of breast size. Meanwhile, among men, it was the change of voice. These changes normally occur at age 12 although others show these signs at an earlier age of 9 or 10 years. The very young population of the country poses higher rates of teenage pregnancy in the country (Acaba, 2006).

Compared to the global rates, the adolescent fertility rate in the Philippines is considered within the average range. This is consistent with Southeast Asia, having the same level compared to Indonesia, but higher than Vietnam and Thailand. The age-specific fertility rate (ASFR) for women 15-19 is a measure of the incidence of fertility; it is the rate of births relative to the person's years of exposure to the risk of childbearing within the given age group. It is highly possible for one woman to contribute more than one birth to the numerator as the reference period is usually about five years before the survey date. Thus, the ASFR is not a good measure to gauge the level of early childbearing in the population (Natividad, 2013).

According to Vicerra (2017), It is observed that certain factors resulting in early pregnancy of Filipino women remained to be associated with the use of family planning and the opposite non-use and lack of intention to utilize such services as age, parity, education, and access to general media. The other factors are observed to have a varying association which may be related to changing cultural underpinnings. In addition, teenage pregnancies are more likely to happen among predominantly poor Filipino households, residing in rural areas and women with lower educational attainment. Among the factors that could help explain this trend are the younger age at menarche, premarital sexual activity at a young age, the rise in cohabiting unions in this age group and the possible decrease in the stigma of out-of-wedlock pregnancy (Natividad, 2013).

Factors Associated with Teenage Pregnancy

Along with poverty, teenage pregnancy exists because of several factors that contribute to early pregnancy. In the study of Posel (2013), it was suggested that adolescent pregnancy is often caused by lack of access to schools, employment, quality information and health care. Early pregnancy reflects powerlessness, poverty and pressures from partners, peers, families, and communities. In South Africa all children have access to free education and health services. The succeeding discussions will provide different factors associated with teenage pregnancy.

Socio-economic Status

Teenage pregnancy is one of the many consequences of poverty which tends to be a determinant as well because of the latter. It was more evident in developing countries, wherein the determinants of individual and environmental risk factors of teenage pregnancy are tied into experiences of poverty (Oke, 2010). In a study conducted in Rwanda, it was observed that teenage women belonging to the richest wealth quintile had a reduced risk of pregnancy (aOR = 0.43) compared to the teenage women in the middle wealth quintile (Wado et al 2019). The result is congruent to the findings of Were (2007) observed that there was a reduced risk

of teenage pregnancy among adolescents of higher wealth status. In Rwanda, it was observed that there was an association between teenage pregnancy and household possession of a bank account. Teenagers belonging in households with at least one adult member with a bank account were nearly 50% less likely to become pregnant (OR: 0.57 with 95% CI: 0.39–0.84) (Uwizeye et al 2020).

In a related study conducted in the Philippines, socioeconomic status and living arrangement shows an opposite direction of odds, wherein teenagers who belonged to middle socioeconomic status lowers the odds of being at risk of pregnancy at 0.60 while those in high SES decreases odds by 0.49. Having sufficient exposure to reproductive health messages through tri-media decreases the odds by 0.63. (Vicerra, 2017). The findings was consistent with the result of the study done by Tabei et al. (2021) which observed that the richest and richer quintiles were less prone to teenage pregnancy, whereas adolescent women in the poorest wealth quintile were 1.8 times (95% CI = 1.34–2.34) more likely to be pregnant than those in the middle wealth quintile (richer: OR = 0.57, 95% CI = 0.39–0.83, the richest: OR = 0.37, 95% CI = 0.23–0.58).

Household Size and Number of Bedrooms

Relative to socio-economic status, large family size can be also attributed to poverty and poor living conditions. In the Philippines, it was observed that teenage women in bigger families had a higher chance of having pregnant adolescents (OR = 1.04, 95% CI = 1.00, 1.08) (Tabei et al. 2021). In a related study done in Rwanda, it was observed that adolescents living in medium-size households were more than 60% (OR: 0.38, 95%CI 0.27–0.55) less likely to have early pregnancy compared to households with less than five members. Consequently, teenagers belonging in bigger families with more than ten members are two times more likely to experience teenage pregnancy compared to those who are belonging in small households (OR: 2.13, with 95% CI: 1.99–4.57). This paradigm indicates that the size of the households has a significant influence on the association. The association between teenage pregnancy and the size of the house can be explained that household size is a predictor of high socioeconomic status (Uwizeye et al 2020).

Consistent with household size, the studies showed that the number of bedrooms is significantly associated with teenage pregnancy. Teenagers belonging to households with 3–4 bedrooms were nearly 30% less likely to experience teenage pregnancy compared to teenagers belonging in households with 1–2 bedrooms (OR: 0.68, 95% CI:0.47–0.99). The odds tend to decrease considerably as the number of rooms increases. In similar studies, researchers found adverse effects on the behavior of children raised in small and crowded houses (Foye, 2017). This situation can be explained by the dynamics of families living in

small houses where young girls and boys were prematurely exposed to sexual acts of their parents that induces their sexual behavior and curiosity (Muche et al 2017).

Educational Attainment and Knowledge on Contraception

Relative influences of educational attainment were found to delay teenage pregnancy (Girma et al, 2015; Koppensteiner, 2016). Higher proportion of adolescents remaining in education after primary schools is likely to increase the opportunity cost of early pregnancy and, hence, may contribute to lower teenage pregnancy rates (Grima et al 2015). It was consistent with the findings of (Rohman et al. 2020), wherein adolescents with higher education are 0.03 times more likely to get pregnant than one that has not gone to school before (Rohmah et al. 2020). Higher educational attainment exhibited a statistically not significant reduction in the risk of teenage pregnancy (OR = 0.26, 95% CI = 0.08–1.15).

In a related systematic review conducted that explored the association of educational attainment in teenage pregnancy in low-income countries, it was noted that teenage girls who had a higher education or longer educational history generally delayed pregnancy longer than teenage girls who had little or no education (Mohr et al 2019). Similarly, in a community-based case-control study in Ghana, observed that the longer the time adolescents spend in educational institutions, the greater the likelihood of contraceptive utilization, which may be loosely related to a reduction in the risk of teenage pregnancy (Ahinkorah et al (Wado et al 2019).

In relation to educational attainment, exposure to sex education and knowledge on contraception which were taught in academic institutions was associated to early pregnancy. However, it was observed in the study of Tabei et al. (2021) that having knowledge on contraception methods increases the chance by 1.2 times of having early pregnancy compared to teenagers who lacked information on contraception (95% CI = 1.14–1.20). In a related study of Ibrahim (1997), contraceptive utilization among the patients showed that 85.5% had never used any form of contraceptive. It was also observed that only 2% to 6% of the sexually active adolescents practice any form of contraception. In addition, the study of Habitu et al (2018) showed that respondents who did not use contraceptives were ten times more likely to be pregnant than their counterparts (AOR=10.62; 95%CI: 5.28, 21.36).

In the Philippines, the utility of contraceptive methods also positively affects the risk by 5.5 which is not as high as in 2008. The utility of contraceptive methods also positively affects the risk by 5.5 which is not as high as in 2008 (Vicerra, 2017). In a related study done in Africa, it was also observed that those teenagers who did not use any contraceptives were eleven times more likely to be pregnant compared to their counterparts who were contraceptive users. It has been suggested that as the proportion of teenagers who were not using contraceptives increased, the proportion of early pregnancy also increased (Vincent and Alemu, 2017).

Age and Working Status

Age was also found to be a significant determinant of teenage pregnancy (Rohmah et al. 2020). Increase in age is significantly associated with teenage pregnancy (AOR=2.10; CI: 1.55, 2.88) (Habitu et al 2018). This was supported by studies conducted in Ethiopia and Kenya where the odds of being pregnant among teenagers increases by 2.1% every year (CSA 2017; Were, 2007). It was evident that as age increases, teenagers can have more exposure to sex and their chance of being married will also increase to procreate children. In relation to increasing age, being employed increases the odds of being pregnant compared to their non-working counterparts. Working teenagers have a higher likelihood of getting pregnant by 1.47 times compared to their non-working counterparts (Rohmah et al. 2020).

Type of Family and Marital Status of Parents

Type of family and marital status has been also observed to be a significant determinant of early pregnancy (Habitu et al 2018; Tabei et al 2021; Uwizeye et al 2021). Teenage pregnancy was found to be 1.6 times (95% CI = 1.10–2.16) more likely to happen among teenagers who are having a single parent. The likelihood of being pregnant was also higher by 8.2 times (95% CI = 6.54–10.23) when a teenager only lives with either her father or mother compared with her counterparts who are living with both parents (Habitu et al 2018). However, in the study of Uwizeye et al (2020), the result showed that households headed by single mothers were less likely to experience teenage pregnancy compared to married or living together couples (OR: 0.25 with 95% CI: 0.11–0.56).

Moreover, teenagers from divorced parents were almost two times more likely to have an early pregnancy compared to those with married parents (AOR=1.98; 95%CI: 1.13, 3.93) (Habitu et al 2018). It was supported by the results of the study done by Uwiizeye et al. (2020) that suggested that households who are headed by divorced or separated couples increases the chance of having a daughter who will get early pregnancy by 1.72 compared to households headed by married couples or living together (95% CI:1.29–3.57). In addition, households headed by widows were 1.18 times more likely to experience teenage pregnancy compared to households headed by married or living together couples (95% CI: 1.06–2.04) (Uwizeye et al 2020).

In relation to single parenthood, the age of the head of household has an inverse association to early pregnancy. Older household heads tend to have a lower likelihood of having a daughter who got pregnant during their adolescence (OR = 0.97, 95% CI = 0.96–0.97) (Tabei et al. 2021). Moreover, living away from parents can also decrease the chance

of having an early pregnancy by 0.60. (Vicerra, 2017). This can be explained by low parental control and communication about sexual and reproductive issues among divorced parents compared to married ones. These lead to increased early sexual debut and risky sexual behaviors among adolescents from divorced parents, and all these expose them to teenage pregnancy (Day, 1992).

Community Residence

In the Philippines, teenagers from rural areas were more likely to be pregnant than students (AOR=3.93; 95% CI: 1.20, 12.83) (Habitu et al 2018). In a related study in the Philippines, it was observed that the residence was found to increase the risk of pregnancy by 1.3 times (Vicerra, 2017). In South Asia, teenagers residing in rural areas tend to be four times more likely to have early pregnancy compared to their counterparts from the urban areas (Acharya, 2014). This might be so because teenagers from the rural areas are less educated and have limited access to contraceptives. Lastly, rural communities tend to be against contraception compared to teenagers in urban areas. (CSA 2017).

Programs and Services Implemented to Reduce Teenage Pregnancy in the Philippines

Teenage pregnancy is a complex issue with no simple, or single agency solution. The impact of prevention programs comes from implementing the evidence through a multi-pronged whole system approach (Hadley, 2018). Reducing the fertility rate of adolescents and addressing the multiple factors underlying it are essential for improving sexual and reproductive health and the social and economic well-being of adolescents. There is substantial agreement in the literature supporting the social, economic, health, and developmental consequences of early pregnancy.

Hence, the complex issue of teenage pregnancy has been targeted by Sustainable Development Goals which has initial targets of ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030.

In the Philippines, Sexual and Reproductive Health (SRH) targets have been included as part of the United Nations Sustainable Development Goals and indictors are important to monitor progress towards these targets. SRH indicators are recommended for setting norms and measuring progress globally. However, given the diverse political, socioeconomic, and cultural contexts in different countries, and lack of global agreement on broad indicators, it is important to select appropriate indicators for specific countries. (Fang et al. 2020)

In 2009, the Magna Carta for Women (RA 9710) was passed into law by the Philippine Congress. This law seeks to eliminate discrimination against women by recognizing, protecting, fulfilling, and promoting the rights of Filipino women. The Magna Carta for women

aims to protect the women from all forms of violence, provide equal opportunity, participation, and treatment before the law. They must also have equal access to programs by the government and eliminate all forms of discrimination. They must also have full access to comprehensive health services and health information and education.

To address teenage pregnancies in the country, the Department of Social Welfare and Development (DSWD) and the Commission on Population and Development (POPCOM) will undertake the Social Protection Program for Teenage Mothers and their Children (SPPTMC) as mandated under the special provision of the 2021 General Appropriations Act of 2021. There are several programs offered by DSWD that aim to protect and promote the psychological well-being and improve the capacity of teenage parents in performing their expected roles as young adults and responsibilities as parenting youth (POPCOM 2021).

Synthesis

Teenage pregnancy is a global health issue which has great implications in the economic and development of a nation. In the Philippines, teenage pregnancy was declared a “National Emergency” wherein the fertility rate was high at 55 births per 1000 women aged 15–19. This national emergency has been associated with different factors related to poverty. Teenage pregnancy is one of the identified consequences of poverty and this paradigm tends to be directly linked in a chain of poverty. On the other hand, poverty can also be a consequence of teenage pregnancy. Higher rates of teenage pregnancy have negative implications in the economic development, health utilization, and other national development consequences. Aside from poverty, teenage pregnancy was found to be significantly associated with different factors including household size, number of bedrooms in the household, educational attainment of parents, type of community where the teenagers are residing, and type of family and marital status of parents.

In response to this national emergency, several policies have been enacted into law to bring down the increasing trend of teenage pregnancy. According to UNESCO (2013), adolescents deserve to enjoy the full extent of their rights and the ‘triple dividend’ of improving their health now, their lives in the future, and the next generation by investing in their health. This can be only achieved if these different agencies must be guided with relevant and valid data that they can use in streamlining their programs and initiatives to reduce the prevalence of teenage pregnancies in the study areas. Hence, this project aims to have an in-depth analysis of the early pregnancy situation in the Eastern Visayas that can serve as a guide for multi-sectoral policies targeting the reduction of teenage pregnancy in the region.

Operational Definition of Terms

Sex of the household head. It is defined as whether the household head is a male or female.

Sex of the caregiver. It is defined as whether the household head is a male or female.

Age of caregiver. Caregiver is defined as someone who tends the rearing of the family. In this study, the age of the caregiver will be measured in years and the answer will be interpreted as is.

Age of household head. Household head pertains to someone who provided the major needs (basic needs) of the family. In this study, the age of the household head will be measured in years and the answer will be interpreted as is.

Age of teenage pregnant. In this study, the age of teenage pregnant woman and will be measured in years and the answer will be interpreted as is.

***Age of gestation*.** It is defined in weeks as the duration of pregnancy before birth based on historical data, fetal ultrasound, or neonatal examination. In this study it will be computed on the day of interview and interpreted as is.

Current marital status of the parents: This is the marital status of the parents of the teenage pregnant women and can be defined in four categories:

(1) Single
(2) Married or living together
(3) Widowed
(4) Divorced or separated

Household income. It is the primary income and receipts from other sources received by all family members during the reference period, as participants in any economic activity or as recipients of transfers, pensions, grants, interests, food, and non-food items received as gifts by the family. This study will use the household income classification set by the Philippines Statistics Authority (PSA 2018).

(1) <PHP. 11,690.00
(2) PHP. 11, 690- PHP. 23, 381.99
(3) PHP. 23, 382.00- PHP. 46,760.99
(4) PHP. 46,761.00- PHP. 81,831.99
(5) PHP. 81,832.00-PHP. 140,283.00
(6) >=PHP. 140,284.00

Highest educational attainment of the teenager. It pertains to the highest educational attainment, or the highest degree earned by the household head or caregiver (FNRI, 2016). In this study, the categories for highest education attainment of caregiver and household head were coded as follows:

(1) Elementary level and graduate
(2) Secondary level and graduate
(3) College level

Highest educational attainment of the caregiver/ household head. It pertains to the highest educational attainment, or the highest degree earned by the household head or caregiver (FNRI, 2016). In this study, the categories for highest education attainment of caregiver and household head were coded as follows:

(1) Elementary level and graduate
(2) Secondary level and graduate
(3) College level
(4) College graduate
(5) Post graduate studies

Type of family. Family is a group of persons united by the ties of marriage, blood, or adoption, constituting a single household, and interacting with each other (Sharma, 2013). In this study it will be coded as:

(1) Nuclear family
(2) Single parent family
(3) Extended family
(4) Grandparent family
(5) Stepfamily

Household size. It is defined by the statistics authority as the total number of people living in one house which may consist of the father, mother, children, in- laws and all others. In this study, this refers to the number of people living in the house. The answer will be interpreted into four categories:

(1) Small (<5),
(2) medium (5-6)
(3) medium-large (7–9) and
(4) large families (>=10).

Geographical Classification. This is defined as the classification of agricultural property according to its utilization. In this study, barangay agricultural classification will be used to stratify the barangay into rural and urban communities. The categorization will be based on the classification set by the Department of Interior and Local Government under Republic Act 7160 (Local Government Code of 1991). This will be categorized as:

(1) Rural
(2) Urban

III. METHODOLOGY

3.1 Research Design

An exploratory study utilizing mixed-method approaches was used to gather information on the impact of teenage pregnancy on the teenage mother, the family, and community and to assess the current provision and utilization of services for teenagers. Quantitative research methodologies (i.e., cross-sectional) were utilized to estimate the burden of teenage pregnancy in Eastern Visayas and recognize the extent and quality of health service delivery aimed at this population.

Qualitative research methodologies (i.e., qualitative descriptive) were also utilized to address the remaining research questions. A combination of semi-structured interviews, focus group discussions (FGDs), and key informant interviews were administered to the research participants.

3. 2 Participants of the Study

Qualitative Descriptive

The target population for the study was made wide and inclusive to obtain information to inform and guide well-designed interventions. The study sampled representatives from the potential direct beneficiaries; and education, health, and service providers/policy makers.

Focus Group Discussion

There were four (4) Focus Group Discussions in each selected province (2 Non-Geographically Isolated Disadvantage Municipalities and (2 Geographically Isolated Disadvantage Municipalities). Each focus group was comprised of five (5) participants:

- 1st Group: teenage girls without children (ages 13-19 years) (5 participants)
- 2nd Group: teenage boys (ages 13-19 years) (5 participants)
- 3rd Group teenage mothers (ages 13-19 years) (5 participants)
- 4th Group parent of teenage mothers (5 participants)

Due to the exploratory nature of the research, stratified purposive sampling, while trying to incorporate maximum variation and intensity qualitative sampling was used.

Inclusion and Exclusion Criteria

Focus Group Discussants as mentioned previously shall be residing in the study areas for at least 1 year prior to the interview. Moreover, their primary source of healthcare must be the institutions managed by their respective local government units and Department of Health. Consequently, discussants who are seeking medical and healthcare needs from private medical institutions shall be excluded in the conduct of the Focus Group Discussion. Moreover, discussants who are part of any ethnic groups or pregnant women who just migrated in the study sites will be excluded in this study to lessen the impact of cultural variations in the result of the study. Lastly, participants who can't finish the 50% of the Focus Group will be automatically withdrawn in the study.

Key Informant Interview

Five (5) key informants were initially identified in each province which includes the following:

- One key informant from the education sector [teachers, school nurses, guidance counselors]
- One key informant from the health care sector provincial level [midwife, nurse, doctor, BHWs]
- One key informant from the health care sector municipal level [midwife, nurse, doctor, BHWs]
- One key informant from the health care sector regional level [midwife, nurse, doctor, BHWs]
- One key informant from the service sector [barangay officials, city/municipal councilor for health, NGOs]

Inclusion and Exclusion Criteria

Key informants as mentioned previously shall be part of their respective institution for 1 year prior to the interview. Moreover, they must be exposed to different programs and activities related to maternal ang childcare, reproductive health, and other related tasks set by the Department of Health and their respective institutions. Consequently, informants who have different major assignments outside the region will be excluded in the study. Lastly, participants who can't finish the 50% of the interview will be automatically withdrawn in the study.

Cross-sectional Survey

For the quantitative aspect, records from the regional/local PSA offices were used to achieve the sampling frame of deliveries occurring among women between 13- and 19-year-old. An estimated need to recruit 270 women in the survey based on a 5% margin of error, an estimated population of women aged 15-24 years in Eastern Visayas at 97,548 based on YAFS 2013, and a hypothesized frequency of teenage pregnancy at about 8% based on PSA (2018). The sample size also considered an oversampling of 15% to account for non-response and a design effect of two considering stratification based on the province.

Inclusion and Exclusion Criteria

The selected respondents must be residing in the study areas for at least 1 year prior to the interview. Moreover, their primary source of healthcare must be the institutions managed by their respective local government units and Department of Health. Consequently, discussants who are seeking medical and healthcare needs from private medical institutions shall be excluded in the conduct of the Focus Group Discussion. Lastly, discussants who are part of any ethnic groups or pregnant women who just migrated in the study sites will be excluded in this study to lessen the impact of cultural variations in the result of the study.

Research Instruments

The survey conducted is a research-team assisted questionnaire and to generate the information needed, the following research instruments were used:

1. Focus Group Discussion Guide. The instrument served as a guide for the data collectors in conducting the focus group discussion. The guide was made available in English language and native tongue of the respondents.

2. Key Informant Interview Guide. The instrument served as a guide for the data collectors in conducting the key informant interview. The guide was made available in English language and native tongue of the respondents.

3. Survey instrument. The instrument collected data on the demographic characteristics of the randomly selected teenage pregnant women. The data collector conducted the interview using the tool. The abovementioned tool underwent face validation from different technical experts in the fields of allied health and reproductive health. The comments that will be gathered during the validation of the instrument were considered by the proponents. Afterwards, pre-testing was done in Southern Leyte prior to the conduct of the study. A translated questionnaire in the native tongue of the respondents was also available. Please see the research instruments translated in the vernacular of the respondents.

3. 3 Study Setting

Figure 2. Political Map of Study Areas (PSA, 2020)

The study was set in select provinces in Eastern Visayas (Eastern Samar, Northern Samar, Western Samar, and Leyte). The selection of the study setting was based on an increased emphasis on the socio-clinic-demographic characteristics related to adolescent pregnancies in Eastern Visayas, while considering the recent disasters experienced in these places. According to PSA (2018), the prevalence of teenage pregnancy in the region was on the rise. In Eastern Samar province alone, five teenagers get pregnant every day while one in 10 pregnant mothers are aged less than 19 years. In 2019, the Commission on Population and Development in Region 8 revealed that a girl as young as 10 years old was already impregnated. Meanwhile, 247 secondary schools in the region have reported teenage pregnancy cases among students annually, data from the Department of Education show (PNA 2019). Being along the country's eastern seaboard, the region is often visited by natural disasters which impede economic growth. In 2021, the National Economic and Development Authority identified Eastern Visayas as the fifth poorest region in the Philippines – at least 29 in every 100 individuals in the region remain poor (PNA 2017; 2022). Therefore, the determination of the burden of teenage pregnancy, associated factors, and perceptions about teenage pregnancy would be of greater benefit in view of the increasing number of reported young pregnancies, and the currently recovering status in the region.

3.4 Data Collection Plan

Figures 4, 5, 6 provide the data collection plan in each component of the project. Electronic spreadsheets were used to gather data on the prevalence of teenage pregnancy, as well as socio-demographic characteristics of the study participants. Themes were recognized and coded in line along with the research question, and FGD/KII topics, while concepts were ranked according to occurrence in the transcribed recordings.

Prior to the data collection, a letter of request was sent to the Provincial Governor of the identified study site (Northern Samar, Western Samar, Eastern Samar, and Leyte through their respective Provincial Health Officers. Records review was performed to gather data on the prevalence of teenage pregnancy across region and time. Local data collectors also contacted the teenage women who delivered using telephone or house-to-house methods to accomplish the brief survey form. The details of the teenage pregnant women were secured from the Municipal Health Office/ Rural Health Units. Key informant interviews were performed to assess the available services and perceptions about the delivery of these services. A series of focus group discussions was conducted despite the sensitivity of the topic because the research question might be better answered based on the noted group dynamics, norms, and perceptions in relation to their peers. The project also used quantitative and qualitative software for analysis. For the qualitative aspect, the method of analysis offered by Sandelowski (2000) was utilized, and simplified in these six steps:

a) Coding of data from notes, observations, or interviews
b) Recording insights and reflections on the data
c) Sorting through the data to identify similar phrases, patterns, themes, sequences, and important features
d) Looking for commonalities and differences among the data and extracting them for further consideration and analysis
e) Gradually deciding on a small group or generalizations that hold true for the data
f) Examining these generalizations in the light of existing knowledge

Focus Group Discussions

The succeeding discussion provides the details on how the participants will be tracked and/ or gathered. Minimum health standards/ protocols for COVID 19 such as wearing masks, physical distancing and conduct of any interview in a well-ventilated area were maintained.

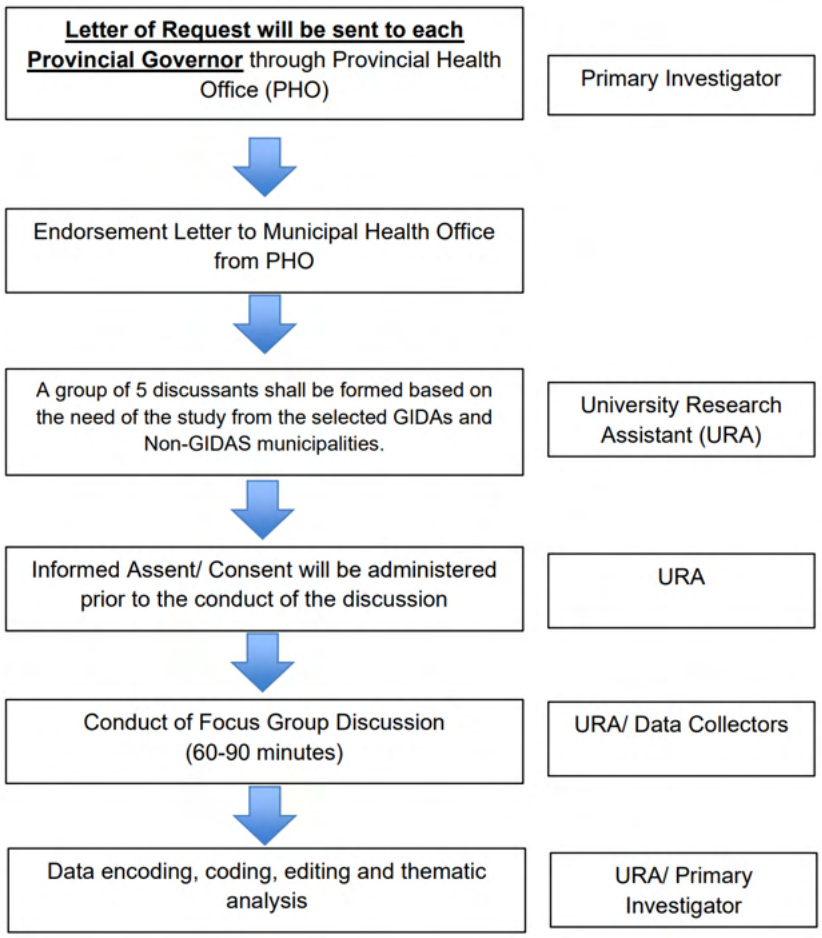

Figure 3. Data Collection Plan (Focus Group Discussion)

Letters were sent to each Provincial Health Office (PHO) prior to the conduct of any data collection. An endorsement letter from the PHO was secured to endorse the research project in the selected municipalities. Signing of informed consent and/ or assent was done prior to any interview and collection of data. There were four (4) Focus Group Discussions in each selected province (2 Non-Geographically Isolated Disadvantage Municipalities and (2 Geographically Isolated Disadvantage Municipalities). Each focus group comprised of five (5) participants including groups of girls without children (ages 13-19 years); groups teenage boys (ages 13-19 years); group teenage mothers (ages 13-19 years); and parent of teenage mothers (5 participants). Focus Group Discussions were moderated by the University Research Assistant with the help of Field Data Collectors.

Key Informant Interview

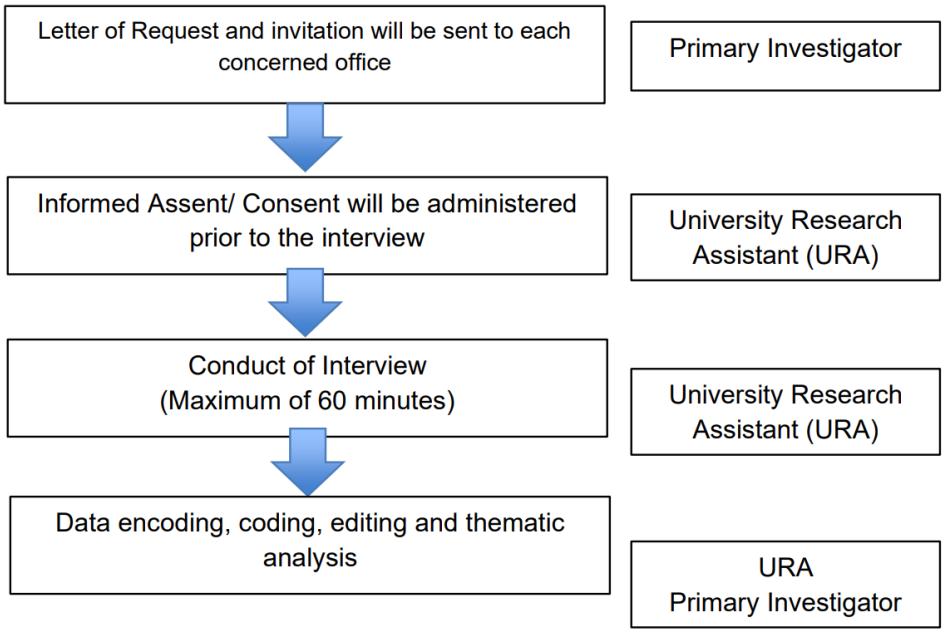

Figure 4. Data Collection Plan (Key Informant Interview)

Five (5) key informants were identified in each province which will comprise different program implementers at different levels from the education sector (e.g., teachers, school nurses, guidance counselors), health care sector representative from the municipal, provincial, and regional level (e.g., midwife, nurse, doctor, city/municipal councilor for health), and from the service sector representatives (barangay officials, NGOs, city/municipal councilor for health). Key Informant Interviews were done by the University Research Assistant with the help of Field Data Collectors.

Cross-sectional survey

The study randomly selected 270 teenage pregnant women to participate in the interview. Prior to data collected Letter of Approval was secured from the Provincial Health Office and Municipal Health Office. Signing of Informed Consent and/ or Assent was done before the interview. The interview was expected to last for about 10 minutes. The survey was done by the University Research Assistant with the help of Field Data Collectors.

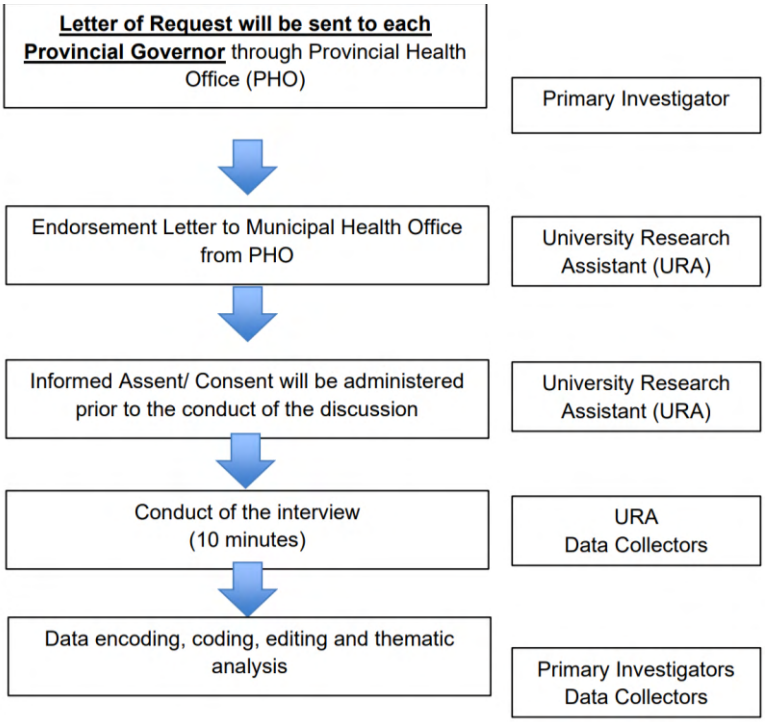

Figure 5. Data Collection Plan (Survey)

3. 5 Data Analysis Plan

The interviews lasted 30–50 minutes. No participants underwent more than one interview, and none withdrew from the study after the interview. Data saturation was reached after interviewing 12 participants. No new information emerged from the three participants who were subsequently interviewed, and we terminated the interviews after repeated information arose from the final three participants.

After analyzing the verbatim data using QDA Miner Lite version 2.0.9 as analytic software, we initially extracted 32 codes from the key informant interviews, which were further abstracted into 24 sub-nodes by rephrasing and combining similar statements (Appendix B). The sub-nodes were further re-classified into twelve nodes (indicated in italics below) and were used to generate the three main themes (indicated in bold) about teenage pregnancy (Table 8). Quotations from the verbatim data are presented in double quotation marks.

The focus group discussions conducted typically lasted between 60–90 minutes. No participants underwent more than one FGD participation, and none withdrew from the study during the conduct of the focus groups. Data saturation was reached after ten focus groups. No new information emerged from the remaining two focus groups subsequently interviewed, and we terminated the discussions after repeated information arose from these focus groups.

The verbatim data were analyzed using the same qualitative analysis software, we initially extracted 33 codes from the focus group discussions, which were further abstracted into 26 sub-nodes by rephrasing and combining similar statements and indicated in italics (Appendix C). The sub-nodes were further re-classified into six theme nodes and four main themes (indicated in bold) about teenage pregnancy from different viewpoints (Table 9). Quotations from the verbatim data are presented in double quotation marks.

3.6 Ethical Considerations

Participants of the study who are teenage pregnant women were included in the list of the groups that need special ethical considerations. Therefore, it is the obligation of the researchers to ensure that the rights and well-being of the study participants are protected, which is why several ethical considerations have been incorporated in the planning and conduct of this study. Moreover, their involvement in the study can be considered low risk without any potential physical effect on their pregnancy, hence their involvement in the conduct of the study was justified.

Considerations with respect to the participants who are minors will strictly adhere to the guidelines set in conducting research, such as confidentiality and anonymity, will be upheld throughout the research process. It was also assured that the conduct of the study caused no harm in their pregnancy and their daily activities. Moreover, the result of this study will be of great help for program planners and implementers for targeting and creation of programs tailored to the needs of this group. Thus, the participation of minors in this study is justified. It is the researcher's responsibility to ensure that the rights and well-being of the study participants were protected; thus, several ethical considerations had been incorporated in the planning and conduct of this research. Considerations with respect to the participants and the guidelines set in conducting research, such as anonymity and confidentiality, will be upheld throughout this research. The respondents' participation will be free from any fees and voluntary; moreover, they will be informed that they could withdraw any time they intended to. The participants were briefed that their identities will be kept confidential, and their answers were used only for academic and research purposes. Attached to the questionnaire was the informed consent explaining the nature and objectives of the study, including its purpose, duration, the risks involved, and their rights as participants. They were informed that they might choose not to answer some of the questions that they will find too sensitive and uncomfortable.

Procedure for Participant Recruitment

A request letter was sent to the Office of Provincial Governor through the Provincial Health Officer of the selected provinces in Eastern Visayas to conduct this study. Upon approval, the researcher sent letters to each selected municipality for endorsement and request to the selected participants. Informed consent was administered prior to the conduct of any interview and data collection. To ensure integrity and justice, the criteria for inclusion and exclusion of participants was itemized before the researcher gathered the data to ensure that there will be no manipulation of participant recruitment to come up with desired results. The researcher clearly described how this research data will be collected, stored, used, disclosed, and outlined how the process conforms to the ethical guidelines. The succeeding discussion will provide details on how the participants will be tracked and/ or gathered. Minimum health standards/ protocols for COVID 19 such as wearing masks, physical distancing and conduct of any interview in a well-ventilated area were maintained.

Key Informant Interviews. Letters were sent to the respective offices of possible key informants from the provincial and municipal level. Inclusion criteria and qualification were identified in the selection of study participants. Interviews were done in the office of the selected key informants.

Focus Group Discussion. There were four (4) Focus Group Discussions in each selected province (2 Non-Geographically Isolated Disadvantage Municipalities and (2 Geographically Isolated Disadvantage Municipalities). Each focus group comprised of five (5) participants:

Table 1. Procedures for Participants Requirement for the Focus Group Discussion

Focus Group	Procedure for Participant Recruitment
1st Group: teenage girls without children (ages 13-19 years) (5 participants)	1. List of possible discussants shall be requested from the selected barangay through the Barangay Captain and Barangay Health Workers. 2. The participants will be invited to participate in the conduct of the focus group discussion with the waiver and informed assent from their parents since study participants are minors. The researchers
2nd Group: teenage boys (ages 13-19 years) (5 participants)	
3rd Group teenage mothers (ages 13-19 years) (5 participants)	

	shall explain the rights of the respondents with other important details of the research. 3. Focus Group Discussion will be done in their respective Barangay Health Stations in a well-ventilated but private area/ room. 4. Briefing/ Orientation shall be done prior to the conduct of the activity. They will be ensured that they are free not to answer any question that they are not comfortable. Moreover, they will be also secured that their answers will be kept confidential, anonymize, and private. 5. After the Focus Group Discussion, a debriefing activity shall be done by the researchers. This will aim to clarify their impressions of emotional themes and common attributes of any discriminative experiences. Participants will be ensured that their answers will be kept confidential at all times and their identity will be anonymized.
4th Group parent of teenage mothers (5 participants)	1. List of possible discussants shall be requested from the selected barangay through the Barangay Captain and Barangay Health Workers. 2. The participants will be invited to participate in the conduct of the focus group discussion. Informed consent will be secured prior to the conduct of the Focus Group Discussion. 3. Focus Group Discussion will be done in their respective Barangay Health Stations in a well-ventilated but private area/ room. 4. Briefing/ Orientation shall be done prior to the conduct of the activity. They will be ensured that they are free not to answer any

	question that they are not comfortable. Moreover, they will be also secured that their answers will be kept confidential, anonymize, and private. 5. After the Focus Group Discussion, a debriefing activity shall be done by the researchers. This will aim to clarify their impressions of emotional themes and common attributes of any discriminative experiences. Participants will be ensured that their answers will be kept confidential at all times and their identity will be anonymized.

Cross-sectional Survey

The study also randomly selected 276 teenage pregnant women to participate in the interview. Prior to data collection, Letter of Approval was secured from the Provincial Health Office and Municipal Health Office. List of teenage pregnant women was secured from the selected municipalities through their respective Municipal Health Office. From the list of teenage pregnant women, study participants were selected through simple random sampling. The selected study participants were provided with the research instrument (survey form) in their respective households through barangay informants from their respective barangays (Barangay Health Workers and/ or Barangay Nutrition Scholars). The participants were invited to participate in the conduct of the focus group discussion with the waiver and informed assent from their parents since study participants were minors. The researchers explained the rights of the respondents with other important details of the research. After the signing of informed consent, a self-administered survey was given to the respondents for them to answer the questionnaire. Upon collection of the answered questionnaires, participants were ensured that their answers will be always kept confidential, and their identity will be anonymized.

3.7 Procedure for Obtaining Informed Consent

Key Informant Interviews and Focus Group Discussions

Respondents of the study were provided with an informed consent and/ or assent form written in English and native tongue of study participants. Moreover, the statement of assent was given to study participants written in the native tongue who are below 18 years old during the conduct of the study. The informed consent and assent explained the nature of the study, its objectives, benefits and risks, rights of the respondents, and duration of the data collection procedure. The research assistants had the responsibility to clearly explain the details of the research study before conducting any phase.

Cross-sectional Survey

Respondents of the study were provided with an informed consent form written in English and native tongue of study participants. Moreover, the statement of assent was given to study participants written in the native tongue who are below 18 years old during the conduct of the study. The research assistants had the responsibility to clearly explain the details of the research study before conducting any phase. The following procedures were employed to obtain the informed consent:

1. The research assistants explained the details of the study, including their responsibilities as study participants. Moreover, participants were informed of their rights, including their right to refuse and withdraw during the conduct of the study.
2. The research assistants and field collectors used a standard introductory script to explain the purpose and objective of the study written at the start of the informed consent. This ensured that the objectives were explained clearly to participants.
3. Details of the study were comprehensively discussed with the study participants, and any clarifications were entertained before the conduct of this study. The participants were also assured that their rights, including the confidentiality of the information they share and their anonymity, will be upheld.
4. A printed document was provided to fill out the necessary information of the study participants and affix their signature to the statement of consent.
5. The signed Informed Consent was sent to the Primary Investigator before conducting any interview. The signed informed consent was stored in a folder with a password.

Procedures for Ensuring Confidentiality and Anonymity

The researcher used code numbers or pseudonyms during data analysis. These data were stored in the researcher's personal computer and were locked with a password. The information obtained remains confidential, and no one else except the primary investigator and research team had access to the information gathered. Information was deleted after the completion of the study, which took approximately 5 to 6 months. A summary of the result of this study was provided to the involved study participant and with their respective municipality and province. After the validation and finalization of the results, this research will be published in a reputable journal so that the community may learn from it.

Lastly, pictures or videos taken during the proceedings served as proof of documentation during the data collection that remained confidential and private throughout the research process and were only used for academic and research purposes. No one had access to pictures or videos gathered in this study except for the primary investigator. The documentation and recording of pictures and videos were written in the informed consent that they voluntarily allow the data collectors to take some photos and videos during the data collection procedure.

Data Handling and Storage

The collected data were stored in the primary investigator's laptop and kept under password-protected folders. Hard copies containing information from the study participants were kept in a safety box with lock. After the data has been encoded, edited, and analyzed, hard copies of the research instrument were destroyed using paper/ document shredder. Data encryption was performed when sending information over the internet. After data analysis, records, raw data, and semi-processed data collected from this study were deleted. All information that might contain important information or identity was deleted immediately.

Participants were assured that based on the Data Privacy Act of 2012; they can access their personal data at any time they ask. They also have the right to ask to delete the data if they found any erroneous entry or deemed to withdraw from the study and ask for alteration of their data if they find any erroneous entry.

Duration of Participation

The Focus Group Discussions and Key Informant Interviews lasted for 90 to 120 minutes, respectively. The signing of informed consent was done prior to each interview, and the signed consent form was scanned and forwarded to the email of the primary investigator for document filing. Meanwhile, the survey only lasted for 20-30 minutes from the signing of informed consent until the end.

Community Considerations

This research provided the community the data on the current issues and concerns of teenage pregnancy in the study areas. Moreover, the result of the study can provide an in-depth analysis of the problematic issues of teenage pregnancies that can be useful to policy makers, program planners, and implementers.

Teenage pregnant women who need medical attention/ support were endorsed to the Municipal Health Officer and/ or Municipal Social Welfare Development Officer for regular monitoring and follow- up.

The result of this study will be presented among stakeholders in the province and in the region to provide an in-depth analysis of the situation using the data being collected in the conduct of this study. A letter will be sent to the Regional Health Officer, Provincial Governor through their respective Provincial Health Officer for the researcher to present the result of this study. Lastly, it served as an avenue for the provincial leaders and stakeholders to include possible intervention and programs aiming to reduce the burden of teenage pregnancy in the study area.

Dissemination Plan

Aside from the previously mentioned activities including stakeholders' meeting in the region and selected provinces, the results of this study will be presented and communicated in research conferences and forums. Moreover, the result of the study will be published in a peer-reviewed journal to ensure that the results of the current study will reach the scientific community and relevant stakeholders.

Risk and Benefits

This study caused minimal distraction from the daily activities of the study participants. Hence, a request letter will be sent to the Provincial Health Office to excuse the participants to perform their duties and responsibilities during the key informant interviews and focus group discussion. Meanwhile, the respondent had the right to skip any sessions, and they can terminate their participation anytime without any indemnification. Lastly, the risk of invasion of the respondents' privacy was addressed by anonymizing and coding to ensure that data collected was always treated with the utmost confidentiality.

Respondents did not receive any remuneration for participating in the study. However, those participants who participated in the Key Informant Interviews and Focus Group Discussions received a transportation allowance amounting to PHP. 400.00 provided after the interview. Moreover, a snack or a token amounting to PHP. 200.00 was provided to the study participants selected in the survey.

Conflict of Interest

The researchers declare no known conflict of interest in the conduct of this study. Meanwhile, the protocol of this study was approved by the UP-Manila Research Ethics Board. Therefore, they can directly access the study participants' records to verify research procedures. The said committee was also responsible for monitoring and keeping track of this research as an ethical approving body of this study.

IV. RESULTS

A total of 296 teenage pregnant women participated in the study coming from four provinces in Eastern Visayas. Details of community characteristics and study sites are presented in Table 2.

Demographic Characteristics of the Teenage Mothers in Eastern Visayas

Table 2. Distribution of Community Characteristics and Ages across Study Sites

Characteristics	Northern Samar	Eastern Samar	Western Samar	Leyte	p-value
Respondents (%)	28 (9.5%)	95 (32.1%)	101 (34.1%)	72 (24.3%)	-
Age during First Pregnancy					
12 – 14 years old	-	3 (3.2%)	2 (2%)	5 (6.9%)	0.32
15 – 19 years old	28 (100%)	92 (96.8%)	99 (98%)	67 (93.1%)	
Age at First Intercourse					
12 – 14 years old	-	9 (9.5%)	10 (9.9%)	5 (6.9%)	0.56
15 – 17 years old	20 (71.4%)	56 (59%)	58 (57.4%)	39 (54.2%)	
18 – 19 years old	8 (28.6%)	30 (31.6%)	33 (32.7%)	28 (38.9%)	
Type of Community					
Non-GIDA	28 (100%)	43 (45.3%)	37 (36.6%)	72 (100%)	<0.01*
GIDA	-	52 (54.7%)	64 (63.4%)	-	

It was observed that there was no notable difference in the respondents' age during first pregnancy. It can be noted that there were no respondents from GIDA communities in Northern Samar and Leyte. This can be attributed to the difficulty of accessing and locating the target population, and issues of safety for the data collectors in these communities.

The researchers compensated by increasing the proportion of GIDA respondents in more accessible communities under an assumption that norms and characteristics are similar across provinces in the Eastern Visayas region. This can be supported by the similarity in the age during first pregnancy and age at first intercourse across the provinces.

Table 3. Fertility Characteristics of the Sample Population

Characteristics	Overall	Non-GIDA	GIDA	p-value
Respondents (%)	296 (100%)	180 (60.8%)	116 (39.2%)	-
Current Age of the Respondent				
15 – 19 years old	129 (43.6%)	89 (49.4%)	40 (34.5%)	0.01*
20 – 25 years old	167 (56.4%)	91 (50.6%)	76 (65.5%)	
Age during First Pregnancy				
12 – 14 years old	10 (3.4%)	8 (4.4%)	2 (1.7%)	0.21
15 – 19 years old	286 (96.6%)	172 (95.6%)	114 (98.3%)	
Marital Status during Pregnancy				
Single with partner	262 (88.5%)	164 (91.1%)	98 (84.5%)	<0.01*
Single without partner	22 (7.4%)	16 (8.9%)	6 (5.2%)	
Married	12 (4%)	-	12 (10.3%)	
Current Marital Status				
Single with partner	258 (87.2%)	161 (89.4%)	97 (83.6%)	0.02*
Single without partner	21 (7.1%)	14 (7.8%)	7 (6%)	
Married	17 (5.7%)	5 (2.8%)	12 (10.3%)	
Current Age of the Respondent's Partner	24.92 ± 5.30	24.74 ± 5.46	25.21 ± 5.03	0.46
Age Difference in years				
At least five years	111 (39.8%)	66 (38.4%)	45 (42.1%)	0.54
At least 10 years	31 (11.1%)	24 (14%)	7 (6.5%)	0.06
Current Educational Attainment				
Elementary	41 (13.9%)	23 (12.8%)	18 (15.5%)	0.69
Secondary	237 (80.1%)	147 (81.7%)	90 (77.6%)	
College	18 (6.1%)	10 (5.6%)	8 (6.9%)	
Number of sexual partners	1 (1 to 5)	1 (1 to 5)	1 (1 to 3)	0.08
Age at First Intercourse				
12 – 14 years old	24 (8.1%)	13 (7.2%)	11 (9.5%)	0.49
15 – 17 years old	173 (58.5%)	110 (61.1%)	63 (54.3%)	
18 – 19 years old	99 (33.5%)	57 (31.7%)	42 (36.2%)	
Number of pregnancies	1 (1 to 5)	1 (1 to 5)	1 (1 to 3)	0.30
Currently pregnant	16 (5.4%)	7 (3.9%)	9 (7.8%)	0.15
Number of live births	1 (0 to 5)	1 (0 to 5)	1 (0 to 3)	0.97
History of preterm labor	29 (9%)	13 (7.2%)	16 (13.8%)	0.06
Inter-pregnancy interval in years	2 (1 to 7)	2 (1 to 3)	2 (1 to 7)	0.09
Family planning method				
None	175 (59.1%)	95 (52.8%)	80 (69%)	<0.01*
Yes	121 (40.9%)	85 (47.2%)	36 (31%)	
Oral contraceptive pills	57 (47.1%)	35 (41.2%)	22 (61.1%)	0.12
Condom	-	-	-	

Intrauterine device	7 (5.8%)	4 (4.7%)	3 (8.3%)
Implant	42 (34.7%)	34 (40%)	8 (22.2%)
Injectable	15 (12.4%)	12 (14.1%)	3 (8.3%)

Among the 296 teenage pregnant women surveyed, a higher proportion (60.8%) of them came from non-GIDA communities. More than half (56.4%) of the study participants were currently 20 to 25 years old. On their first pregnancy, nearly all (96.6%) of them were aged 15-19 years. During pregnancy, most (88.5%) of the participants reported that they were single with partners. Presently, the respondents who were “single with partners” slightly reduced to 87.2% but the proportion of married participants have risen to 5.7% compared to 4% at the time of their pregnancies. A higher proportion (39.8%) of the study participants have partners whose age difference is at least five years. Most (80.1%) of the women surveyed were in secondary schools. Meanwhile, more than half (58.5%) of the respondents reported that they were aged 15-17 years at their first intercourse. More women from GIDA communities were currently pregnant (7.8%) and had a history of preterm labor (13.8%). Furthermore, more than half (59.1%) of the study participants do not utilize family planning methods. When aggregated according to study area, more (69%) respondents from GIDA communities were not using family planning methods as compared to their counterparts ($p<0.01$). Among the five listed family planning methods, oral contraceptives pills emerged as the most used (47.1%) method overall. However, a larger proportion (61.1%) of study participants from geographically challenging areas utilize OCPs.

Table 4. Socio-Demographic Characteristics of the Sample Population

Characteristics	Overall	Non-GIDA	GIDA	p-value
Respondents (%)	296 (100%)	180 (60.8%)	116 (39.2%)	-
Educational Level of Woman’s Mother				
Elementary	182 (61.5%)	94 (52.2%)	88 (75.9%)	<0.01*
Secondary	97 (32.8%)	70 (38.9%)	27 (23.3%)	
College	17 (5.7%)	16 (8.9%)	1 (0.9%)	
Educational Level of Woman’s Father				
Elementary	201 (67.9%)	108 (60%)	93 (80.2%)	<0.01*
Secondary	79 (26.7%)	60 (33.3%)	19 (16.4%)	
College	16 (5.4%)	12 (6.7%)	4 (3.5%)	
Educational Level of Woman’s Partner				
Elementary	106 (35.8%)	57 (31.7%)	49 (42.2%)	0.09
Secondary	161 (54.4%)	107 (59.4%)	54 (46.6%)	
College	29 (9.8%)	16 (8.9%)	13 (11.2%)	
Employment Status of Woman’s Father during Pregnancy				
Employed, regular	41 (13.9%)	31 (17.2%)	10 (8.6%)	<0.01*
Employed, part-time	106 (35.8%)	61 (33.9%)	45 (38.8%)	
Self-employed	67 (22.6%)	31 (17.2%)	36 (31%)	

Not employed	67 (22.6%)	48 (26.7%)	19 (16.4%)	
NA	15 (5.1%)	9 (5%)	6 (5.2%)	
Employment Status of Woman's Mother during Pregnancy				
Employed, regular	28 (9.5%)	19 (10.6%)	9 (7.8%)	
Employed, part-time	63 (21.3%)	40 (22.2%)	23 (19.8%)	
Self-employed	29 (9.8%)	18 (10%)	11 (9.5%)	0.61
Not employed	164 (55.4%)	98 (54.4%)	66 (56.9%)	
NA	12 (4.1%)	5 (2.8%)	7 (6%)	
Current Employment Status of Woman's Partner				
Employed, regular	32 (10.8%)	25 (13.9%)	7 (6%)	0.03*
Employed, part-time	158 (53.4%)	99 (55%)	59 (50.9%)	
Self-employed	36 (12.2%)	16 (8.9%)	20 (17.2%)	
Not employed	70 (23.7%)	40 (22.2%)	30 (25.9%)	
Current Employment Status of the Respondent				
Employed, regular	6 (2%)	3 (1.7%)	3 (2.6%)	0.96
Employed, part-time	21 (7.1%)	13 (7.2%)	8 (6.9%)	
Self-employed	8 (2.7%)	5 (2.8%)	3 (2.6%)	
Not employed	261 (88.2%)	159 (88.3%)	102 (87.9%)	
Type of Family				
Nuclear family	142 (48%)	85 (47.2%)	57 (49.1%)	0.02*
Single parent family	8 (2.7%)	7 (3.9%)	1 (0.9%)	
Extended family	130 (43.9%)	73 (40.6%)	57 (49.1%)	
Grandparent family	13 (4.4%)	12 (6.7%)	1 (0.9%)	
Stepfamily	3 (1%)	3 (1.7%)	-	
Household Monthly Income (PHP)				
<10,000	272 (91.9%)	165 (91.7%)	107 (92.2%)	0.42
10,000 to 20,000	23 (7.8%)	15 (8.3%)	8 (6.9%)	
21,000 to 30,000	1 (0.3%)	-	1 (0.9%)	
Household Size				
Small (<5)	155 (52.4%)	90 (50%)	65 (56%)	0.19
Medium (5-6)	46 (15.5%)	31 (17.2%)	15 (12.9%)	
Medium-Large (7–9)	63 (21.3%)	35 (19.4%)	28 (24.1%)	
Large families (≥10)	32 (10.8%)	24 (13.3%)	8 (6.9%)	
Number of Bedrooms				
None - Single room	215 (72.6%)	122 (67.8%)	93 (80.2%)	0.06
2-3 rooms	73 (24.7%)	52 (28.9%)	21 (18.1%)	
3-5 rooms	8 (2.7%)	6 (3.3%)	2 (1.7%)	

As reflected in Table 4, most (61.5%) of the mothers of study participants were elementary graduates. However, when aggregated according to study area, mothers of study participants from GIDA communities tend to have lower educational attainment since the majority (75.9%) of them finished elementary school compared to their counterparts ($p<0.01$). Similarly, most (67.9%) of the respondents' fathers were elementary graduates, the higher proportion (80.2%) of them also came from GIDA barangays. Meanwhile, more than half

(54.4%) of the study participants' partners received secondary education. In general, a higher educational level among the respondents' parents and partners in non-GIDA communities was observed. During the pregnancy of the study participants, most (35.8%) of their fathers were employed in a part-time occupation while more than half (55.4%) of respondents' mothers had no job. The majority (53.4%) of the study participants' partners were currently employed part-time but the results also showed that nearly one in four (23.7%) of them were jobless at present. Relative to community type, a higher proportion of the women's partners from non-GIDA communities were employed – either regular or part-time – which can be attributed to the higher probability of jobs in non-isolated communities. Meanwhile, most (88.2%) of the respondents themselves were presently unemployed. A higher proportion (48%) of the study participants live in a nuclear family setting, closely followed by the extended family type (43.9%). Most (91.9%) of the respondents reported that they live in a household whose income falls below PHP 10,000 a month. In terms of household size, more than half (52.4%) of the study participants live in small families with less than five members. In both community settings, the majority (72.6%) of the respondents live in houses with a single bedroom or no bedroom at all.

Table 5. Comparison of Early Pregnancy and Motherhood Characteristics with Background Characteristics

	Gravidity and Parity			***Coitarche***		
Background Characteristics	*Had a live birth*	*First-time pregnant*	*Begun Childbearing*	*<15 years*	*<18 years*	*18-19 years*
Age in years						
15 - 19	44.8	59.4	47.3	86.4	59.3	15.7
20 - 24	55.3	40.6	52.8	13.6	40.7	84.3
Residence						
Non-GIDA	62.1	62.4	60.8	54.2	63.6	57.6
GIDA	37.9	37.6	39.2	45.8	36.4	42.4
Educational Attainment						
Elementary	14.3	7.8	13.9	20.8	17.9	5.1
Secondary	79.3	86.3	80.1	79.2	79.8	80.8
College	6.4	5.9	6.1	-	2.3	14.1
Household Monthly Income						
<10,000	92.1	92.2	91.9	95.8	91.3	91.9
10,000 to 20,000	7.5	7.3	7.8	4.2	8.7	7.1
21,000 to 30,000	0.4	0.5	0.3	-	-	1.0

In terms of age, more study participants from the 20-24 years age bracket had a live birth (55.3%) and had begun childbearing (52.8%). Meanwhile, more (59.4%) respondents aged

15-19 years reported that they were first-time pregnant. More study participants living in non-GIDA communities reported that they had a live birth (62.1%), were first-time pregnant (62.4%), and had begun childbearing (60.8%), compared to their rural counterparts. The majority of the respondents who attained secondary education had a live birth (79.3%), were first-time pregnant (86.3%), and had begun childbearing (80.1%). Finally, study participants who had a live birth (92.1%), were first-time pregnant (92.2%), and had begun childbearing (91.9%) belong to households whose monthly income falls below PHP 10,000. There was no notable association found between the first sexual intercourse characteristics and the background characteristics of the respondents.

Exploration of Teenage Pregnancy as a Problem from the Lens of Key Informants

To provide an in-depth understanding of what has been done in the study area, program planners and implementers were invited to participate in an interview. Most of the key informants were female and mainly coming from the health department. Almost half of the respondents were employed between 1-5 years. Equal representations of key informants were observed across the four provinces of Eastern Visayas. Details were shown in Table 7.

Table 7. Demographic characteristics of recruited participants in the conducted Key Informant Interviews in Eastern Visayas

Characteristics	**n=**15 n(%)
Sex	
Male	3 (20)
Female	12 (80)
Province	
Leyte	4 (27)
Samar	2 (13)
Eastern Samar	4 (27)
Northern Samar	5 (33)
Institutions	
Barangay Hall	3 (20)
Municipal/ Provincial Health Office	7 (47)
DepEd Division Office	1 (7)
High School	3 (20)
Church	1 (7)
Years in Service	
1-5 years	8 (53)
6-10 years	1 (7)
11-15 years	1 (7)
16-20 years	2 (13)
21 years above	3 (20)

Key Informant Interviews (KII)

Based on the interviews, perceived predisposing factors and muti-sectoral service delivery concerns were considered as contributing to teenage pregnancy as a problem. Likewise, the interviews further mentioned the consequences of teenage pregnancy that further compound its role as a multi-sectoral problem.

Table 8. Identified Themes and Codes from the Key Informant Interviews

Main Themes	Sub-Themes (Codes)
Perceived Predisposing Factors	1. Teenage Pregnancy Cases as External 2. Parental Influence 3. Variation between Boys and Girls 4. Technological Influence
Multi-sectoral Responsibility	5. Importance of SRH Education 6. Structural Needs of Facilities 7. Unclear Policies and Guidelines
Consequences of Teenage Pregnancy	8. Spousal Abuse 9. Societal Implications 10. Impact on Parents of Teenage Pregnancy Cases 11. Continuing Schooling after Teenage Pregnancy 12. Access to Contraception

For the **perceived predisposing factors**, statements like “because in our communities, you will seldom find a case [of teenage pregnancy] like that. If there are those cases, they were not originally from here” (KIID 14, Male, 19 years as church pastor), and “Maybe they have seen or heard of cases [of teenage pregnancy], and they [referring to DOH and LGUs] consider that as preparation for the known trend of increasing teenage pregnancy. But, if you look at the teenage pregnancy data [in our community], it is just seldom, a few isolated cases only” (KIID 12, Female, 21 years in the health sector) was explained as service/health/religious sectors of the community view cases of *teenage pregnancy as external* or outside the influences of their scope.

Statements like “because I feel like there are mothers, parents, who are also lacking so, there are those [parents] who can discipline and also those who cannot” (KIID 13, Female, 3 years in the service sector); “although we all have our own decisions, for me, if only the family has been molded properly…these issues [teenage pregnancy] could have been avoided" (KIID 10, Male, 1 year in the service sector), and "our victims [of teenage pregnancy] really are the poor, with the parents having no proper education so they just tolerate their kids' actions like staying outside [their homes] and not focusing on studying anymore” (KIID 8, Female, 27 years in the health sector) were interpreted as *parental influence* contributing to teenage pregnancy.

The phrase *variation between boys and girls* was extracted from “There is a difference between the motivation of boys and girls to engage in sex early. Girls tend to be easily attached and more emotional in giving what their partner wants, while boys are just kind of curious and merely interested in exploring” (KIID 11, Female, 4 years in the education sector).

Technological influence and its perceived effect on early sexual intercourse was derived from statements such as “the curiosity of boys might be influenced by their reports of watching porn with their friends - and eventually try to imitate what they see carelessly" (KIID 15, Female, 9 years in the education sector), " the influence of social media because even if they live in remote areas, their phones already have access to social media allowing them to see how people their age already engage in relationships" (KIID 11, Female, 4 years in the education sector), and "they [teenagers] are easily influenced with new technology, it is already possible for them to easily communicate about where they can meet or share and believe ideas expressed by other people in social media” (KIID 10, Male, 1 year in the service sector).

For the theme **multi-sectoral responsibility**, "[sexual and reproductive] health education must really be done first, even in elementary it should have already been started, so that at least their minds are open about that [such topics]...when they come here, they already have awareness and we can continue the health education from there [elementary]" (KIID 8, Female, 27 years in the service sector), "there are adolescent mothers waiting for prenatal [check-up] in one of our centers, and they have not been adequately advised or lack information about family planning and similar topics" (KIID 3, Female, 5 years in the health sector), and "training or learning activities are needed for teenagers to become involved and understand the impact and how to avoid teenage pregnancy" (KIID 11, Female, 4 years in the education sector) were interpreted as the key informants having an idea of the *importance of sexual and reproductive health education*.

The sub-theme *structural needs of facilities* were derived from raised concerns of the key informants such as: "we [key informants] are trying to reach a Level 1 Adolescent Friendly facility however we [local health unit personnel] are still lacking trainings. It is only when we reach it [Level 1] where you will see concrete support and funding for programs targeting adolescents" (KIID 12, Female, 21 years in the health sector), "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" (KIID 8, Female, 27 years in the health sector), "[the LHU] does not withhold [contraceptives] because they don’t like to give out among adolescents but because we do not have supplies" (KIID 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" (KIID 12, Female, 21 years in the health sector), and "maybe that problem [teenage pregnancy] is being overlooked because of a really big problem already [COVID pandemic]" (KIID 9, Female, 22 years in the health sector).

In addition, the key informants underscored the resulting hesitancy among teenagers to reach out and inquire about sexual and reproductive health topics due to lack of preparedness among personnel as exemplified by the statement: "especially if the person handling the program [SRH education], is not that trained on how to handle these adolescents. In handling them, it's very sensitive for them, so if the person [they are talking to] is too strict or does not appear to be comfortable - they would not come to us. So, we really need to be groomed for this [adolescent targeted programs]" (KIID 5, Male, 3 years in the health sector as supervisor).

Another facet of this theme is *unclear policies and guidelines* as supported by statements such as "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)" (KIID 12, Female, 21 years in the health sector), and "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" (KIID 4, Female, 13 years in the education sector).

In line with this, concerns on the *access to contraception* among teenagers were raised by the key informants. One informant stated: "if you're not yet of legal age, there must be consent from your parents or guardian. But the said policy is one hindrance in the family planning program for our teenagers because even if they want to use, they still need to ask for their mother's or their guardian's signature and it is a problem since sometimes they refuse to give consent" (KIID 8, Female, 27 years in the health sector).

There are also no explicit repercussions to government employees who refuse to offer such services despite the RH Bill stating that everyone should have access to such services. There have been a significant number of key informants who set limits to the delivery of SRH education, as evidenced by statements like: "we only give it [contraceptives] out to married couples, we don't give it to those who have no partners since we can identify who are the married from the single ones, unless they have irregular menstruation" (KIID 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" (KIID 14, Male, 19 years as church pastor), and "they [teenagers] will be more complacent since they won't get pregnant and they will not be careful anymore [in avoiding sexual intercourse] because there is contraceptive already" (KIID 7, Female, 4 years in the health & education sector).

Moreover, the key informants also mentioned that the lack of specific guidelines or policies on adolescent sexual and reproductive health education resulted to overlapping and confusion about which agency will handle a situation, and which is not part of their scope of responsibility.

For the theme **consequences of teenage pregnancy**, the issues of *contraceptive use and access* among cases yet do not have parental consent or are not yet married has been mentioned in the previous section but an important consequence to already identified cases of teenage pregnancy. The lack of specific guidelines and structures to support these teenagers to *continue their education* has also been mentioned in the previous section but in this sub-theme statements such as: "we need to make them [teenage pregnancy cases] are still welcome to school, and there is no hindrance to continue with their studies...there is a need to support them and protect them from discrimination coming from their schoolmates" (KIID 11, Female, 4 years in the education sector), and "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" (KIID 8, Female, 27 years in the health sector).

Other areas needing support from the different agencies and sectors to address not only the risk factors for teenage pregnancy cases but also address its consequences were mentioned by the key informants. The *impact on the parents* was based on the statement such as "not just them [teenage pregnancy cases] but sometimes other family members as well. Because the parents, when they already discover what happened to their child, it is also difficult for them - like when other people see their child as pregnant and get talked about" (KIID 13, Female, 3 years in the service sector). The focus group discussions also made mention of the need to provide support to parents of these teenage pregnancy cases.

Statements such as "if everyone [teenage girls] will get pregnant early, you can imagine their kind of future, the dreams of their parents for them, and it seems that it will not be as successful" (KIID 8, Female, 27 years in the health sector), or a contentious statement such as "in the part of the woman...the life is destroyed or changed because of that [teenage pregnancy], better if she will find a good man but it is not always the case" (KIID 14, Male, 19 years in the religious sector) can be interpreted as *societal implications* of teenage pregnancy. Furthermore, statements such as "they [teenage pregnancy couples] are already living together but are not legally married and I pity them, and they remain hesitant even if I am helping them to get married, those who already have three or four kids, yet they still haven't been married" (KIID 6, Female, 3 years in the service sector), and "if they get pregnant at the age when they must not be pregnant yet, they can be outcasted or treated differently by their peers and it's really embarrassing for them" (KIID 3, Female, 5 years in the health sector) reinforce the ideals or expectations that compound the problem of teenage pregnancy among the men and women involved in the circumstances.

Another not commonly discussed consequence of teenage pregnancy would be the occurrence of *spousal abuse* among these adolescents. This was supported by statements such as "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" (KIID 3, Female, 5 years in the health sector), "they [teenage pregnancy cases] might become victims of violence since these couples tend to fight more due lack of enough or loss of income to sustain their needs" (KIID 7, Female, 4 years in the health & education sector), and "there was a case of one teenager who was pregnant, and was locked up and beaten by her partner - but no complaint was done since the process of complaining takes a long time - and they do not have a choice but settle for him" (KIID 1, Female, 1 year as health sector supervisor).

In-depth exploration on the existing issues of concern among different groups towards the implementation of Reproductive Health programs and initiatives

Table 8 summarizes the demographic characteristics of the respondents recruited for the focus group discussion. It was observed that all groups were represented across the four provinces except for teenage girls and parents with a pregnant child because the collected data easily achieved its desired saturation. It was also noted that most of the discussants were high school graduates and unemployed at the time of data collection.

Table 8. Demographic characteristics of recruited participants in the conducted Focus Group Discussion in Eastern Visayas

Characteristics	Groups			
	Teenage Boys n=23	**Teenage Girls n=17**	**Teenage Mothers n= 21**	**Guardian/Parents of Teenage Parents n=14**
Province				
Leyte	5	-	6	-
Samar	5	5	5	5
Eastern Samar	8	5	6	5
Northern Samar	5	7	4	4
Age				
13-19	23	17	15	-
20-25	-	-	6	-
26 above	-	-	-	14
Educational attainment				
Elementary Level	-	-	3	6
Elementary Graduate	-	-	-	1
High School Level	18	16	2	-
Senior High School Level	5	1	11	3
High School Graduate	-	-	-	-
College Level	-	-	5	3
Vocational Graduate				

College Graduate	-	-	-	1
	-	-	-	-
Marital Status				
Single, with partner	-	-	16	2
Single, without partner	23	17	5	-
Married	-	-	-	11
Separated	-	-	-	1
Employment				
Employed, part time	-	-	-	2
Self-employed	-	-	-	1
Not employed	23	17	21	11

Based on the discussions, response to the situations, perceptions of risk factors and consequences, and perceptions or previous experience with services interplay to create the experience and concerns with teenage pregnancy. Like the conducted key informant interviews, the perspectives of stakeholders (i.e., teenage pregnant women and their parents; teenage boys and girls) suggest that teenage pregnancy is indeed a multi-sectoral problem.

Table 9. Identified Themes and Codes from the Focus Group Discussions

Main Themes	Sub-Themes (Codes)	
Immediate Feelings	1.	Being Lied To
	2.	Frustrated
	3.	Derailed Plans
Coping Responses	4.	Setting Negative Feelings Aside
	5.	Fear of Further Harm
	6.	Handling Marital Issues
	7.	Learning from the Incident
Community Perceptions	8.	Parental Shortcomings
	9.	Family Background
	10.	Technology
	11.	Friends/Peer Pressure
	12.	Invincibility
	13.	Consequences to Cases
Perception of Community Services		
Facilitators of Access to Services	14.	Sex Education
	15.	Supportive Family
Barriers of Access to Services	16.	Inadequate Supplies/Information
	17.	Approach of the Public Servants
	18.	Religious Influence
	19.	Irregular or Infrequent Activities
	20.	Lack of Tailored Activities
Limitations to Current Services	21.	Economic Support
	22.	Unclear School Policies
	23.	Lenience from Teachers
	24.	Counselling and Mental Health
	25.	Dissemination of Services
	26.	Parenting Support

For the **immediate feelings**, it focused on the response and reaction of the teenage pregnancy case and their families. The statement "…when my daughter got pregnant at 15, it

broke my heart so much because she lied to me. I do not know what she was thinking when she did those things. I allowed her to skip household chores because she told me that she will be working on a project even during weekends so that she can focus on her studies, and yet she still did these things." [ID 61, 42 years old, mother of a teenage parent], and "…I told her that she should learn from my experience that marrying early is a very hard situation. I reminded her to take care, just care of herself, and I was assured that she listed to me, but this still happened to them." [ID 19, 56 years, mother of a teenage parent] exemplified feelings of *being betrayed or lied to*, and *frustration* particularly among parents of a teenage pregnancy case.

Statements from both teenage parents and mothers of teenage parents reported feelings of life *plans being derailed* due to the pregnancy. These statements included "...I don't have a job, but I do every household chore and make sure that I am able to take very good care of the things they need. But, when she told me of the situation, I felt bad, I felt that I did everything to take care of them, but it still happened. I don't know what to think or do about our plans for my daughter to finish school and have a job with better salary" [ID 37, 39 years, mother of a teenage parent], and "...around the time my mother found out that my sister got pregnant, she cried and told her that she was the only hope of the family to have a better future, since she will help them in financing for my studies too. My parents got around to it later since there is nothing, we can do about it. The partner was very kind to my sister and made amends for what happened. My parents just keep on reminding them that they should not get pregnant anytime soon, but initially, they were very sad about the situation" [ID 50, 15 years old, teenage boys].

After the instantaneous reaction from the families, **coping responses** tend to take over given the teenage pregnancy must be prioritized. The statement: "…when I found out about the pregnancy, I initially got angry but, in the end, there is nothing to do about it anymore. It's better now since she decided to continue her studies, and she listens to our advice more frequently which is how my anger decreased" [ID 60, 41 years old, mother of a teenage parent] exemplifies how parents of these cases tend to *set negative feelings aside* to focus on the situation and *prevent further harm* especially on the pregnant adolescent. The latter is supported by the statement: "…we were afraid since a similar incident happened just recently where a girl committed suicide because the parents kept on getting angry at her because of the pregnancy. The girl was found the next morning already dead, and with a note - so we were afraid for my niece. We tried to support so that she will not think of similar ideas" [ID 36, 58 years old, aunt of a teenage parent].

Moreover, parents (and parents-in-law) also tend to take responsibility in discussing and *handling marital issues* between the young couples. An example would include verbalizations like "…my husband told me that they [teenage couple] will fight a lot in the house. Initially, I

was very angry with the partner of my pregnant daughter because he does not have enough money or does not know what to do in case of situations like sudden vaginal bleeding. However, I had to understand since they are still kids and are not prepared for these things. I should be the one guiding and helping them" [ID 61, 42 years, mother of a teenage parent]. Another one would be: "…becoming physically violent when they fight. I don't want our son to enter a situation like that, even though I feel pity for both. As much as possible, we (with her husband) had to meddle with their quarrels and take control of the situation. They are still young and must work things out since they have a child together" [ID 17, 45 years, mother of a teenage parent].

From the side of the adolescents who got pregnant early, the common theme is that they are *learning from the incident*. This was not directly expressed by these teenagers, but changes were noticed by the parents as supported by statements like: "…things are different now; I can notice the huge difference based on how my daughter behaves. She already has her own daughter and since she has been separated from her former partner. She is more careful with boys courting her now" [ID 20, 41 years old, mother of a teenage parent]; and "My daughter was more comfortable to attend school after birth, unlike when she was still pregnant. She did not want to be ashamed of the situation because she did it and has to be accountable for the consequences" [ID 20, 41 years old, mother of a teenage parent].

However, a potential reason for the immediate feelings and coping response would be the **community perceptions** on risk factors and consequences of teenage pregnancy. The perceived risk factors based on the focus groups include perceived *parental shortcomings* as supported by statements like: "for me, it is not a good feeling among parents when they hear of (cases of) teenage pregnancy. Other people think that such actions of the children is reflection that there is a problem on the parents (and how they parent their children). People would guess (assume) that they (teenage pregnancy cases) did not have a bond with their parents and only got along well with their partner; and that is the reason for the pregnancy because there is a lack of parental guidance" [ID 19, 56 years, mother of a teenage parent]. These ideas are further noted among young boys and girls attributing *family background* with teenage pregnancy cases, as supported by: "according to my parents, people who experience teenage pregnancy were not disciplined well by their elders in the family" [ID 63, 14 years old, teenage girl].

Another set of perceived risk factors for cases would be those attributed to impulsive and grouping behavior among adolescents. These include *technology* ("These children tend to become more engaged in social media or look for things on the Internet such as pornography or sex-related content using their cellphones." [ID 19, 56 years, mother of a teenage parent]), *friends/peer pressure* ("I had sexual intercourse without regard whether it is right or wrong

because I was too drunk around the time that I did it. I do not have any other explanation, but it seemed normal between most people our age, and I just got along with what my friends are doing. So, when I got pregnant, I apologized to my parents, because I knew it was all my fault." [ID 12, 18 years old, teenage mother]), and perceived invincibility of teenagers ("When I was younger, I tend not to listen to what my parents say, because I think I know better. Like what happened to other people will not happen to me. That is why teenagers are different from adults, with what happened to me (teenage pregnancy), younger people should realize not to engage with sex too early since it can destroy their dreams, it can destroy them." [ID 35, 23 years old, teenage mother]).

Another aspect of community perceptions that contributed to negative reactions would be the perceived *consequences to cases* of teenage pregnancy. This was supported by statements such as: "according to our teacher, these cases (teenage pregnancy) are reported as a warning for other teenagers not to get pregnant. It is a reminder that it is still too early to engage in such activities, so that your future will not be destroyed. When these teenagers experience early pregnancy, they will lose their dreams and the future ahead of them." [ID 46, 15 years old, teenage girl]; and "I think these boys feel like there is nothing to lose for them, like it's the girls who will lose more since they get pregnant (other boys agree)." [ID 8 & 11, 13 & 14 years old respectively, teenage boys]

The different responses and perceptions mentioned previously interplay to create a perceived idea of the situation. But in terms of a more tangible concept, the **perception of community services** directly affects access and behavior to these activities. This theme can be sub-divided into three secondary themes which gave the researchers an insight into how they see and receive these services.

The first sub-theme would be the facilitators of accessing these community services. Adolescents appeared to understand the *importance of sex education*, but also reported issues of getting the message across the target audience. This can be exemplified by the statement: "It's like when sex education sessions are conducted, they make us feel like we are not supposed to ask questions and just listen. It feels like there is malice or you are a pervert when you try to clarify things during lectures like this. That is why, may be the lessons were not clear to them (teenage pregnancy cases)." [ID 10, 16 years old, teenage boy]. Furthermore, the statement: "in school and in barangay seminars, they try to teach about pills and family planning. But it's like they just go through the session, they do not seem to be interested in answering questions or even giving details about how to avail of these services. We do not want to practice it, but we are aware of its importance so that the population will not increase, and we avoid unwanted pregnancies." [ID 8, 13 years old, teenage boy] provides support in the key informant findings where the national policies in reproductive health are

sufficient in content. However, its implementation and dissemination at the sub-national levels appeared to still need improvement.

Moreover, a *supportive family* motivates teenage pregnancy cases and adolescents to avail of community services as noted in the following verbalization: “from my side, my family supported our (partner) decision to move in together because I was already pregnant. Our parents were initially angry, but it went well since they are supportive of us, and even help us with accessing services like family planning and immunizations for the child. Right now, I don't think there are regrets, since we continue to take care of each other, together.” [ID 33, 17 years old, teenage mother].

On the other end of the spectrum, there were also notable barriers to accessing community-based services. One of the mothers mentioned that: “as parents of these children, we feel that there is a need to have them more informed about family planning services given their situation. However, there are times when supplies are not available in the center or the side effects and how they (contraceptives) work cannot be fully explained by the people in these centers.” [ID 17, 45 years old, mother of a teenage parent]. The statement exemplified not only the *lack of supplies* but also the limited number of trained personnel in these facilities.

The *approach of public servants* appears to be another deterrent in the access to these services, as explained by a discussant: “one of the reasons why teenagers do not want to go to the center is because they keep on scolding us. For me, it's alright since you understand where they are coming from and given our situation. But sometimes, it tends to be repetitive and at times, you also feel ashamed because they reprimand us in front of other patients that became pregnant normally (at an older age).” [ID 34, 15 years old, teenage mother]. The RH Bill and other adolescent friendly policies have stipulated that government facilities should be safe spaces, but the beliefs and accepted norms of public servants seemed to be imposed to other people as supported by the statement: “There are even situations when the doctors refuse to give family planning advice on these children. I encountered one where the (teenage) couple were kicked out of their house and are both minors - they are asking about family planning services, and they cannot avail themselves of it because parental signature is still needed. As young as they are, these kids are concerned of having more children than they can provide for. The nurses were even judgmental in tone and attitude to these kids.” [ID 21, 52 years old, mother of a teenage parent].

The same situation appears to be felt by stakeholders in terms of *religious influences or beliefs* of other people, with one discussant mentioning: “Because of what happened to me, my family is interested in engaging me with family planning activities. They understand that it is important for us to know about it well. But it was not supported by our church (another participant of a different religion agreed), they will not teach it. They always reason that once

teenagers are taught about sex education, they will use this knowledge and apply it themselves." [ID 57, 21 years old, teenage mother].

Despite efforts to adhere to the proposed activities in national policies, its implementation at the local level might be *infrequent or irregular*. This was exemplified in the statement: "There are some activities targeting youth and teenage pregnancy and was announced by the barangay people. But it happened a long time ago and was organized by a non-government organization. There are activities like these, but they are not regularly done." [ID 3, 18 years old, teenage mother].

If there are programs, there is a noted *lack of tailored activities* catering to what these adolescents felt they needed. One discussant had issues with the way sex education is delivered: "From my experience, even if sex education is taught in school, it was boring. I tried reading and learning it, but it was not easy to understand and contained too many "sermon" (reprimands) that it was really boring, and I was not able to get anything from it. At that time, I even prioritized going out with my partner rather than focusing on it." [ID 15, 18 years old, teenage mother]. Other discussants felt that they also need to receive information or engage in activities teaching them how to deal with other health-related issues ("Like if I experience abdominal pains (mild contractions), I and other people do not know what to do and the school nurse will have to refer us to the midwife or the center doctor." [ID 34, 15 years old, teenage mother]); or similar social concerns ("From the cases that we know, teenage pregnancies were the result of abuse like rape…the girl was also afraid of what people will say, like they will think that you just let your body become harassed, like you could have fought back. The girl felt ashamed, and for us (girls) we understand the situation, but not everyone will think like that." [ID 45 & 46, 17 & 15 years old respectively, teenage girls]).

The third sub-theme comprised of recommendations or proposed solutions to limitations in the current services in the community. Most of the efforts are focused on curbing the number of teenage pregnancy cases, but the care for already noted cases have been overlooked. Since these adolescents cannot be employed through legal means, and if given jobs, do not pay much to support their families, the burden is left to the parents of these adolescents. There is lack or absence of economic support for teenage couples and even their parents as exemplified in this statement: "As much as I want to be positive, my son does not have any capacity to care and support a family of his own. The girl's family is intent on making sure that our son takes care, provides for, and stays with their pregnant daughter. Unfortunately, no economic support or livelihood activity is available for these children, and as parents we also have too little money to support them for everything such as check-ups and delivery." [ID 17, 45 years, mother of a teenage parent].

A lot of interviews on the topic repeatedly mentioned that teenage pregnancy is not a hindrance to continue their education, but there are still *unclear school policies* for these

adolescents. One parent mentioned that: “From what I know, there are no clear school rules and regulations about teenage pregnancy. We just obey the instructions given to us by the teachers.” [ID 61, 42 years old, mother of a teenage parent]. In addition, there are also no specific guidelines on how to safeguard the vulnerable status of these teenagers, since there are also no clear sanctions or disciplinary actions to their peers. As one discussant puts it: “The sad thing about teenage pregnancy is that their situation becomes even more difficult because of the “marites” (rumormongers). There are a lot of them everywhere (other boys nod in agreement). They just want to destroy other people, just because they happened to be pregnant early. Even their (pregnant couple) friends, they are the first ones to spread rumors and tell negative things about them to other people. There should be school policies against rumormongers.” [ID 9 & 10, 12 & 16 years old respectively, teenage boys].

The teenage mothers and their parents appreciated the *lenience from teachers* as exemplified by: “when she was 15 years old, she decided to transfer schools because of the situation (pregnancy), and the teachers are more accommodating. The time she was about to give birth, the teacher allowed her to take the examination next time so that she will not fail or repeat the school year.” [ID 21, 52 years old, mother of a teenage parent]. However, the decision of the faculty is still on a case-to-case basis and no clear document or ruling supports these decisions.

The discussants also mentioned services that are lacking such as *counselling or mental health services* (“There are NGOs (non-government organizations) that offer counselling services for teenagers but not regularly. I think it would be great if there is a focus on them (teenage pregnancy cases) such as a written and consistent guide to handle different issues that come along with this situation. Sometimes, it is difficult for these kids to open to us because they are ashamed of their situation, so another support will do good. If there is one for the parents also, I would be glad to partake in such activity (group laughs but agrees).” [ID 20, 41 years old, mother of a teenage parent]); *parenting support* (“Aside from avoiding pregnancy, I would want to be helped on how to become a good mother. Like what are the things we need to do or know, or how to take care of a child because we are still teenagers. Our parents do guide and teach us, but sometimes they are busy or not around. Sometimes, it is difficult to look for someone who will guide and teach us without giving angry comments.” [ID 5, 17 years old, teenage mother]); and even the *dissemination* of these services.

Storyline for the Qualitative Findings

From the perspective of the key informants, the lack of sufficient parental influence, and the feeling of being external to the community predispose adolescents to the variation in motivations and technological influences that exposes them to early sexual intercourse. The

lack of sexual and reproductive health education, lack of training among service delivery personnel, and the limited access to information further result to hesitancy and embarrassment among teenagers to inquire about such topics.

The importance of health education among teenagers though salient to key informants cannot be implemented properly due to lack of sufficient resources (i.e., training needs, supplies and materials, dissemination, space, partnerships, and support), and the lack of clear policies. All these aforementioned factors tend to significantly contribute to the occurrence of teenage pregnancy cases.

However, aside from preventing the cases of teenage pregnancy, the key informants also noted the need for supportive measures targeting known cases.

From the perspective of the stakeholders (focus group discussants), the community perceptions on socio-demographic characteristics attributed to teenage pregnancy, as well as the perceived consequences of such cases contribute to the immediate feelings and concerns felt by the adolescents, teenage pregnancy cases, and their families. However, coping measures take over to support and care for the teenage couples.

Regardless of a successful or otherwise coping measure, access to community-based services would depend on the interplay of facilitators, barriers, and limited services for them. Inputs from participants in the focus groups suggest that improving the access and quality of these services would not only affect teenage pregnancy cases, but even non-case adolescents.

The figure below presents a map of interrelated factors that contribute to the teenage pregnancy as well as its identified impact.

Figure 6. Map of Identified Factors Contributing to Teenage Pregnancy and its Impact

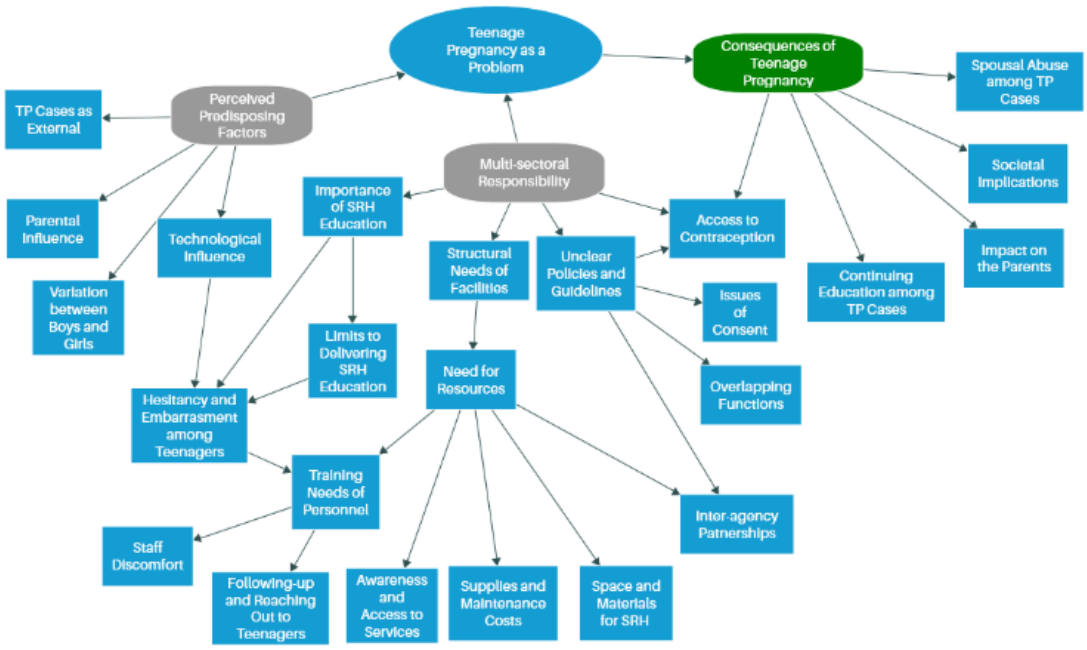

Table 9 presents the salient points of several policies identified to be associated with the narratives from the conducted key informant interviews and focus group discussions. The implementation status of the said policies was also identified.

Table 9. Policy Review on Reproductive Health in the Study Areas and in the Philippines

Policy	Salient Points	Current Status of Implementation	Contextualized Understanding from the Results of the Study	Narratives from the Key Informants and Discussants
RA 10354. Responsible Parenthood and Reproductive Health Act of 2012				
Section 4.03 *Availability of Information and Services in General.*	All public health facilities shall provide full, age-and development-appropriate information on responsible parenthood and reproductive health care to all clients, regardless of age, sex, disability, marital status, or background.	National government agencies have established AHD information and service delivery networks, school-based teen centers, and One AHD Program, an initiative that seeks to use demand generation activities to satisfy the ASRH needs of adolescents. Meanwhile, USAID has conducted workshops that aim to increase the number of functional adolescent-friendly health facilities nationwide (2021 RPRH Annual Report)**.**	Informants shared that no teenager has ever requested information on reproductive health from their facility, citing reasons of embarrassment and hesitation. Discussants said that they had difficulties in availing services in public health facilities due to negative attitudes by some health care providers, denial of reproductive health 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." There is a lack of information about sexual activities that is why this becomes a problem. 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] I would like to be helped on how to become a good mother or on how to raise a child since we are still teenagers. 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] 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. 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. Services offered were up to them if they wanted to help you or not. [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, so she was forced to continue the pregnancy even if she received no support from the health center or government. [ID 13, 17 years old, teenage mother]
Section 4.07 *Access of Minors to Family Planning Services*	Any minor who consults at health care facilities shall be given age-appropriate counseling on responsible parenthood and reproductive health. Health care facilities shall dispense health products and perform procedures for family planning: Provided, that in public health facilities, any of the following conditions are met: a) The minor presents written consent from a parent or guardian; or b) The minor has had a previous pregnancy or is already a parent as proven by any one of the following circumstances, among others:	In 2020, DOH, Commission on Population and Development, and implementing partners under the Responsible Parenthood and Reproductive Health Law amended the National Objectives for Health for modern contraceptive prevalence rate to include adolescents and sexually active unmarried women with unmet need for family planning, instead of just catering to married women (2021 RPRH Annual Report).	***Quantitative Results*** Only 4 in 10 (40.9%) respondents have used family planning methods, where the majority comes from non-GIDA communities (47.2%). The most utilized family planning method, in both communities, was oral contraceptive pills (47.1%), followed by implants (34.7%), injectables (12.4%), and intrauterine devices (5.8%). ***Qualitative Results*** Most of the informants opposed the idea of providing family planning products and services to teenagers, contradicting the rules and regulations set by the law. Discussants shared that healthcare	“If you’re not yet of legal age, there must be consent from your parents or guardian. But the said policy is one 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 it is a problem since sometimes they refuse to give consent.” (ID 8, Female, 27 years in the health sector) "We only give it [contraceptives] out to married couples, we don’t give it to those who have no partners since we can identify who are the married from the single ones, unless they have irregular menstruation." (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)

	1. Written documentation from a skilled health professional; 2. Documentation through ancillary examinations such as ultrasound; 3. Written manifestation from a guardian, local social welfare and development officer, local government official or local health volunteer; or 4. Accompanied personally by a parent, grandparent, or guardian.		workers showed negative attitudes when teenagers attempted to avail family planning products and services.	"They [teenagers] will be more complacent since they won't get pregnant, and they will not be careful anymore [in avoiding sexual intercourse] because there is contraceptive already." (ID 7, Female, 4 years in the health & 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]
Section 4.10 *Responding to Unmet Needs and/or Gaps for Reproductive Health Care*	With assistance from the DOH, each province-, city-, or municipality-wide health system shall carry out measures to reduce the unmet need and/or gaps for reproductive health care.	During the height of the pandemic until now, the country suffered a great shock to its healthcare systems, including protection mechanisms for women and children. Disruption of services and re-alignment of resources away from essential reproductive health care to prioritize COVID-19 response were felt across all levels of health and social	The informants aired their grievances about the insufficiency of reproductive health products, services, and facilities available. Discussants also expressed their dissatisfaction on the unavailability of reproductive health care services for adolescents. The law states that all levels of the health system	"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 LHU] does not withhold [contraceptives] because they don't like to give out among adolescents but because we do not have supplies." (ID 12,

	service delivery RPRH program implementers at the national and local level managed to avert the collapse of essential reproductive health services by sustaining high-impact strategies and employing innovative adaptive management approaches and tactics to deliver the same (2021 RPRH Annual Report).	should address the gaps in the delivery of reproductive health care.	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. There is no available testing for HIV or other diseases." (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 pandemic]." (ID 9, Female, 22 years in the health sector) 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] 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. 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]
Section 10.01 *Public Awareness, Promotion, and Communication*	The DOH and the LGUs shall initiate and sustain a heightened nationwide multimedia-campaign to raise the level of public awareness on the protection and promotion of responsible parenthood and reproductive health and rights including, but not limited to, maternal health and nutrition, family planning and responsible parenthood information and services, adolescent and youth reproductive health, guidance and counseling and other elements of reproductive health care.	Government agencies have virtually launched several national and local campaigns that educate and engage young people in promoting sexual and reproductive health (2021 RPRH Annual Report).	Informants shared that they lack resources that will guide them in understanding and interpreting the national policies concerning teenage pregnancy and other reproductive health issues among the youth. Discussants claimed that they are not aware of existing programs and services dedicated to tackle teenage pregnancy. The law mandates the health department and local government units to be responsible for the wide dissemination of information regarding reproductive health to the general public.	"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]

Section 10.07 *Private Sector and Civil Society Organization Involvement.*	The private sector and civil society organizations are encouraged to actively participate in the promotion and/or communication of responsible parenthood and reproductive health, rights and concerns as part of people-centered programs to enhance the quality of life. Government agencies may engage the private sector in the implementation of these provisions through effective partnership and cooperation, subject to restrictions as may be provided for in applicable guidelines.	Civil society organizations heavily contributed to the delivery and provision of demand generation activities for reproductive health through various partnerships with the local and national government, private sectors, and other stakeholders (2021 RPRH Annual Report).	Discussants revealed that several civil society organizations have provided them with reproductive health services that benefit the adolescents. The law states that alongside government interventions, non-government organizations are highly encouraged to take part in providing reproductive health information and services for all, including 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's really there to support."
Section 11.03 *Supportive School Environments.*	Private and public schools, as avenues for development, shall provide young people a supportive environment where they have access to the following services with regards to teenage problems, among others:	National agencies, regional offices and LGUs pursued the roll-out of the Comprehensive Sexuality Education – Adolescent Reproductive Health (CSE-ARH) Convergence program, engaging buy-in and building the capacity of schools to implement the same in selected pilot sites in the	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 the law which states that educational facilities should be an encouraging and nurturing place for the youth while	"... pregnant students must be allowed to continue with the modular because they will really get shy to go to school. So here, really we don't discriminate against the pregnant…we accept them, we even help with whatever is good, in fact when they come back to school again, we accept them, the only problem ma'am is they are often absent." "... our first policy is they have to continue schooling, they really

	a) Counseling and psycho-social support services; b) Facilities for information on prevention of risky behaviors, including addiction; c) Facilities for information on prevention and diagnosis and proper management/treatment of STIs; and d) Facilities for information and referral to service providers on all RPRH concerns	country (2021 RPRH Annual Report).	providing them with appropriate services	must continue, that's our policy. Second, we don't have medical assistance for them because they're not employed, they're just students, however our nurses, if they've seen students who are pregnant in school, they give advocacy to do check-up and really go to prenatal check-up already." "Yes, they are still welcome to go back to school. We encourage, even others miss one quarter for example, it's been one month already since she last attended school still, we give her a chance." "We need to make them feel that they are still welcome to school, and there is no hindrance to continue with their studies...there is a need to support them and protect them from discrimination coming from their schoolmates." (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 regular ask about the health and well-being of their children. However, we can only do so, since as school nurse, my resources are limited but we, including teachers, try to help them finish their studies." (ID 7, Female, 4 years in the health & education sector)
Section 12.02 Duties and Responsibilities of Local Government Units.	Since the LGUs play a vital role in the implementation of the RPRH Act as the direct provider of both services and information to their respective constituents, LGUs shall: Ensure that all skilled health professionals assigned to public health facilities have appropriate training to provide the full range of reproductive health services; Provided, That cities and municipalities shall endeavor that all nurses and midwives assigned to public primary care facilities such as RHUs are given training and certification to administer life-saving drugs within one (1) year	Government agencies and its partners are continuously providing training to community health workers to ensure that they are adequately capacitated to perform their tasks in providing reproductive health services (2021 RPRH Annual Report).	Informants suggested that as health care workers, they should be provided with proper training and assistance in maintaining their professional licenses active. The law mandates that local government units should guarantee that appropriate training is provided for health care professionals designated in public health facilities that offer reproductive health services.	"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) "Especially if the person handling the program [SRH education], is not that trained on how to handle these adolescents. In handling them, it's very sensitive for them, so if the person [they are talking to] is too strict or does not appear to be comfortable - they would not come to us. So, we really need to be groomed for this [adolescent targeted programs]." (ID 5, Male, 3 years in the health sector as supervisor) "Right now, we are having difficulty giving access to birthing services since our license to

	from the effectivity of these Rules			practice was not renewed. Our pregnant mothers [in the area] are having difficulties now since we must transfer them to another RHU. The problem is that they are opting for home deliveries, but it is not allowed because of course even if they are going to give birth normally, they would still need to go to the hospital." (ID 2, Female, 34 years in the health sector)
Administrative Order 2013-0013. *National Policy and Strategic Framework on Adolescent Health and Development*				
VI. General Guidelines	B. Improving access to quality and adolescent-friendly health care services and information for adolescents, including access to quality hospitals and health care facilities following the National Standards and Implementation Guide for Adolescent-friendly Health Services and utilizing various settings outside the health system, such as schools, cruising sites, and social media, to promote adolescent health.	As of 2019, the country has a total of 704 adolescent-friendly health facilities –617 Level I, 52 Level II, and 35 Level III. The DOH is targeting at least 20% increase in AFHFs per year (DOH, 2019)	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 health care 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)

IX. Roles and Responsibilities	10. Non-Government, Faith-based, Civil Society Organizations, the United Nations and other development partners working with and for adolescents • Implement adolescent-centered programs and outreach services in priority communities that are consistent with the AHDP in coordination with government agencies • Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development • Contribute to research on adolescent health and development • Advocate, mobilize and generate resources for adolescent health and development	Current partners identified by the Department of Health include the following civil society organizations: Likhaan, Y-PEER, National Youth Parliament, ACHIEVE, ACT Philippines, DSWP; and international partners: WHO, UNFPA, UNAIDS, USAID, Reachhealth, UNICEF, World Vision, Save the Children.	Discussants revealed that several civil society organizations have provided them with reproductive health services that benefit the adolescents. A national policy encourages non-government and civil society organizations to participate in providing 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's really there to support."
	12. Local Government Units	Four in 10 female youth who had a live birth encountered at least one challenge in	Informants shared that health care services rendered to teenage	It is important for those people in position to hear the things we need and suggest improvements

	• The provision of reproductive health information, care and supplies shall be the joint responsibility of the National Government and Local Government Units (LGUs). • LGUs must ensure provision of basic adolescent health care services including, but not limited to, the operation and maintenance of facilities and equipment necessary for the delivery of a full range of reproductive health care services and the purchase and distribution of family planning, goods and supplies as part of the essential information and service delivery package defined by DOH. • LGUs, specifically the Rural Health Units, City Health Offices, and Provincial Health Offices, are responsible for designing, funding, implementing, and	accessing prenatal or postnatal health care services. Distance and lack of transportation are among the major barriers. Four in 10 Filipino youth reported that they have no material sources of information about sex. As a result, male youth tend to consult their friends for questions about sex, while female teens consult their mothers (2021 Young Adult Fertility and Sexuality Study). Existing training activities for the youth include Adolescent Health Education and Practical Training (ADEPT), Foundational Course (including Healthy Young Ones), Healthy Young Ones (HYO) Training, and Adolescent Job Aid (AJA) Training.	parents are very limited. A national policy directs local government units, in coordination with the national government, to have the full responsibility in ensuring the delivery of adolescent health care services and programs.	to understand the struggles that come with teenage pregnancy. 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. Services offered were up to them if they wanted to help you or not. [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, so she was forced to continue the pregnancy even if she received no support from the health center or government. [ID 13, 17 years old, teenage mother]

	monitoring local Adolescent Health and Development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector, under the technical guidance of the CHD and this Order. LGUs should design specific strategies to reach marginalized and vulnerable adolescent sub-sectors. They should ensure meaningful participation of adolescents and communities in this process. Hospitals and health care facilities under LGU management must meet the National Standards for the Provision of Adolescent-Friendly Health Services.			

RA 11148. *Kalusugan at Nutrisyon ng Mag-Nanay Act*

Rule 8. Program Components. Section 2. General services and interventions to be	k. Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, early	A regional office of the National Nutrition Council, in February 2022 conducted a webinar focused on proper	A discussant shared her concern over the unavailability of services intended for the early development of the children	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

rendered in the first one thousand (1,000) days period of a child, pregnant and lactating women including adolescent females and adolescent mothers, and women of reproductive age, giving high priority to high-risk groups and those belonging to the vulnerable population are the following:	stimulation, and promotion of early literacy for early childhood development and early detection, identification, referral, and provision of appropriate intervention for developmental delays and disabilities;	health and nutrition in early years (NNC, 2022). The Early Childhood Care and Development First 1,000 Days (ECCD-F1K) was launched in 2016 and fully implemented in 2018 (PNA, 2018).	of teenage mothers. The law states that new mothers on their first 1000 days must be given support and counseling sessions on early childhood development.	victims who get pregnant. [ID 13, 17 years old, teenage mother]
	m. Protection against child abuse, violence against women and children, injuries, and accidents including the provision of first aid, counselling, and proper referrals;	The existing Inter-Agency Council on Violence Against Women and their Children (IACVAWC) through RA 9262 is tasked to formulate programs and projects to eliminate violence against women and their children (PCW).	Informants have shared several cases of abuse and violence that involved teenage partners. The law states that during the first 1000 days of a child, pregnant and lactating women including adolescent females and adolescent mothers should be provided with protection against abuse and violence.	"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 since these couples tend to fight more due lack of enough or loss of income to sustain their needs." (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. When he found out that he will be punished with life imprisonment, his relatives tipped him thus he was able to escape.” (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. All we can do is check for wounds or bruises, but we still must wait clearance from other agencies like the police before doing anything.” (ID 12, Female, 21 years in the health sector)
	q. Counseling on, and utilization of, modern methods of family planning and access to reproductive health care services, as defined in RA	In 2020, DOH, Commission on Population and Development, and implementing partners under the Responsible Parenthood	Discussants have shared their negative experiences when they attempted to avail family planning services. An informant said teenagers find it difficult to	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. Services offered were up to them if they wanted to help

	No. 10354, otherwise known as “The Responsible Parenthood and Reproductive Health Act of 2012;”	and Reproductive Health Law amended the National Objectives for Health for modern contraceptive prevalence rate to include adolescents and sexually active unmarried women with unmet need for family planning, instead of just catering to married women (2021 RPRH Annual Report).	access reproductive health services due to a national policy. During the first 1000 days of a child, pregnant and lactating women including adolescent females and adolescent mothers, should gain access to family planning and other reproductive health care services, in consideration with the regulations set by RA 10354.	you or not. [ID 1, 17 years old, teenage mother] 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] “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, 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)

V. DISCUSSION

Community and Fertility Characteristics and Ages of the Sample Population

Teenage pregnancy is a global health issue that adversely affects birth outcomes and can lead to intergenerational cycles of poverty and ill-health (Mann et al., 2020). Early childbearing can derail girls' otherwise healthy development into adulthood and have negative impacts on their education, livelihoods, and health (UNICEF, 2022). In terms of the demographic characteristics of the teenage mothers in Eastern Visayas, the results showed that there were no respondents from GIDA communities in Northern Samar and Leyte. This can be attributed to the difficulty of accessing and locating the target population, and issues of safety for the data collectors in these communities. Therefore, the researchers compensated by increasing the proportion of GIDA respondents in more accessible communities under an assumption that norms and characteristics are similar across provinces in the Eastern Visayas region. This can be supported by the similarity in the age during first pregnancy and age at first intercourse across the provinces. The results also showed that among the 296 teenage pregnant women surveyed, most of them were 15 to 19 years old during their first pregnancy, the youngest being aged 12. This is consistent with the 2022 National Demographic and Health Survey which revealed that among the age group 15 to 19 years old, women aged 19 had the highest incidence of adolescent pregnancies at 13.3%. It is noteworthy, however, that this number is a 9.1 percentage points decline from the last survey conducted in 2017. In terms of the age of the respondents' children, about a quarter have ages less than one year old and about half of the children are toddlers.

It was also revealed that there was a higher proportion of 20 to 25-year-olds responding to the survey among those in GIDA communities which can be attributed to the greater ease in identifying and locating recent teenage pregnancy cases in non-GIDA communities. Similarly, the latest data from PSA (2022) revealed that teenage women in rural areas had a higher number of pregnancies than those living in urban areas. A study by Sutton and colleagues in 2019 also found that adolescent birth rates in rural areas are about one third higher than in urban areas. They emphasized that adolescents living in rural communities may be vulnerable to local conditions that limit unintended pregnancy management options. Additionally, teenagers from the rural areas are less educated and belong to poor families (Natividad, 2013). A notable proportion of women from both communities who were "single with partner" was also observed. In addition, more women use family planning methods in

non-GIDA communities, but more women in isolated communities utilize OCPs. Similarly, several studies abroad suggest that the use of family planning methods is higher in urban areas while less contraceptive utilization is often present in more socially disadvantaged groups (Ross, 2021; Anyatonwu and San Sebastián, 2022). In contrast, the 2017 and 2022 NDHS revealed that more women in rural areas utilize modern family planning methods (such as sterilization, IUD, injectables) than in urban areas. Many factors remained to be associated with the use of family planning and the opposite non-use and lack of intention to utilize such services as age, parity, education, and access to general media. The other factors are observed to have a varying association which may be related to changing cultural underpinnings (Vicerra, 2017). Lastly, the results also revealed that women from GIDA communities tend to have a smaller number of sexual partners, longer inter-pregnancy intervals, and a higher proportion of preterm labor.

Socio-Demographic and Early Pregnancy & Motherhood Characteristics of the Sample Population

A higher educational attainment among the respondents' parents and partners in non-GIDA communities was observed. More Filipinos (around 60 percent) living in urban areas had completed at least four years of secondary education compared to those living in rural areas which only accounted to approximately 40 percent (PSA, 2020). A 2020 study by Aljassim and Ostini also found that urban populations had higher health literacy than rural populations. In addition, compared to urban residents, people living in rural communities had lower access to health information (Chen et al., 2018). However, rural and urban educational inequalities in the Philippines are generally improving over time as suggested by Zamora and Dorado (2015). In GIDA communities, unemployment among the respondent’s fathers was lower since more of them were self-employed. A similar pattern for self-employed status was observed for the respondents' partners. Meanwhile in non-GIDA communities, a higher proportion of the women's partners were regular or part-time employed which can be attributed to the higher probability of jobs and occupations in non-isolated communities. In the Philippines, it was suggested that labor force participation rate is slightly higher in urban areas whereas unemployment is higher in rural areas. Employed individuals in urban settings are more likely to be in the private sector and rural areas have a higher percentage of individuals who are not in paid work and not looking for work (OECD/Scalabrini Migration Center, 2017). Furthermore, higher proportions of the participants in both communities live in nuclear and extended family settings. An analysis of the NDHS 2017 conducted by Tabei and colleagues (2021) suggested that Filipino adolescent women in a large family showed a relatively higher

tendency of having pregnant teenage adolescents. Similarly, a study from the Journal of International Women's Studies pointed out that several factors, including large family size contribute to teenage pregnancy (Odebode and Kolapo, 2016). In contrast, similar papers overseas argued that teen girls from small households are more likely to get pregnant than those from large families (Mohammed, 2023; Uwizeye et al., 2020). Finally, most of the teenage mothers received a secondary level of education while those who had college level of educational attainment was the lowest regardless of early pregnancy and motherhood characteristics. The 2022 NDHS revealed that teenage pregnancy was more common among teenage women who reached or finished primary education than those who were in high school or college. In general, the incidence of teenage pregnancy decreases as educational level increases (PSA, 2023). Meanwhile, a study by Mohr and colleagues (2019) emphasized that adolescents who had attended secondary education had lower rates of teenage pregnancy than those who had attended less than secondary school. They also suggested that longer school attendance translates to a higher education level and lower possibility of teenage pregnancy.

Narratives of Exploration of Teenage Pregnancy as a Problem from the Lens of Key Informants and Discussant

The succeeding part will be focusing on the discussion of the conducted focus group discussions and key informant interviews in Eastern Visayas. The discussion will focus on the thematic analysis done for the qualitative data as presented in the results section.

Views of program planners and implementers on the status of teenage pregnancy in the region

According to the key informants in this study, the teenage pregnancy rate in the region was observed to be rising in recent years. This is in congruence with the Philippines' recorded increasing rates of teenage pregnancy for the last two decades, along with other Southeast Asian and developing countries. According to Natividad (2013), a total 1,784,316 births were registered in the year 2008; 10.4% of these (186,527 births) were born to mothers less than 20 years old.

The use of technology and social media, the absence of knowledge regarding sexual and reproductive health, peer pressure, and the lack of parental guidance are among the factors suggested by the informants as contributing factors to teenage pregnancy in the region. Meanwhile, a study suggests that adolescent pregnancy is often caused by lack of access to schools, employment, quality information and health care (Posel, 2013).

Teenager's access to sexual and reproductive health information and services

The informants argued that there are barriers for adolescents to access sexual and reproductive health (SRH) information and services. Choosing not to go to clinics because of shame, hesitancy, and the long distance between their home and the facility, are among the reasons. The study of Thongmixay and colleagues (2019) determined that the main barriers preventing young people from accessing SRH services are the feelings of shyness and shame caused by negative cultural attitudes to premarital sex, and the fear of parents finding out about visits to public SRH facilities. It has long been recognized that access to SRH services is essential to positive health outcomes, especially in rural areas of developing countries. Long distances to healthcare facilities and poor transportation conditions can also be potential barriers to accessing SRH services and information (Yao et al., 2013; Soule & Sonko, 2022).

The government, along with other organizations should implement stronger programs to meet the SRH needs of Filipino teens. As suggested by the informants in the study, improvements on adolescent health facilities and reinforcement of sexual education in schools and at home should be prioritized. A 2018 study by Melgar and colleagues pointed out that several governmental norms and standards in the country agree with adolescents' human rights to contraceptive information and services as recommended by the World Health Organization (WHO). However, a significant number are restrictive, reflecting the strong influence of conservative religious beliefs. Meanwhile, sex education received at home and school have been found to influence attitudes and beliefs of adolescents. Thus, it is recommended that schools implement a well-constructed program that addresses sexuality-related concerns of the youth. Furthermore, resources should be made available to parents who need support in educating their children on this topic (Hailu et al., 2018).

Providing reproductive/contraceptive-related services for the youth

It was revealed by the current study that program planners and implementers in the region have contrasting opinions on the use and availability of contraceptive-related services in their community intended for adolescents. These perspectives are also evident on the study by Yabushita (2019) in Cebu city where healthcare workers have positive attitudes toward the overall idea and the practice of promoting adolescent reproductive rights, while Nigerian healthcare providers show unfavorable attitudes towards the provision of contraceptives for unmarried adolescents (Ahanonu E. L., 2014).

Social norms are believed to be particularly important barriers in the Philippines. These norms prevent women, especially adolescents and unmarried women, from accessing

services and using methods effectively (Nagai et al., 2019). A study by Dioubaté and colleagues (2021) suggests that strengthening contraceptive uptake interventions by involving different stakeholders, including adolescents, parents, religious, and community leaders, and improving the quality of sexual and reproductive health services would help in reducing barriers to contraceptive use among adolescents. In addition, a wider reach of these different family planning and contraception messages are essential, especially by utilizing social media and other print and online media platforms commonly used by the youth (Pepito et al., 2022).

Making facilities in the community well-equipped, welcoming, and youth-friendly

Youth-friendly health service interventions are promising, cost-effective approaches to delivering sexual and reproductive services that cater to the developmental needs of young people (Obiezu-Umeh et al., 2021). Community workers in the current study consider their facilities as youth-friendly but support is needed to further deliver services that benefit adolescents. According to The Challenge Initiative, an urban reproductive health program, youth-friendly health services must be offered in an environment where competent service providers are non-judgmental, unbiased, and considerate in their dealings with adolescents. Health facilities must be equipped to provide the youth with services they need and commodities that they want in an appealing and friendly manner (WHO, 2012).

Moreover, ensuring that community healthcare workers have adequate support and resources to execute their duties, and can contribute to decisions on their role in delivering health services could increase both community participation and the overall impact of the health programs in a community (Mallari et al., 2020).

Perceptions and experiences of the community to teenage pregnancy

A study by Habito et al. (2021) found that childbearing among Filipino adolescents exhibited a generally increasing trend over the last 20 years, with data collected in 2017 showing roughly one in 10 Filipinas in this age group was already a mother or pregnant with their first child. In this current study, a growing concern regarding teenage pregnancy in their localities was also observed among the discussants. Recent reports concerning teenage pregnancy include the provinces of Eastern Visayas with 7 percent of teenage girls in the region were already mothers. Five teenagers get pregnant every day in Eastern Samar, whereas 11% of pregnant mothers in the province are 19 years old and below (UNFPA, 2018).

Furthermore, the discussants of this study also shared that the families of the teenage girls who got pregnant were shocked and angered, that some even lead to physical attacks. But families, especially parents, were quick to accept their teenage daughters' pregnancies

and ended up supporting them. A similar study also suggests that pregnant adolescents feared being scolded, physically hurt, disowned, and/or kicked out of the house by their parents but most of them revealed that their family and friends were quick to become resigned to the pregnancy news and from then on, became the young parents' primary sources of support (Habito et al., 2021).

Availability and accessibility of healthcare services and programs for teenage mothers

According to UNFPA (2020), those adolescents who have already become parents need to be provided with access to quality social welfare services (e.g. postpartum family planning support for teenage parents to space pregnancy and delay the next birth) and case management interventions. Health care must be affordable and accessible to all young people to adequately address the SRH needs of adolescents.

In the current study, teenage mothers face challenges availing healthcare services in the community which are very limited or not available at all. Lack of services and information about adolescent reproductive health are fueling the rise of teen pregnancies and hurting child survival rates, health experts argued (OCHA, 2012). Structural inequalities make young people more vulnerable to adolescent pregnancy by denying them access to education and SRH resources (Habito, 2021).

Review of Policies on Reproductive Health in Eastern Visayas

The succeeding part will be focusing on the discussion of the conducted policy review on reproductive health in Eastern Visayas. The discussion will focus on the salient provisions of applicable policies as presented in the results.

Availability of Information and Services in the Rural Health Unit and Barangay Health Stations

The availability of reproductive health and contraceptive information and services in the RHUs and BHS in the Philippines varies depending on several factors, including location, funding, and staffing (RamaRao and Jain, 2016). These institutions are expected to provide a range of reproductive health services, including family planning counseling and the provision of contraceptives, to underserved communities in rural areas (Adongo et al, 2013). However, there are challenges that can affect the availability of these services, including limited funding, staffing shortages, and cultural barriers. Despite the available services in the RHUS and BHS, this present study observations suggested that teenagers were quietly hesitant to seek reproductive health services from their RHUs and BHS because of embarrassment because of negative observations of adolescents in the health care providers, denial of reproductive health products and services, and the lack of services in general. This concern can be attributed to the limited availability of trained healthcare workers in these facilities. Many RHUs and BHSs are understaffed, with only one or two healthcare workers serving a large community. This can lead to long wait times, limited services, and reduced quality of care (Montalban and Marcelo, 2008).

Another challenge is the limited availability of contraceptive supplies and equipment (Smith, 2014). RHUs and BHSs may not have the necessary resources to provide a wide range of contraceptive options, and some rural areas may have limited access to pharmacies or stores that sell contraceptives (Woog et al, 2015). In this present study, discussants shared their negative experiences when they attempted to avail family planning services. Dissatisfaction was also expressed by the discussants on the unavailability of reproductive health care services for adolescents even though that the existing law states that the health system must address the gaps in the delivery of reproductive health care.

Aside from the previously mentioned concerns of related to availability of information and services on reproductive health, religion was also a point of concern for some of the informants and discussants as it affects the people's moral values and beliefs. The religious

teachings cited that premarital sex as morally wrong leading to teenage mothers being viewed as immoral or sinful, and can result in social ostracism and discrimination. This concern is related to the study of Nagai et al (2019) suggesting that cultural barriers can also be a factor in limiting the availability of reproductive health and contraceptive services in some rural areas. Some communities may have cultural or religious beliefs that discourage the use of contraception or family planning services, which can make it difficult for healthcare workers to provide information and services to those who need it (Msoka et al, 2019).

Accessibility of Minors to Family Planning Services in the Rural Health Unit and Barangay Health Stations

In the Philippines, minors under the age of 18 are legally allowed to access family planning services without parental consent. However, the accessibility of minors to family planning services in Rural Health Units (RHUs) and Barangay Health Stations (BHS) in rural areas can be limited by several factors (Melgar et al, 2018). One of the main challenges is the lack of information and education about family planning and reproductive health among minors, which can make it difficult for them to seek out and access services. This is particularly true in rural areas where there may be limited access to information and education about reproductive health and family planning.

Another challenge is the stigma associated with teenage pregnancy and family planning services. Some communities may have cultural or religious beliefs that discourage the use of contraception or family planning services among minors, which can make it difficult for healthcare workers to provide information and services to those who need it (Pinter et al 2016). There may also be limited availability of trained healthcare workers in RHUs and BHSs to provide family planning services, particularly for minors. Healthcare workers may lack the necessary skills and training to provide confidential and age-appropriate family planning services to minors (Loevinsohn et al 2015).

As cited by the informants, the RH law in the country envisions the inclusion of adolescents in the RH program, but mainly through education and counseling, however it is silent on contraception for adolescents. There is a strong mandate to provide comprehensive RH education in all mainstream and alternative schools. The curriculum must be age- and development- appropriate. The comprehensive and developmental approach would correct the old practice of doing isolated lessons in specific grades, such as teaching contraceptive methods in Grade 10. The law 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 of these efforts, the Department of Education stopped its implementation due to the appeal of the opposing sector (Melgar et al, 2018).

It was also observed that some of the service providers were also hesitant to provide reproductive health services to adolescents including dispensing of pill and condoms because it might provide the misimpression that sex is permissible as long it is protected. The technical guides on contraceptive services and information reflect the equivocation of the law (DOH 2012). According to the DOH guidelines, most guidance materials recommend abstinence as the best behavior for all adolescents regardless of their specific life situation. The guides are silent on relevant factors such as age, marital status, experience of sexual violence, and capacity for responsible decision-making. They promote abstinence-only or abstinence-centered values and practices (DOH 2012).

Aside from the previously mentioned concerns, the devolved implementation of reproductive health services throughout the country. The restructuring of the program implementation in the country allowed the local government unit to spearhead their health functions include financing and budgeting, operating facilities from health posts to provincial hospitals, hiring and managing health personnel, and creating local health policies and programs (Atienza, 2004). Hence, local officials may also refuse to cooperate with other local officials because of political or personal differences. This situation can result in a disparate, poorly-integrated health system that could also account for the country's stagnating performance in areas like tuberculosis control, immunization, family planning and maternal mortality reduction.

Role of Local Government Units (LGUs) in the implementation of Reproductive Health Services among Adolescents

Local Government Units (LGUs) play a vital role in the implementation of reproductive health services among adolescents. The LGUs are responsible for providing access to reproductive health services, including family planning, counseling, and education. One of the primary roles of LGUs is to ensure that adolescents have access to information and education about reproductive health. This includes providing information 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 topics related to reproductive health.

In addition to providing education, LGUs should also ensure that adolescents have access to reproductive health services. This includes providing access to contraception, as well as testing and treatment for sexually transmitted infections. LGUs should also provide counseling services for adolescents who may be experiencing reproductive health issues, including unplanned pregnancies (Lee et al, 2015). Based from the results of this present study, informants were very eager to improve their facilities towards being adolescent-friendly but the lack of support and funding hinders it. Moreover, some of the health workers were also hesitant to dispense contraceptives due to the misimpression that may happen.

LGUs should also work to remove barriers to access for adolescents. This may include providing services in schools or other community-based locations, as well as providing services outside of regular business hours. LGUs should also work to reduce the stigma surrounding reproductive health services, particularly for adolescents, to encourage more young people to seek out the care they need.

Government Organizations, Private Sector, and Civil Society Organization (CSOs) Involvement in the implementation of RH Law

Despite these challenges, efforts are being made to improve the availability of reproductive health and contraceptive services in RHUs and BHSs in the Philippines. This includes increasing funding and staffing for these facilities, providing training and resources for healthcare workers, and addressing cultural barriers through community education and outreach programs (Witmer et al, 1995). Some RHUs and BHSs have also partnered with non-governmental organizations and other stakeholders to expand their range of services and reach more people in need (Araos et al, 2020).

The implementation of the law involves different sectors of society, including the private sector and civil society organizations (CSOs). Private sector involvement in the implementation of the RH Law can take different forms. Private companies can provide funding, technical expertise, and resources to support the implementation of RH programs. For example, some companies have partnered with the government to provide free or subsidized family planning services to their employees. In this study, discussants suggested that number of civil society organizations have provided them with reproductive health services that benefit the adolescents.

The private sector can also play a role in raising awareness about RH issues. Private companies can use their marketing and communication channels to promote the importance of family planning and reproductive health. For instance, companies can use their advertising resources to create public service announcements and campaigns that educate people about family planning. Civil society organizations (CSOs) can also play a vital role in the implementation of the RH Law. These organizations can provide advocacy, technical assistance, and capacity building to government agencies and other stakeholders. CSOs can also work directly with communities to provide information, education, and services related to reproductive health. CSOs can also help monitor the implementation of the RH Law and hold the government accountable for its commitments. For example, CSOs can conduct research and gather data to assess the impact of RH programs on different communities. They can also provide feedback to the government on the effectiveness and efficiency of RH programs and policies.

Gaps in the implementation of national and local policies targeting reproductive health of teenagers in the Philippines

As previously discussed, the Philippine government has implemented several initiatives aimed at improving reproductive health, including the Responsible Parenthood and Reproductive Health Law (2012) and the Adolescent Health and Development Program. However, there is still much work 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 sexual and reproductive health. The present study observed that the perceived burden of teenage pregnancy is high in the study areas particularly among the parents and teenagers. Hence, it is necessary that there is a need to improve the accessibility of contraceptives, improving sexuality education in schools, reducing stigma around premarital sex, and improving the quality and availability of reproductive health services (Chandra-Mouli et al 2014). This recent suggested that utilization rates of contraceptives in the Eastern Visayas Region was low as evidenced by low usage of contraceptives among teenage pregnant.

The limited access to contraceptives among young people in Eastern Visayas Region might be mainly attributed to cultural and religious beliefs, limited availability in rural areas, and financial barriers (Parker et al 2009). Moreover, inadequate sexuality education is not widely taught in schools in the Philippines including the schools of Eastern Visayas because teachers and parents are uncomfortable discussing sex with their children. This can leave

young people without the knowledge they need to make informed decisions about their sexual and reproductive health.

In addition, there is a stigma around premarital sex in the region since most of the population were mainly Catholic resulting to significant concerns attached to premarital sex. Stigma around abortion and contraception can also prevent individuals from accessing needed services (Bankole & Malarcher, 2010). This can lead to young people being afraid to seek out information and services related to sexual and reproductive health (Nguyen, 2019). These factors are leading to lack of comprehensive reproductive health services suggesting that even young people seek out reproductive health services, they may encounter challenges such as long wait times, lack of confidentiality, and insufficient information about available services. Aside from the stigma around premarital sex, these cultural beliefs and practices may discourage individuals from seeking family planning services or using contraceptives (Tanyag, 2018).

Another concern resulting to early pregnancy is the limited access to family planning services of many remote and disadvantaged communities in Eastern Visayas as depicted in this present study. In addition, there is 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 reproductive health issues (Ramarao, 2003).

The region also faces a lack of comprehensive education on reproductive health, particularly among young people. Sex education is not widely taught in schools, and many families are reluctant to discuss the topic at home. This lack of education can lead to misconceptions and stigma around reproductive health, which can negatively impact individuals' health-seeking behavior (Nguyen et al 2022). In relation to poor coverage and accessibility, the region also faces challenges in providing adequate maternal and child health 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 (Pagatpatan et al 2015).

VI. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Teenage pregnancy is still a public health concern in Eastern Visayas particularly among low-income teenagers with parents having low educational attainment. It was observed that the youngest age of pregnancy was 12 years old. In terms of the age of the respondents' children, about a quarter are less than one year old. It can be noted that women from GIDA communities tend to have a smaller number of sexual partners, longer inter-pregnancy intervals, and higher proportion of preterm labor, than otherwise.

Programs on reproductive health were implemented from the regional to barangay level, however, low utilization was observed among teenagers which can be attributed to cultural and social influences as dictated by the current norms of the society in the province. The role of different environmental factors to the sustained prevalence of teenage pregnancy was unclear between different groups. However, to some extent, major environmental factors affecting teenage pregnancy include early exposure to social media, influence of peers, lack of education, and abuse. Hesitancy to participate and utilize basic services on reproductive health among teenagers and their parents were observed in the study areas. Some healthcare providers were also observed to be reluctant in discussing and involving young individuals to reproductive health programs which can be explained by the stigma created by cultural taboos in the study areas.

Recommendations

National level

1. Engage the Department of Education (public and private schools) in their efforts to shift from an abstinence-only framework to comprehensive sexuality education in its K to 12 curricula by providing technical support and capacity building. Moreover, clarity on school guidelines and policies involving the continued attendance of teenage pregnancy cases in school, and support for special circumstances (e.g., delivery, prenatal check-up, limited physical education). As well as disciplinary actions for students' behaviors such as bullying, name calling, etc.
2. Review the Department of Health guidelines on the financing of adolescent health services with a policy focusing on the role of different agencies including the national health units, local governments, and other funding partners can support contraceptive

services to adolescents. Moreover, review the existing guidelines on behavior change communications to remove its abstinence-centered and sex-negative content and to agree with the education department's Comprehensive Sexuality Education framework.

3. Encourage the legal clarification and policy forum discussion on the restrictive parts of the RH law based on Section 27 stating that "liberally construed to ensure the provision, delivery and access to reproductive health care services, and to promote, protect and fulfill women's reproductive health and rights."
4. Develop a multidisciplinary toolkit that will guide uniform yet culture-appropriate programs towards improving well-being of teenage pregnancy cases, as well as adolescents spearheaded by the Department of Health and engaging non-government or specialty organizations.
5. Develop and implement a standardized training program for health, education, and leadership service providers to improve their manner of approaching, teaching, and delivering service to their constituents.

Provincial level

1. Encourage provincial government offices to create ordinance institutionalizing the involvement of adolescents and young people decision-making on sexuality and reproductive health including the use of contraceptives and capacitating the health workers on providing appropriate sexual health condition among adolescents.
2. Issuance of the Provincial Administrative in terms of their legal opinion clarifying that while the law recognizes spousal consent, it does not include penalties for those who prefer to omit this procedure. It is also suggested to clarify the prohibition on the procurement, distribution, and provision of emergency contraception pertains only to government hospitals and therefore does not apply to private and nongovernment providers.
3. Discuss and create strategies to provide economic, health care, social, and educational support among teenage pregnancy cases and their families – specifically financial assistance to parents of adolescent pregnancy cases, livelihood projects for teenage couples, etc.
4. Implement capacity-building strategies among different sectors (e.g., education, health, religion) on improving their capabilities to participate in adolescent-related programs and activities.

Municipal/ Barangay level

1. Institutionalize local policies and ordinances that will enable the provision of contraceptive services to adolescents which are allowed by the RH law, such as services to adolescents aged 18 and above; minors who have consent from their parents or guardians; and minors consulting in private and NGO facilities, which are not explicitly covered by the prohibition in the law.
2. Addressing these gaps in Eastern Visayas requires a multi-sectoral approach that involves the government, civil society organizations, and the private sector. Efforts should focus on increasing access to family planning services, providing comprehensive education on reproductive health, improving maternal and child health services, and addressing cultural barriers and stigma. With sustained efforts, the region can achieve significant progress towards improving reproductive health outcomes for its people.
3. Implement and sustain developed strategies to provide economic, health care, social, and educational support among teenage pregnancy cases and their families – specifically financial assistance to parents of adolescent pregnancy cases, livelihood projects for teenage couples, etc.
4. Sustain and regularly implement capacity-building strategies among different sectors (e.g., education, health, religious) on improving their capabilities to participate in adolescent-related programs and activities tailored to the needs of the municipality constituents.

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APPENDICES

Appendix A. Documentation

Cross-sectional Survey

	
This photo was taken in the barangay hall in Pilit, Sta. Fe, Leyte. Shown here are two teenage mothers together with their toddlers being interviewed by Ms. Elame Melquiades. The participants were gathered thru the help of the barangay officials and BHWs. A total of 72 women participated in the survey conducted in Leyte.	There were 95 participants in the survey conducted in the towns of Eastern Samar namely Taft, Quinapondan, Dolores, and General MacArthur. In the photo above, Ms. Sharmene Esplago can be seen interviewing a teenage mother who is breastfeeding her baby and at the same time taking care of her older child. This photo was taken inside the house of the Barangay Captain of Pangabutan, Taft who can be seen in the photo wearing a green shirt.
	
Teenage mothers from Canjumadal, Pambujan Northern Samar can be seen laughing and interacting in this photo taken during the 2-day data collection in Northern Samar. With a limited time in Samar Island's tip province, a total of only 28 mothers were surveyed. The data gathering collection was spearheaded by Mr. Rufino Alegre and Ms. Uelaiza Hope Baldonado-Rama.	A group of teenage mothers in Barangay San Roque Marabut, Samar gathered inside the barangay's evacuation center/temporary health center as early as 9AM in the morning. The activity was conducted by Ms. ELM and Ms. UHBR. A total of 101 participants coming from GIDA & Non-GIDA barangays of Western Samar were surveyed for this research.

Focus Group Discussion

	
Ms. Sharmene Esplago and Mr. Rufino Alegre together with the teenage mothers from Eastern Samar are all smiles in the photo shown above after conducting their focus-group discussion. Aside from this group, Ms. SEC and Mr. RAA were able to conduct 3 other FGDs (teenage boys without children, teenage girls without children and parents of teenage mothers) in the province.	Thanks to the cooperation and hospitality of the school principal and teachers, another successful and insightful focus-group discussion was conducted with the teenage boys from Canjumadal National High School. A total of 4 FGD were held in Northern Samar, moderated by Ms. Uelaiza Hope Baldonado-Rama and observed by Mr. Rufino Alegre.
	
The photo shown above was taken in Barangay San Antonio, Basey, Samar's health center. The participants for this focus-group discussion were parents of teenage mothers. The moderator for this activity was Ms. Elame Melquiades (extreme right), observer was Ms. Uelaiza Rama (not in the photo) with the special participation of Dr. Kim Dela Luna (extreme left) as another observer during the activity.	Shy but never not ready for the camera, that's the teenage girls from Marabut Western Samar. Together with their moderator Ms. Elame Melquiades, they pose for the camera as a souvenir for the successful focus-group discussion they just had inside one of the rooms of the Marabut RHU. Meanwhile, upstairs Ms. Uelaiza Hope Baldonado-Rama was also doing an FGD with the teenage boys of Marabut.

Key Informant Interview

Ms. Uelaiza Hope Baldonado-Rama accompanied by Ms. Sharmene Esplago was able to interview the school nurse of Taft National High School who was enthusiastic to answer the interview questions. Despite their lack of a bigger school clinic and health equipment, Nurse LBL continues to serve the students with passion and determination.

Dr. Gina L. Palines (shown above on the right) a member of DepEd Samar's Division Comprehensive Sexuality Education Curriculum planning team came prepared with numbers and records for Ms. Uelaiza Hope Baldonado-Rama during the key informant interview held last November 10, 2022, via Google Meet. The interview was filled with knowledge, new perspectives and fun as the two enjoyed their exchange of ideas about teenage pregnancy in schools.

Appendix B. Tabular Presentation of Key Informant Interview

Main Theme	Sub-themes	Illustrative Quotes
Perceived Predisposing Factors	Teenage Pregnancy Cases as External	"Because in our communities, you will seldom find a case of teenage pregnancy but if there are, they were not originally from here." (*ID 14, Male, 19 years as church pastor*) "DOH and LGUs consider that as preparation for the known trend of increasing teenage pregnancy [elsewhere]. But, if you look at the teenage pregnancy data [in our community], it is just seldom, a few isolated cases only." (*ID 12, Female, 21 years in the health sector*) "Things are getting better unlike before… I feel like things are quieter and these cases are probably not within our municipality." (*ID 13, Female, 3 years in the service sector*)
	Parental Influence	"There are mothers, parents, who can discipline while there are those who cannot discipline." (*ID 13, Female, 3 years in the service sector*) "Although we all have our own decisions, for me, if only the family has been molded properly…teenage pregnancy could have been avoided." (*ID 10, Male, 1 year in the service sector*) "Our victims of teenage pregnancy really are the poor, with the parents having no proper education so they just tolerate their kids' actions like staying outside [their homes] and not focusing on studying anymore." (*ID 8, Female, 27 years in the health sector*)
	Variation between Boys and Girls	"There is a difference between the motivation of boys and girls to engage in sex early; girls tend to be easily attached and more emotional in giving what their partner wants, while boys are just curious and exploring." (*ID 11, Female, 4 years in the education sector*) "Boys are exposed to pornography while girls are not, so boys would boast to their peers like, "I have done this, how about you?" There's really a difference between

Main Theme	Sub-themes	Illustrative Quotes
		the reasons why girls engage in teenage pregnancy compared to boys." (*ID 4, Female, 13 years in the education sector*) "Male and female students are hesitant to inquire to adults about sex, but gay students, are not hesitant to approach me." (*ID 7, Female, 4 years in the health & education sector*) "Girls are very weak. Once they'll be with someone from the opposite sex - since they don't have experience - they would really engage to that [sex] especially when guys would insist." (*ID 4, Female, 13 years in the education sector*)
	Technological Influence	"The curiosity of boys might be influenced of watching porn with their friends - and eventually imitating what they saw." (*ID 15, Female, 9 years in the education sector*) "The influence of social media because even if they live in remote areas, their phones already have access to social media allowing them to see how people their age already engage in relationships." (*ID 11, Female, 4 years in the education sector*) "Teenagers are easily influenced with new technology. It is possible for them to easily communicate about where they can meet or share and believe to the ideas expressed by other people in social media." (*ID 10, Male, 1 year in the service sector*)
Multi-sectoral Responsibility	Importance of SRH Education	"Sexual and reproductive health education must really be done first, even in elementary, so that their minds are open about such topics and when they come here, they are already aware." (*ID 8, Female, 27 years in the service sector*) "There are adolescent mothers waiting for prenatal check-up in one of our centers, and they have not been adequately advised about family planning. I asked them on what family planning method they are using but they did not have one. There was a currently pregnant 17-year-old, but caring for her 6-month-old baby, and an 18-year-old woman who already has two children, and currently pregnant, but she is not taking any pills." (*ID 3, Female, 5 years in the health sector*)

Main Theme	Sub-themes	Illustrative Quotes
		"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*)
	Structural Needs of Facilities	"We [key informants] are trying to reach a Level 1 Adolescent Friendly facility however we [local health unit personnel] are still lacking trainings. 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*) "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 LHU does not withhold contraceptives. It's not like they don't want 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 coming to us. Maybe the government has a budget for adolescent targeted programs but it's not reaching the local units. There is no available testing for HIV or other diseases." (*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 pandemic]." (*ID 9, Female, 22 years in the health sector*) "If the person handling the SRH education is not that trained on dealing with adolescents, they would not come to us. So, we really need to be groomed for this [adolescent targeted programs]." (*ID 5, Male, 3 years in the health sector as supervisor*) "We find it hard to provide access to birthing services since our license to practice was not renewed. Now, pregnant mothers in the area are having difficulties since we must transfer them to another RHU." (*ID 2, Female, 34 years in the health sector*)

Main Theme	Sub-themes	Illustrative Quotes
	Unclear Policies and Guidelines	"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]." (*ID 12, Female, 21 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. All we can do is check for wounds or bruises, but we still must wait clearance from other agencies like the police before doing anything." (*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*) "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, 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*) "We are advised to control the number of complains; before we make any actions, we allow time for the people involved to settle it on their own first, and not go to us in the barangay [office] immediately." (*ID 6, Female, 3 years in the service sector*)
Consequences of Teenage Pregnancy	Spousal Abuse	"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 since these couples tend to fight more due lack of enough or loss of income to sustain their needs." (*ID 7, Female, 4 years in the health & education sector*)

Main Theme	Sub-themes	Illustrative Quotes
		"There was 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. When he found out that he will be punished with life imprisonment, his relatives tipped him thus he was able to escape." (*ID 2, Female, 34 years in the health sector*)
	Societal Implications	"If every teenage girls will get pregnant early, can you imagine their future or their parents' dreams for them, and it seems that it will not be as successful." (*ID 8, Female, 27 years in the health sector*) "For the woman, her life is destroyed or changed because of teenage pregnancy, better if she will find a good man." (*ID 14, Male, 19 years in the religious sector*) "They [teenage pregnancy couples] are already living together but are not legally married and I pity them, and they remain hesitant even if I am helping them to get married, those who already have three or four kids, yet they still haven't been married." (*ID 6, Female, 3 years in the service sector*) "If they get pregnant early, they can be treated differently by their peers and it's really embarrassing for them. They might not yet be ready emotionally and can lead to things like depression." (*ID 3, Female, 5 years in the health sector*)
	Impact on Parents	"When parents discover what happened to their child, it is also difficult for them - like when other people see their child as pregnant and get talked about." (*ID 13, Female, 3 years in the service sector*) "If the answer is to go back to school, so who can help them? We can refer to the government to help them, and deliver family planning to them, counsel their parents as well, because it's fine as long as the guardian will sign." (*ID 8, Female, 27 years in the health sector*)

Main Theme	Sub-themes	Illustrative Quotes
	Schooling after Teenage Pregnancy	"We need to make them feel that they are still welcome to school, and there is no hindrance to continue with their studies... there is a need to support and protect them from discrimination." (*ID 11, Female, 4 years in the education sector*) "They are encouraged to continue with their studies because if they don't 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 pre-natal visits. After birth, I regular ask about the health and well-being of their children. However, we can only do so, since as school nurse, my resources are limited but we, including teachers, try to help them finish their studies." (*ID 7, Female, 4 years in the health & education sector*)
	Access to Contraception	"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, 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*) "We only give out contraceptives to married couples. We don't give it to those who have no partners for us to identify the married from the single ones, unless they have irregular menstruation." (*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*) "Teenagers will be more complacent since they won't get pregnant. They will not be careful anymore [in avoiding sexual intercourse] because there is contraceptive already." (*ID 7, Female, 4 years in the health & education sector*)

Appendix C. Tabular Presentation of Focus Group Discussion

Main Theme	Sub-themes	Illustrative Quotes
Immediate Feelings	Being Lied to	When my daughter got pregnant at 15, it broke my heart so much because she lied to me. I allowed her to skip household chores so that she can focus on her studies, and yet she still did these things. [*ID 61, 42 years old, mother of a teenage parent*]
	Frustrated	I was very frustrated, and my blood pressure increased. I also felt that I was betrayed since only a friend noticed that her abdomen is getting bigger. I wish I could have looked closer or listened to my doubts about the long hours of practice for a school presentation. [*ID 60, 41 years old, mother of a teenage parent*] It was hard because when I caught her leaving the house late at night, it was very difficult to reprimand her. She always told me that she's not going to do it because she learned from my experience that marrying early is a very hard situation. [*ID 19, 56 years, mother of a teenage parent*]
	Derailed Plans	My child was in grade 9 and she told me that she did not want to study anymore.I felt bad when she told me the situation because even after everything I did to her, this still happened. I don't know what to do about her plans, either finish school or have a job with a better salary. [*ID 37, 39 years, mother of a teenage parent*] We are still young to get jobs, our parents wanted us to study first, and help them in household chores for now. But I think, parents should also be given support for providing for us and our child since we cannot yet help financially. [*ID 34, 15 years old, teenage mother*]

Main Theme	Sub-themes	Illustrative Quotes
		Around the time my mother found out that my sister got pregnant, she cried and told her that she was the only hope of the family to have a better future. [*ID 50, 15 years old, teenage boys*]
Coping Responses	Setting Negative Feelings Aside	Though I was angry and would punish her in some ways, my neighbor told me not to do it because she might lose her baby because of stress, and it will be a bigger problem. [*ID 59, 44 years old, mother of a teenage parent*] When I learned about the pregnancy, I initially got angry but, in the end, there is nothing to do about it anymore. It's better now since she decided to continue her studies, and she listens to our advice more frequently. [*ID 60, 41 years old, mother of a teenage parent*] My parents were angry, but they continued supporting and helping me. They just keep on making comments that we still do not have any job, no money to spend for giving birth, or no one to sustain the needs of the child. [*ID 35, 23 years old, teenage mother*] People from our church say that providing sex education in school will just feed our curiosity, but my parents approve of it. They remind me not to do sexual acts early, but it gives them comfort that I know what to do just in case it happens. [*ID 7, 15 years old, teenage boy*]
	Fear of Further Harm	We felt the need to support my niece because we were afraid of an incident where a girl committed suicide because her parents were angered of her pregnancy. We tried to support so that she would not think of similar ideas. [*ID 36, 58 years old, aunt of a teenage parent*]
	Handling Marital Issues	I was told that the teenage couple fought a lot in the house. Initially, I was very angry with the partner of my pregnant daughter but I had to understand since they are still

Main Theme	Sub-themes	Illustrative Quotes
		kids and are not prepared for these things. I should be the one guiding and helping them. [*ID 61, 42 years, mother of a teenage parent*] My son and his partner were 15 years old when they lived with us during her pregnancy. She was mentally unstable and tends to be physically violent when they fight, so my husband and I had to meddle. They are still young and must work things out since they have a child. [*ID 17, 45 years, mother of a teenage parent*] One of the things that we discuss with these children is the need for contraception. Even if they tell us that they are not doing it, they are young and are more likely to get separated if they do not do it (referring to sex). [*ID 19, 56 years, mother of a teenage parent*] When there is a fight between couples, they should settle it on their own. Since both of them decided to make a family, try to settle issues like a family also. When things become very difficult, that's the time when parents can meddle. [*ID 51, 15 years old, teenage boy*]
	Learning from the Incident	I can notice a huge difference in how my daughter behaves now that she already has her own daughter. Being separated from her former partner, she is more careful with boys courting her. I told her that it's up to her if she wants to be involved in a similar situation again. [*ID 20, 41 years old, mother of a teenage parent*] My daughter was more comfortable attending school after birth, unlike when she was still pregnant where she did not want to go to school because of shame. Her father and I had to force her to keep on going to school, not be ashamed, and be held accountable. [*ID 20, 41 years old, mother of a teenage parent*]

Main Theme	Sub-themes	Illustrative Quotes
Community Perceptions	Parental Shortcomings	Most people say that teenage pregnancy happens due to lack of guidance from parents, but in my case, this is not true. I focused on her, and it still pains me that she was already pregnant for how many months, and I didn't even notice. I thought that she stayed away from her friends. [*ID 61, 42 years, mother of a teenage parent*] People think that such actions of the children are a reflection that there is a problem with the parents. People would assume that their teenage child who is pregnant got along well with their partner because there is a lack of parental guidance. [*ID 19, 56 years, mother of a teenage parent*] As much as we want to guide our children to avoid having sexual relationships, teenagers still make their own final decision.. Like in my case, my daughter and I go to church regularly, and we even have outdoor vacations, but they still they wanted to follow their own rules and refrain from listening to their parents [*ID 17, 45 years, mother of a teenage parent*] My child only confessed that she has been drinking and smoking when one of my friends just informed me about the situation. My friend told me that I should advise and be stricter with my daughter but I just ignored the comment. I should have listened before. [*ID 61,42 years old, mother of a teenage parent*]
	Family Background	The mother of my son's partner had a daughter from another partner who became a person with a disability. However, she keeps abandoning her children. I think such a family background resulted in the girl's desire to marry early and leave their family. [*ID 18, 45 years, mother of a teenage parent*] According to my parents, people who experience teenage pregnancy were not disciplined well by their elders in the family. [*ID 63, 14 years old, teenage girl*]

Main Theme	Sub-themes	Illustrative Quotes
		Most of my older relatives tell us that if parents do not give enough time to advice and check on their children. These incidents (teenage pregnancy) happen, and it is a sign of parental neglect. [*ID 63, 14 years old, teenage girl*]
	Technology	One probable explanation would be the influence of devices used as a distraction like television and cellphone. They can stay up all night on their phones sending text messages to each other or scheduling meetups . [*ID 62, 50 years, mother of a teenage parent*] These children tend to become more engaged in social media or look for things on the Internet such as pornography or sex-related content using their cellphones. [*ID 19, 56 years, mother of a teenage parent*] It started with hanging out with friends, smoking, and watching pornographic stuff on their cellphones. The boys and some girls got curious about sex and since they tend to hang out in places where they were left alone by their parents, they have the freedom to do these things. [*ID 20, 41 years old, mother of a teenage parent*]
	Friends/Peer Pressure	My daughter tends to hang out with her friends for a long time. The fact that she got pregnant when she was always hanging out with her friends. [*ID 62, 50 years old, mother of a teenage parent*] My daughter was studying well until she had these friends. [*ID 61,42 years old, mother of a teenage parent*] It started with these children hanging out, smoking, and watching pornographic stuff on their cellphones. [*ID 20, 41 years old, mother of a teenage parent*]

Main Theme	Sub-themes	Illustrative Quotes
		I was always scolded at the house, and it came to a point where I just decided to go with what everyone was thinking. I did not get pregnant right away, but I left home and lived with my partner for many months. [*ID 16, 19 years old, teenage mother*] I had sexual intercourse without regard to whether it was right or wrong because I was too drunk around the time that I did it and it seemed normal because most people of our age including my friends are doing it. [*ID 12, 18 years old, teenage mother*] Boys will pressure the girls to do it with them. The boys will make you feel assured that they will be responsible for you, once they get what they want, it will be a pitiful situation for the girls. [*ID 2, 18 years old, teenage mother*] One reason for the pregnancy cases could be the presence of fraternities, like brotherhood in the neighborhood. It's like a gang that promotes these activities with their girlfriends. Most of the kids who are members of these gangs are abandoned by their parents. [*ID 69, 15 years old, teenage boy*]
	Invincibility	When I was younger, I tended not to listen to what my parents say, because I think I know better. Younger people should realize not to engage with sex too early since it can destroy their dreams, it can destroy them. [*ID 35, 23 years old, teenage mother*]
	Consequences to these Cases	According to our teacher, these teenage pregnancy cases are reported as a warning for other teenagers. It is a reminder that it is still too early to engage in such activities, so that your future will not be destroyed. [*ID 46, 15 years old, teenage girl*] From what I know, teenagers who engage in such activities do not have control or have no idea how difficult their situation might be. I know someone who has children, but they still do not have their own house and has to move back to their parents. [*ID 24, 13 years old, teenage girl*]

Main Theme	Sub-themes	Illustrative Quotes
		My elders tell us that teenage parents did not think first when they did it. They did not think about what they were doing even though they already saw how hard it is for other people. They should have focused on finishing their studies first. [*ID 25, 15 years old, teenage girl*] When I heard about teenage pregnancy, I recall that these classmates were bullied, like actual bullying and cyber-bullying. They are usually the topic of gossip in the school. I feel bad for them. [*ID 47, 48 & 51, 15 years old, teenage boys*] The teenage pregnancy that we know are very quiet and intelligent, but they get easily deceived by boys. I think these boys feel like there is nothing to lose for them, like it's the girls who will lose more since they get pregnant. It's like they don't really care, they just want to experiment or try what they see in their phones (pornographic materials). [*ID 8 & 11, 13 & 14 years old respectively, teenage boys*] The girls are at a disadvantage in these situations. Most of the people I know did not really want to disobey their parents but were forced to do it because their partners were having sexual intercourse as a sign of love for them as their boyfriends. But these boys do not really care, they just want to do it for the sake of doing it and bragging about it. [*ID 10, 16 years old, teenage boys*]
Facilitators of Access to Services	Sex Education	There is a lack of information about sexual activities that is why this becomes a problem. I know someone who is twenty years old and asked for condoms in the health center, but they were scolded since he is not yet married but asking for these things. [*ID 9, 12 years old, teenage boy*] In school and in barangay seminars, they try to teach about pills and family planning but it's like they just go through the session and they do not seem to be interested in

Main Theme	Sub-themes	Illustrative Quotes
		availing of these services. We do not want to practice it but we are aware of its importance and avoid unwanted pregnancies. [*ID 8, 13 years old, teenage boy*] It's like when sex education sessions are conducted, they make us feel like we are not supposed to ask questions and just listen. It feels like there is malice or you are a pervert when you try to clarify things during lectures. That is why, maybe the lessons about early pregnancy were not clear to them. [*ID 10, 16 years old, teenage boy*] Aside from sex education, people should also be taught about sensitivity. Like boys being more sensitive about the feelings and concerns of the girls; and the girls to be also sensitive and exercise more control in refusing to do it and use protection [*ID 26, 17 years old, teenage girl*]
	Supportive Family	My family supported our decision to move in together because I was already pregnant. Our parents were initially angry, but it went well since they were supportive of us, and even helped us with accessing services for the child. [*ID 33, 17 years old, teenage mother*] We were told to focus first on deciding what we want to do in our lives as a teenage couple. They were supportive of our plans to continue studying and even helped us enroll or get free materials from organizations.[*ID 34, 15 years old, teenage mother*] At first, they were disappointed but her parents did not abandon her, even supporting and helping them as a couple. They were asked to stay just near the parents' house. [*ID 8, 13 years old, teenage boy*]
Barriers to Accessing Services	Inadequate Supplies/Information	There is a need to have them more informed on family planning services. There were times when supplies were unavailable in the health center, or the workers cannot fully explain how contraceptives work. [*ID 17, 45 years old, mother of a teenage parent*]

Main Theme	Sub-themes	Illustrative Quotes
		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*] 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*] 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*] Some couples were afraid of using contraceptives because of the restrictions on daily activities. Like when IUD is inserted, she must avoid lifting heavy things for a while, or stories on the side effects of pills. [*ID 20, 41 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*] There is no kind of help from anybody else. Families, relatives, and friendly neighbors only helped each other like how my parents helped my cousins who got pregnant. [*ID 49, 15 years old, teenage boy*]
	Approach of the Public Servants	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*]

Main Theme	Sub-themes	Illustrative Quotes
		My daughter was given an IUD after delivery as part of family planning but she later developed a fever. It was found out that the IUD was not placed well. The doctors insisted on placing it back, but we refused. They did not give us other options for family planning. [*ID 20, 41 years old, mother of a teenage parent*] 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. Services offered were up to them if they wanted to help you or not. [*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 so she was forced to continue the pregnancy even if she received no support from the health center or government. [*ID 13, 17 years old, teenage mother*] I am sometimes afraid to go to the health center in the municipal hall because the people there always scold me. [*ID 56, 20 years old, teenage mother*] Teenagers do not want to go to the center because they keep on scolding us. It tends to be repetitive and at times, you feel ashamed because they reprimand us in front of other patients. [*ID 34, 15 years old, teenage mother*] There will be a lot of things that they say to you but I just don't mind it. There is nothing else I can do about my situation, so the repeated reprimands are of no use anymore. They are not as active when other people are inquiring or trying to access stuff (condoms or OCPs). [*ID 35, 23 years old, teenage mother*]

Main Theme	Sub-themes	Illustrative Quotes
		According to our teacher, cases of teenage pregnancy serve as a warning for other teenagers. It is a reminder that it is still too early to engage in such activities and they will lose their dreams and the future ahead of them. [*ID 46, 15 years old, teenage girl*] Some girls who got pregnant early have difficulties coping in school or visiting the center. In school, they are used as examples of being disgraceful. In health center consultations, when they learn how old they are, they start spreading stories or change their attitude. [*ID 7, 15 years old, teenage boy*] Even during the pandemic where people have no jobs, people in the barangay and in the center always seemed rude. [*ID 48, 14 years old, teenage boy*] I know someone who is twenty years old and asked for condoms in the center, but they were scolded since he is not yet married. [*ID 9, 12 years old, teenage boy*]
	Religious Influence	My family is interested in engaging me with family planning activities but it was not supported by our church. They argued that once teenagers are taught about sex education, they will use this knowledge and apply it themselves. [*ID 57, 21 years old, teenage mother*]
	Irregular or Infrequent Activities	There are some activities targeting the youth and teenage pregnancy but it happened a long time ago and was organized by a non-government organization. There are activities like these, but they are not regularly done. [*ID 3, 18 years old, teenage mother*] The health center near us does not have regular clinic hours. Prenatal checkup for teenage women is only available here. [*ID 56, 20 years old, teenage mother*]
	Lack of Tailored Activities	Even if you see in the news that the cases are increasing, we tend to feel that it will be a different case for us. I tend not to listen to what my parents say, because I think I

Main Theme	Sub-themes	Illustrative Quotes
		know better, like what happened to other people will not happen to me. [*ID 35, 23 years old, teenage mother*] Even if sex education is taught in school, it is really boring and not easy to understand so I was not able to get anything from it. [*ID 15, 18 years old, teenage mother*] I am not sure if there are services in school dedicated for teenage pregnant students. They do not know what to do and the school nurse will just refer us to a midwife or a doctor. I hope they will also have additional services in the school. [*ID 34, 15 years old, teenage mother*] We know someone who was harassed but the family decided to keep it to themselves because no one believed them. The girl felt ashamed, and for us, girls, we understand the situation, but not everyone will think like that. [*ID 45 & 46, 17 & 15 years old respectively, teenage girls*] I recommend having services like home check-up or provision of basic needs. Since we live far from the town hall, it was difficult to do prenatal visits and even more difficult after delivery. [*ID 70, 15 years old, teenage boy*]
Limitations of Services	Economic Support Support for Parents/Guardians	My son does not have any capacity to support a family of his own. The girl's family wants our son to provide for and stay with their pregnant daughter but no economic support or livelihood activity is available for these children. As parents, we also have too little money to support them. [*ID 17, 45 years, mother of a teenage parent*] Right now, I must take care of them (the couple) since they should focus on studying as it is difficult to find a job when you did not finish studying. It is also difficult for us since we, parents, must work harder. [*ID 37, 39 years, mother of a teenage parent*]

Main Theme	Sub-themes	Illustrative Quotes
		My daughter considered getting an abortion because her partner was not sure if he could support them. It was difficult because no services were available to help them financially. [*ID 20, 41 years, mother of a teenage parent*] As much as we want our daughter to continue studying, no one else can look after the child other than her, since my husband and I had to provide for them. There is nothing else we can do. [*ID 20, 41 years old, mother of a teenage parent*] Since we are too young to get jobs and our parents wanted us to study, I think that our parents should provide for us and our child since we cannot yet help financially. [*ID 34, 15 years old, teenage mother*] There are services not available for us, teenage mothers, or for rape victims who get pregnant and were forced to continue pregnancy. Support is unavailable from the health center or the government. [*ID 13, 17 years old, teenage mother*] We also need assistance for prenatal medicine and additional expenses like ultrasound. There are times when we are not able to do the laboratory tests since we cannot afford it. We do not have money because we still do not have jobs. [*ID 32, 21 years old, teenage mother*] After being kicked out by her father, a girl who got pregnant decided to live with her partner. It was hard for them because they couldn't find jobs, and the parents of the boy were already old. Eventually, the girl's father supported them, but it was still difficult since the father only earns little. [*ID 11, 14 years old, teenage boy*]
	Unclear School Policies	Pregnant teenagers are encouraged to finish their studies but not allowed to go up on stage during graduation. She was also reprimanded for sleeping during class and her

Main Theme	Sub-themes	Illustrative Quotes
		partner is also being teased. Even if I keep giving her allowance just to attend school, she does not want to go to school anymore. [*ID 60, 41 years old, mother of a teenage parent*] There are no clear school rules and regulations about teenage pregnancy. We just obey the instructions given to us by the teachers. [*ID 61, 42 years old, mother of a teenage parent*] It becomes more difficult for her to go to school since she also needs to take care of the child. As much as I want her to study and continue school, no one else can take care of the child other than her. [*ID 20, 41 years old, mother of a teenage parent*] The sad thing about teenage pregnancy is that their situation becomes even more difficult because of the rumormongers. There should be school policies against rumormongers. [*ID 9 & 10, 12 & 16 years old respectively, teenage boys*] There should be help available for teenage parents in schools. Some people got shy and bullied that they didn't want to go to school anymore. The teachers will not probe on why these students drop out. [*ID 11, 14 years old, teenage boy*]
	Lenience from Teachers	Even if my daughter comes tardy for school and submits requirements late, the teachers understand her situation and the teacher even reminds me to be more patient with her because my daughter might be too tired from taking care of the infant. I am very much appreciative of such gestures from her teachers. [*ID 60, 41 years old, mother of a teenage parent*] When she was 15 years old, she decided to transfer schools because of her pregnancy and the teachers were more accommodating. When she was about to give birth, the teacher allowed her to take the examination at a later time so that she would not fail or repeat the school year. [*ID 21, 52 years old, mother of a teenage parent*]

Main Theme	Sub-themes	Illustrative Quotes
	Counselling and Mental Health	There are non-government organizations that offer counseling services for teenagers but not regularly. I think it would be great if there is a focus on teenage pregnancy to handle different issues that come along with it. [*ID 20, 41 years old, mother of a teenage parent*]
	Dissemination of Services	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. 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*]
	Parenting Support	I would like to be helped on how to become a good mother or on how to raise a child since we are still teenagers. 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*] 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*]

Appendix B. Ethics Approval Certificate and Certificate of Registration from Research Grants Administration Office

CERTIFICATION OF APPROVAL

This certifies that the **University of the Philippines Manila Research Ethics Board UPMREB Review Panel 1** which is constituted and established, and functions in accordance with the requirements set by the University of the Philippines Manila, the Philippine Health Research Ethics Board (PHREB); and in compliance with the WHO Standards and Operational Guidance for Ethics Review of Health-related Research with Human Participants (2011), the International Council for Harmonization of Technical Requirements for Pharmaceuticals for Human Use (2016), and the National Ethical Guidelines for Health and Health-related Research (2017), has approved the following study protocol and related documents:

TYPE OF SUBMISSION: Resubmission	
UPMREB CODE: UPMREB 2022-0474-01	
SUBMISSION DATE: 21 October 2022	
STUDY PROTOCOL TITLE: Strategies on Teenage Pregnancy (STEP): Analysis of Early Pregnancy Situation in the Eastern Visayas as a Basis for Multi-Sectoral Policies to Reduce Teenage Pregnancy in the Region	
PRINCIPAL INVESTIGATOR: Ernani R. Bullecer, MD	
TYPE OF REVIEW: Expedited	
SPONSOR/FUNDING AGENCY: Korea International Cooperation Agency-World Vision Philippines	
APPROVAL DATE: 02 November 2022	**EXPIRY OF ETHICAL CLEARANCE:** 01 November 2023
DUE DATE OF APPLICATION FOR RENEWAL OF ETHICAL CLEARANCE (30 days before expiry): 01 October 2023 Submit application using the UPMREB FORM 3(B): Continuing Review Application Form.	**FREQUENCY OF CONTINUING REVIEW:** Yearly
APPROVED SITE/S: Eastern Visayas (Eastern Samar, Northern Samar, Western Samar, and Leyte).	
DATE OF BOARD MEETING: Not Applicable	
QUORUM: Not Applicable	
CONFLICT OF INTEREST: Primary reviewers declare no conflict of interest	
MEMBERS IN ATTENDANCE: Not Applicable	
ACTION TAKEN DURING BOARD MEETING: Not Applicable	
DOCUMENTS APPROVED BY UPMREB: 1. Study Protocol version 2; dated 17 October 2022; 2. Informed Consent English version 2; dated 17 October 2022; 3. Informed Consent Tagalog version 2; dated 17 October 2022;	

4. Key informant Interview version 2; dated 17 October 2022;
5. Cross-sectional Survey version 2; dated 17 October 2022;
6. Research Instrument version 2; dated 17 October 2022;
7. Key Informant Interview Guide version 2; dated 17 October 2022;
8. Research Instrument (Survey) version 2; dated 17 October 2022;
9.Summary Form for Secondary Data.

TECHNICAL DOCUMENTS INCLUDED IN THE REVIEW:

1. Curriculum Vitae and GCP training certificate (06 September 2022) of Ernani Bullecer,MD as principal investigator;
2. Curriculum Vitae and GCP training certificate (22 January 2020) of Alvin Duke Sy, MSPH,RN as co investigator;
3.Curriculum Vitae and GCP training certificate (05 January 2021) of Kim Leonard dela Luna, RND,MSPH,PhD as co investigator.

ADDITIONAL DOCUMENTS APPROVED BY DEPARTMENT OF HEALTH THROUGH SINGLE JOINT RESEARCH ETHICS BOARD REVIEW: Not Applicable

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR WHILE STUDY IS IN PROGRESS (*Please note that forms may be downloaded from the UPMREB website:* ***reb.upm.edu.ph*****):**

1. Register research study in the Philippine Health Research Registry upon approval (http://registry.healthresearch.ph)
2. Progress report using the attached UPMREB FORM3(B)2012: Continuing Review Application Form, as indicated above, which includes the following: *(NOTE: In view of active ethical clearance, this report is mandatory even if the study has not started or is still awaiting release of funds.)*
    a. Date covered by the report
    b. Protocol summary and status report on the progress of the research
    c. Philippine Health Research Registry ID
    d. Number of participants accrued
    e. Withdrawal or termination of participants
    f. Complaints on the research since the last UPMREB review
    g. Summary of relevant recent research literature, interim findings and amendments since the last UPMREB review
    h. Any relevant multi-center research reports
    i. Any relevant information especially about risks associated with the research
    j. A copy of the informed consent document
3. Any amendment/s in the protocol, especially those that may adversely affect the safety of the participants during the conduct of the trial including changes in

personnel, and revisions in the informed consent, must be submitted or reported using UPMREB FORM3(A)2012: Study Protocol Amendment Submission Form.

4. Report of non-compliance (deviation/violation), whether minor or major, at the soonest possible time up to six (6) months after the event, using UPMREB FORM 3(D)2012: Study Protocol Non-Compliance (Deviation/Violation) Report.
5. Reports of adverse events including from other study sites (national, international) using the UPMREB FORM 3(G)2012: Suspected, unexpected serious adverse event/reaction/s report, with timelines for submission guided by the GL 02 Version 2.0: Guideline on Reporting Serious Adverse Events; or list of reportable negative events using the UPMREB FORM 3(I)2012: Queries, Notification, and Complaints.
6. Notice of early termination of the study and reasons for such using UPMREB FORM 3(E)2012, or notice of time of completion of the study using UPMREB FORM 3(C)2012: Final Report Form.
7. Any event which may have ethical significance, and/or any information which is needed by the UPMREB to do ongoing review.

CECILIA A. JIMENO, MD
Chair, UPMREB Review Panel 1

UNIVERSITY OF THE PHILIPPINES MANILA
Research Grants Administration Office
G/F Room 111 National Institutes of Health Building, UP Manila, 623 Pedro Gil St., Ermita, Manila 1000, Philippines
Tel: (632) 85672054 • Email: rgao@post.upm.edu.ph

CERTIFICATE OF REGISTRATION

Research Title	*Strategies on Teenage Pregnancy (STEP): Analysis of Early Pregnancy Situation in the Eastern Visayas as a Basis for Multi-Sectoral Policies to Reduce Teenage Pregnancy in the Region*
Principal Investigator	Ernani R. Bullecer, RND, MSPH, DrPH
Co-investigator(s)	Kim Leonard G. dela Luna RND MSPH PhD, Alvin Duke Sy RN MSPH
Status at Time of Registration	Proposal
Date of Registration	25-Aug-2022
RGAO Reference No.	RGAO-2022-0846 Note: For ease of identification, please use this assigned RGAO Reference Number for all communications with RGAO that is related to this research.

This is to certify that the abovementioned research is registered with the Research Grants Administration Office for records purposes. However, this does not equal to nor guarantee technical and/or ethics review approval.

MARK ANTHONY S. SANDOVAL, MD
Head, Research Grants Administration Office
Office of the Vice Chancellor for Research, UP Manila

Informed Consent

Project Title:	**S**trategies on **TE**enage **P**regnancy (STEP): Analysis of Early Pregnancy Situation in the Eastern Visayas as a Basis for Multi-Sectoral Policies to Reduce Teenage Pregnancy in the Region
Institution/Sponsor:	University of the Philippines Manila – College of Public Health/World Vision Development Foundation, Inc.
Primary Investigators:	Ernani Bullecer, RND, MPH, DrPH; Kim Leonard dela Luna, RND, MSPH, PhD; Alvin Duke R. Sy, RN, MSPH

This Informed Consent Form has two parts:

- Information Sheet (to share information about the research with you)
- Documentation of Consent (for signatures if you agree to take part in the study)

PART I: Information Sheet

A. Purpose and Background

We are researchers who are currently interested in identifying, and developing effective strategies (e.g., interventions, advocacies, policies) to reduce the risks associated with teenage pregnancy in the Eastern Visayas region.

The current project is supported by the World Vision Development Foundation, Inc., the University of the Philippines Manila – College of Public Health.

B. Participant Selection

The researchers are composed men and women affiliated with the University and the organization based in the region.

You are being invited as a participant since the study will sample representatives from the potential direct beneficiaries, and education, health, and service providers/policy makers which include women who had experienced pregnancy at less than 19 years of age.

Around 270 participants will be included in this cross-sectional survey, and approximating about 68 women per province in the Eastern Visayas region included in the study setting.

C. Data Collection Procedures

Upon agreeing to participate in the current study, you will be asked to sign the consent form for agreeing to participate in the survey. The securing of consent, and answering the survey will last for about an hour at most, and composed of two parts.

The first part involves providing a background of the study, and securing consent to participate in the survey. The second part is answering the survey form which would last for about 15-30 minutes.

Every participant is encouraged to ask questions and has a freedom to discuss whatever he/she wants to talk about. This aspect of data collection will be conducted along with the key informant interviews and focus group discussions in the region. This part is targeted to last for one to two months at most. However, your participation will be limited to participating in the survey which would last for about one hour, depending on the flow of the data collection.

D. Potential Use of Secondary Data

This study is collecting personal information from the participants. We would like to make the data available for other research studies that may be done in the future. The research may be about similar conditions or environments as the current study. However, the research could also be about unrelated conditions, or other types of research; and these studies may be done by researchers from the University of the Philippines, and the World Vision Project, Inc. as well.

However, the decision to share your data is controlled by the investigators of the study. To be able to have access to the information you shared, future researchers must seek approval from the World Vision Project, Inc. and the University of the Philippines College of Public Health as well. Your name and identifying information will be removed from any data collection form or information frame before they are shared with other

researchers. Researchers will not be able to link your identifying information to the data.

E. Risks

There is *no direct harm or risk* from participating in the study. There will be no expenses on your part from participating in the said activity. We are aware of the possibility that personal information or experience shared in the survey form will be known to other people. However, the personal information written in the demographic forms would not be divulged in any way. At the same time, the data that you have shared cannot be used against you in any form or way.

F. Benefits

There is *no direct or immediate benefit* from participating in the study, except for the honorarium from participating in the said survey. A better understanding of the potential and perceived factors on adolescent pregnancy in the select provinces of Eastern Visayas will be helpful in developing and implement effective strategies to address this concern.

The results of the study may also serve as a basis for development or redesigning of regarding health care delivery services and interventions targeting adolescents.

G. Summary of the Participant's Rights

With your participation in this study, you are made aware that the result of this study could be published in local or international journals and give consent to this if your records will not be disclosed to anyone aside from the investigators and the Ethical Review Board members if they wish to examine the individual records of the study.

Your name, initials, or anything that ties you with the discussion will not be written, used, or shared to other people except for the investigators. We would be using a different name to protect your identity.

You do not have to participate in this study if you do not want to. Since engagement in the study is voluntary, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled.

In addition, the information that you would be sharing cannot be used against you in any way. The transcriptions or forms can never be used as evidence in any trial or audit that may affect your employment status or reception of services.

Moreover, you cannot share or divulge what was done in the data collection to any other person aside from the investigators, or in any other place aside from the setting of the survey. Whoever will be found to breach this privacy and confidentiality clause will not be protected by this contract anymore.

The collected data will be stored in the primary investigator's laptop and kept under password-protected folders. Data encryption will be performed when sending information over the internet. Once data analysis has been done, records, raw data, and semi-processed data collected from this study will be deleted. All information that might contain important information or identity will be deleted immediately.

We assure you, as participants in the study, that we will act based on the Data Privacy Act of 2012. You can request to have access to your personal data, and have the right to ask for alteration or deletion of the shared data if you found any erroneous entry, or even consider removal of your data from the study.

As previously mentioned, the results of the study will be made available to you upon request, within three months from the final data collection. This will contain the summary of the key findings, as well as the conclusion and recommendations. However, the full breadth of results and the manuscript will not be accessible to the study participants.

H. Questions

The protocol of this study has been reviewed and approved by the college and the ethics review board. If you have any questions or concerns about your participation in this study or do not wish to continue, you may reach out to the investigators, Prof. Alvin Duke Sy via e-mail at arsy3@outlook.up.edu.ph, or Prof. Kim Leonard dela Luna via telephone at (02) 8526-0811 local 110 or 09088772876 for any concerns.

In addition, you may contact Dr. Cecilia Jimeno, Chair of the UP-Manila Review Ethics Board Panel 1, which is concerned with the protection of volunteers in research projects. You may reach the board office between 8:00 AM and 5:00 PM, Monday through Friday via phone at (+63 2) 85264346. You can also send an email at upmreb@post.upm.edu.ph or by writing at the University of the Philippines- Manila Review Ethics Board, Room 126, G/F, NIH Building, UP Manila, 623 Pedro Gil St, Ermita 1000 Manila.

Participant No.: _____

Part II: Documentation of Consent

Please check if you agree to the following:

_____ *I give consent to participate in this study.*

_____ *I agree that I cannot share or divulge what has transpired in the data collection.*

OR: Documentation of Assent (for minors)

Please check if you agree to the following:

_____ *Since the person being considered for this study is unable to consent for themselves because they are a minor. I am giving permission for my*_____, (relationship) _____ *to be included in this study.*
(name of participant <18 years)

_____ *I also agree that we cannot share or divulge what has transpired in the data collection.*

Part III: Documentation of Consent for Secondary Analysis

Please check depending on your choice:

_____ **YES**, *use the data shared for other related research studies*

_____ **NO, DO NOT USE** *the data shared for other related research studies.*

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks have been explained to my satisfaction. I understand I can withdraw at any time.
I was also given the opportunity to ask and clarify, and I was given appropriate and sufficient answers to my questions.

_____	_____
Signature of Study Participant/Legal Guardian	Date
_____	_____
Signature of Witness	Date
_____	_____
Signature of Investigator	Date

F
Use the left thumbmark when the respondent has no capacity to sign the document due to inability to read and write, and any other physical disability.

LEFT THUMBMARK

Research Instrument (Survey)

GENERAL INSTRUCTION: Please answer the following questions that you can comfortably answer for 10 minutes. Rest assured that your answers will be always confidential.

Q1	**Name:** (*Optional*)	Q2A	**Age of the respondent (*years*):**
Q2B	**Age of the respondent during the teenage pregnancy?** *Specify multiple births.*		
Q3	**Age of Gestation (*Kulang o sakto sa buwan noong nanganak*):**		
Q4	**Current Marital Status:** ***(1)*** Single, with partner ***(2)*** Single, without partner ***(3)*** Married ***(4)*** Widowed/separated	Q5	**Marital Status of the Teenage Pregnant:** ***(1)*** Single, with partner ***(2)*** Single, without partner ***(3)*** Married ***(4)*** Widowed/separated
Q6	**Educational attainment of partner:** ***(1)*** Elementary level and graduate ***(2)*** Secondary level and graduate ***(3)*** College level and graduate	Q7	**Educational attainment during pregnancy:** ***(1)*** Elementary level and graduate ***(2)*** Secondary level and graduate ***(3)*** College level and graduate
Q8	**Educational attainment of her mother:** ***(1)*** Elementary level and graduate ***(2)*** Secondary and graduate ***(3)*** College level and graduate	Q9	**Educational attainment of her father:** ***(1)*** Elementary level and graduate ***(2)*** Secondary level and graduate ***(3)*** College level and graduate
Q10	**Employment Status of Woman's Mother during the Teenage Pregnancy:** ***(1)*** Employed, regular ***(2)*** Employed, part-time ***(3)*** Self-employed ***(4)*** Not employed	Q11	**Employment Status of Woman's Father during the Teenage Pregnancy:** ***(1)*** Employed, regular ***(2)*** Employed, part-time ***(3)*** Self-employed ***(4)*** Not employed
Q12	**Current Age of Partner:**	Q13	**Current number of children:**
Q14	**Employment Status of Partner:** ***(1)*** Employed, regular ***(2)*** Employed, part-time ***(3)*** Self-employed ***(4)*** Not employed	Q15	**Employment Status of the Woman:** ***(1)*** Employed, regular ***(2)*** Employed, part-time ***(3)*** Self-employed ***(4)*** Not employed
Q16	**Type of family:** ***(1)*** Nuclear family ***(2)*** Single parent family ***(3)*** Extended family ***(4)*** Grandparent family ***(5)*** Stepfamily	Q17	**Household Monthly Income (PHP)** ***(1)*** <10,000 ***(2)*** 10,000 to 20,000 ***(3)*** 21,000 to 30,000 ***(4)*** 31,000 to 40,000 ***(5)*** 41,000 to 50,000 ***(6)*** >50,000
Q18	**Household Size** ***(1)*** Small (<5), ***(2)*** medium (5-6) ***(3)*** medium-large (7–9) and ***(4)*** large families (>=10)	Q19	**Geographical Classification** ***(1)*** Rural ***(2)*** Urban
Q20	**Number of Bedrooms** ***(1)*** One rooms ***(2)*** 2-3 rooms ***(3)*** 3-5 rooms ***(4)*** >6 rooms	Q21	**Used any form of contraceptive after the teenage pregnancy** ***(1)*** Yes: [a] pills, [b] condom, [c] IUD, [d] implant, [e] injectable, [f] others ***(2)*** No
Q22	**Current age of the child/ren**	Q23	**Age at first sex/intercourse:**

		Q24	**Number of sexual partners:**

Appendix C. Interview Guide

Focus Group Discussion

Individual FGD Socio-Demographic Data Form

FGD Session No.: _____
Participant No.: _____

Age: _____ Gender: Male – Female Marital Status: _____
Highest Educational Attainment: _____
Living with Partner: Yes - No Ownership of House: _____
Number of Children: _____ Number of Children <5 years: _____
Age during First Pregnancy: _____ Mode of Delivery: _____
Employed: Yes - No Current Employment: _____
Number of Workdays: _____
Usual Responsibilities Outside of Work: _____

What are your thoughts or perspectives on teenage pregnancy especially in the region?
[*Ano ang mga palagay o opinyon mo sa maagang pagbubuntis ng ibang mga batang babae dito sa lugar natin?*]

_____
_____
_____
_____
_____

Field Notes

(To be filled-up by Observer)

FGD Session: ____ Observer: _____ Date of FGD: _____
Number and Control No. of Participants: _____

A. Describe the composition of the participants in the current focus group discussion
(Ilan ang lalaki? Ang babae? Magkaka-edad ba sila? Mukha ba silang magkakakilala? Mukha ba silang komportable sa mga kasama nila?)

B. Take down the summary and highlights of the FGD. Please include your observations of the participants, pertinent answers, and their dynamics with the group.

C. Overall feeling, observation and thoughts about the focus group discussion conducted

D. List down possible problems or factors that influenced data gathering (e.g., noise, interruptions)

E. Other Concerns/Issues

FGD Guide for Teenage Boys/Girls

Introduction:

- Greet everyone, and reiterate the oral consent for FGD
- Reiterate that the discussion will be recorded, and only refer to the other person using the assigned letters to retain confidentiality.
- Emphasize that there is no "wrong answer", and all responses are valid.

Opening Questions:

1. List down what comes first to mind when you think of "teenage pregnancy"
   [*Ano ang unang pumapasok sa isip ninyo kapag sinasabing "teenage pregnancy"? O kaya kung ano ang alam ninyo o nasabi sa inyo ng mga magulalng ninyo tungkol dito?*]
2. Ask the participants to share their thoughts. *List down their key points and only after everyone has read their notes would the moderator facilitate the discussion.*
   [*Ask every participant if they share the same thoughts, and to share in the group also if they have different thoughts about the topic.*]
3. Kaninang interbyu, tinanong namin kayo tungkol sa pagtaas ng maagang pagbubuntis dito sa atin sa Eastern Visayas. Sa inyong palagay, ano ang mga dahilan kaya napapabalita ang mga ganito? *List down these thoughts and discuss why these situations/events are reportable or threatening to safety.*

Key Questions:

4. Do you know someone who was pregnant at less than 18 years of age?
   [*Ask the participants if they know them personally – if they are a relative, ask them about the reaction of the family upon hearing the news. If not a relative, we can ask them what was their reaction upon hearing that she was pregnant?*]
   [*One can also ask if the family was supportive of the pregnancy, or if she lived/s with her family. One can also ask if she got married or if she got pregnant again.*]
5. In your school, what happens to a teenage girl when she becomes pregnant? What is the schools' official policy on teenage pregnancy?
6. In your opinion, what are the factors contributing to teenage sex/pregnancy?
   [*Sa palagay mo, ano ba ang mga posibleng dahilan kaya may mga kabataang nakakabuntis o nabubuntis nang mas maaga?*]
7. Are there certain groups of people who you think are more predisposed to experience adolescent pregnancy?
   [*Sa palagay mo, ano ba ang mga katangian o sitwasyon ng mga kilala mo na nakabuntis o nabuntis nang mas maaga?*]
8. Do you think the reasons girls engage in teenage sex is different from the reasons boys do it? How?
   [*Sa palagay mo, ano mga dahilan kaya may ibang kabataan na maagang nakikipag-sex? Magkaiba ba ang mga dahil sa mga kabataang lalaki at sa kabataang babae?*]
9. *Ano ang opinyon mo sa mga kabataang gumagawa nang ganitong gawain nang maaga*?
10. *Sa inyong eskwelahan ba, nagtuturo sila tungkol sa family planning, paggamit ng condom, o tungkol sa sex education*?

11. *Ikaw, sumasang-ayon ka ba o ang iyong pamilya o ang inyong simbahan sa mga pagtuturo tungkol dito*?
12. *Base sa mga napag-usapan natin tungkol sa maagang pagbubuntis kanina. Sapat ba ang mga serbisyo para sa kanila na alam ninyong naibibigay ng barangay, health center, simbahan, paaralan, at iba pa?*
13. How can young pregnant women and mothers be best supported within the health care system? What should be provided?
    [*Paano kaya sila maaaring mas suportahan? At sa anong mga paraan sila mas matutulungan?*]
14. In your opinion, what can be done to prevent teenage pregnancy and support teenage mothers willing to return and complete studies?
    [*Sa inyong palagay, sapat ba ang ginagawang pagtulong ng titser o kaklase ninyo para makapagpatuloy nang pag-aaral ang kakilala ninyong maagang nagbuntis?*]
15. If we were to start a programme for teenagers in your school, would you be willing to be part of it.
    [*Kung magkakaroon ng programa sa inyong eskwelahan na magbibigay ng pagtuturo sa mga kabataan tungkol sa sex education, sasama ka ba? Ano ang dahilan sa pagsali o hindi mo pagsali?*]

Concluding Questions:

16. In general, you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (*Wait for response*).
    [*Sa inyong palagay, ano ang pakiramdam mo sa ginawa nating usapan?*]
17. Are there important issues that we have not discussed?
18. Do you have recommendations for the next focus group discussions? What are these recommendations?

FGD Guide for Teenage Pregnant Women/Parents

Introduction:

- Greet everyone, and reiterate the oral consent for FGD
- Reiterate that the discussion will be recorded, and only refer to the other person using the assigned letters to retain confidentiality.
- Emphasize that there is no "wrong answer", and all responses are valid.

Opening Questions:

1. List down what comes first to mind when you think of "teenage pregnancy"
   [*Ano ang unang pumapasok sa isip ninyo kapag sinasabing "teenage pregnancy"? O kaya kung ano ang alam ninyo o nasabi sa inyo ng mga magulalng ninyo tungkol dito?*]
2. Ask the participants to share their thoughts. *List down their key points and only after everyone has read their notes would the moderator facilitate the discussion.*
   [*Ask every participant if they share the same thoughts, and to share in the group also if they have different thoughts about the topic.*]
3. *Kaninang interbyu, tinanong namin kayo tungkol sa pagtaas ng maagang pagbubuntis dito sa atin sa Eastern Visayas. Sa inyong palagay, ano ang mga dahilan kaya napapabalita ang mga ganito?*
   [List down these thoughts and discuss why these situations/events are reportable or threatening to safety.]

Key Questions:

1. Do you know someone who was pregnant at less than 18 years of age?
   [*Ask the participants if they know them personally – if they are a relative, ask them about the reaction of the family upon hearing the news. If not a relative, we can ask them what was their reaction upon hearing that she was pregnant?*]
   [*One can also ask if the family was supportive of the pregnancy, or if she lived/s with her family. One can also ask if she got married or if she got pregnant again.*]
2. In your school, what happens to a teenage girl when she becomes pregnant? What is the schools' official policy on teenage pregnancy?
3. In your opinion, what are the factors contributing to teenage sex/pregnancy?
   [*Pasensya na kung medyo sensitibo ang magiging tanong namin. Pero sa inyong palagay, ano ang naging dahilan o maaaring nagdulot sa inyong maagang pagbubuntis [o maagang pagbubuntis ng inyong anak.*]
4. Are there certain groups of people who you think are more predisposed to experience adolescent pregnancy?
   [*Sa palagay mo, ano ba ang mga katangian o sitwasyon ng mga kilala mo na nakabuntis o nabuntis nang mas maaga?*]
5. Do you think the reasons girls engage in teenage sex is different from the reasons boys do it? How?
   [*Sa palagay mo, ano mga dahilan kaya may ibang kabataan na maagang nakikipag-sex? Magkaiba ba ang mga dahil sa mga kabataang lalaki at sa kabataang babae?*]
6. What do you think are reinforcing or enabling factors for teenage or adolescent pregnancy?
   [*Ano sa tingin mo ang mga dahilan o sitwasyon kaya may mga kabataang nakakaranas ng ganitong mga sitwasyon o gawain*?]

7. Are you aware of the services availed or subscribed to by the pregnant woman or partner during such time?
   [*Noong nagbubuntis ka o noong nagbubuntis ang inyong anak, ano ang mga serbisyong nakuha ninyo para sa mga kabataang maagang nagdalang-tao? Bukod sa health center, may ibang organisasyon ba na may tulong para sa mga kabataang maagang nagbuntis? Simbahan, barangay, eskwelahan?*]
8. We will be giving you a list of services from government or non-government sectors targeting teenage pregnancy. We will be asking whether you are aware or not aware of such services?
   [*Maaari ba kayong magbigay ng mga serbisyo na nakuha mula sa iba't-ibang organisasyon? Paano niyo nalalaman ang mga impormasyon tungkol sa mga serbisyong ito? Parepareho ba kayo nang nalalamang mga serbisyo?*]
9. What do you think are the possible barriers and facilitators for the uptake of such services?
   [*Sa inyong palagay, ano ang mga dahilan kaya may mga gumagamit at hindi gumagamit ng mga serbisyo na nabibigay ng health center, barangay, simbahan, eskwelahan, at iba pa para sa mga maagang pagbubuntis?*]
   The moderator can clarify "vague" or "unfamiliar" situations, but s/he cannot give clues or hints about their implications.
10. How can young pregnant women and mothers be best supported within the health care system? What should be provided?
    [*Base sa mga napag-usapan natin tungkol sa maagang pagbubuntis kanina. Sapat ba ang mga serbisyo para sa kanila na alam ninyong naibibigay ng barangay, health center, simbahan, paaralan, at iba pa?*]
11. In your opinion, what can be done to prevent teenage pregnancy and support teenage mothers willing to return and complete studies?
    [*Paano kaya sila maaaring mas suportahan? At sa anong mga paraan sila mas matutulungan?*]
    [*Ano sa palagay mo ang mga maaaring gawin upang maiwasan o mabawasan ang dami ng mga kabataang maagang nakakabuntis o nabubuntis?*]
12. If we were to start a programme for teenagers in your school, would you be willing to be part of it.
    [*Kung magkakaroon ng programa sa inyong eskwelahan na magbibigay ng pagtuturo sa mga kabataan tungkol sa sex education, sasama ka ba? Ano ang dahilan sa pagsali o hindi mo pagsali?*]
    [*Kung magkakaroon ng programa sa inyong eskwelahan na magbibigay ng pagtuturo sa mga kabataan tungkol sa sex education, sumasang-ayon ka ba na ituro ito sa inyong mga anak? Ano ang dahilan sa pagpayag o hindi mo pagpayag?*]

Concluding Questions:

1. In general, you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (*Wait for response*).
   [*Sa inyong palagay, ano ang pakiramdam mo sa ginawa nating usapan?*]
2. Are there important issues that we have not discussed?
3. Do you have recommendations for the next focus group discussions? What are these recommendations?

Informed Consent

Project Title:	**S**trategies on **TE**enage **P**regnancy (STEP): Analysis of Early Pregnancy Situation in the Eastern Visayas as a Basis for Multi-Sectoral Policies to Reduce Teenage Pregnancy in the Region
Institution/Sponsor:	University of the Philippines Manila – College of Public Health/World Vision Development Foundation, Inc.
Primary Investigators:	Ernani Bullecer, RND, MPH, DrPH; Kim Leonard dela Luna, RND, MSPH, PhD; Alvin Duke R. Sy, RN, MSPH

This Informed Consent Form has two parts:

- Information Sheet (to share information about the research with you)
- Documentation of Consent (for signatures if you agree to take part in the study)

PART I: Information Sheet

A. Purpose and Background

We are researchers who are currently interested in identifying, and developing effective strategies (e.g., interventions, advocacies, policies) to reduce the risks associated with teenage pregnancy in the Eastern Visayas region. The current project is supported by the World Vision Development Foundation, Inc., the University of the Philippines Manila – College of Public Health.

B. Participant Selection

The researchers are composed men and women affiliated with the University and the organization based in the region.

You are being invited as a participant since the study will sample representatives from the potential direct beneficiaries, and education, health, and service providers/policy makers which will include:

- education sector (teachers, school nurses, guidance counselors)
- health care sector (midwife, nurse, doctor, BHWs), and
- service sector (barangay officials, city/municipal councilor for health, NGOs)

Around 10-20 participants will be included in the key informant interviews that will be conducted among the four provinces in the Eastern Visayas region.

C. Data Collection Procedures

Upon agreeing to participate in the current study, you will be asked to sign the consent form for agreeing to participate in the key informant interview. The focus group discussions (FGDs) will last for at most two hours and composed of two parts.

The first part involves gathering information about the facility, as well as the interviewee. While, the second part is the actual interview about the services provided and insights about teenage pregnancy from the perspective of a service provider. Prior to the interview, one of the investigators will be reinforcing and repeating what was written in this consent.

The interviewee is encouraged to ask questions and has a freedom to discuss whatever he/she wants to talk about. The discussion will be recorded electronically to capture everything that will be talked about. The interviewer will also be taking down notes of the interview, and be allowed to have copies of reports or records as consented by the interviewee.

There is no prescribed or exact duration to the study since the only time to stop collecting data is upon reaching the saturation point. However, your participation will be limited to joining the key informant interview which will be at most two hours, depending on the flow of the discussion.

The research takes place in the field for about one to two months, depending on the availability and schedule of the respondents invited to participate in the study. However, the investigators may ask for another time to meet or talk to you to clarify certain points, and at the end of the study, to give information about the results of the study, with your consent also.

D. Potential Use of Secondary Data

This study is collecting personal information from the participants. We would like to make the data available

for other research studies that may be done in the future. The research may be about similar conditions or environments as the current study. However, the research could also be about unrelated conditions, or other types of research; and these studies may be done by researchers from the University of the Philippines, and the World Vision Project, Inc. as well.

However, the decision to share your data is controlled by the investigators of the study. To be able to have access to the information you shared, future researchers must seek approval from the World Vision Project, Inc. and the University of the Philippines College of Public Health as well. Your name and identifying information will be removed from any data collection form or information frame before they are shared with other researchers. Researchers will not be able to link your identifying information to the data.

E. Risks

There is *no direct harm or risk* from participating in the study. There will be no expenses on your part from participating in the said activity. We are aware of the possibility that personal information or experience shared in the discussion will be known to other people. However, the personal information written in the demographic forms or shared in the interview would not be divulged in any way. At the same time, the data that you have shared cannot be used against you in any form or way.

The investigators cannot completely assure total privacy of what has transpired during the key informant interviews. However, we highly encourage all the participants of the study to respect and keep in private what would be shared or discussed during the activity.

F. Benefits

There is *no direct or immediate benefit* from participating in the study, except for the honoraria for the participating in the key informant interview. A better understanding of the potential and perceived factors on adolescent pregnancy in the select provinces of Eastern Visayas will be helpful in developing and implement effective strategies to address this concern.

The results of the study may also serve as a basis for development or redesigning of regarding health care delivery services and interventions targeting adolescents.

G. Summary of the Participant's Rights

With your participation in this study, you are made aware that the result of this study could be published in local or international journals and give consent to this if your records will not be disclosed to anyone aside from the investigators and the Ethical Review Board members if they wish to examine the individual records of the study.

Your name, initials, institution, or anything that ties you with the discussion will not be written, used or shared to other people except for the investigators. We would be using a different name to protect your identity.

You do not have to participate in this study if you do not want to. Since engagement in the study is voluntary, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled.

In addition, the information that you would be sharing cannot be used against you in any way. The transcriptions or forms can never be used as evidence in any trial or audit that may affect your employment status or reception of services.

Moreover, you cannot share or divulge what was done in the data collection to any other person aside from the investigators, or in any other place aside from the setting of the interview. Whoever will be found to breach this privacy and confidentiality clause will not be protected by this contract anymore.

The collected data will be stored in the primary investigator's laptop and kept under password-protected folders. Data encryption will be performed when sending information over the internet. Once data analysis has been done, records, raw data, and semi-processed data collected from this study will be deleted. All information that might contain important information or identity will be deleted immediately.

We assure you, as participants in the study, that we will act based on the Data Privacy Act of 2012. You can request to have access to your personal data, and have the right to ask for alteration or deletion of the shared data if you found any erroneous entry, or even consider removal of your data from the study.

As previously mentioned, the results of the study will be made available to you upon request, within three months from the final data collection. This will contain the summary of the key findings, as well as the conclusion and recommendations. However, the full breadth of results and the manuscript will not be accessible to the study participants.

H. Questions

The protocol of this study has been reviewed and approved by the college and the ethics review board. If you have any questions or concerns about your participation in this study or do not wish to continue, you may reach out to the investigators, Prof. Alvin Duke Sy via e-mail at arsy3@outlook.up.edu.ph, or Prof. Kim Leonard dela Luna via telephone at (02) 8526-0811 local 110 or 09088772876 for any concerns.

In addition, you may contact Dr. Cecilia Jimeno, Chair of the UP-Manila Review Ethics Board Panel 1, which is concerned with the protection of volunteers in research projects. You may reach the board office between 8:00 AM and 5:00 PM, Monday through Friday via phone at (+63 2) 85264346. You can also send an email at upmreb@post.upm.edu.ph or by writing at the University of the Philippines- Manila Review Ethics Board, Room 126, G/F, NIH Building, UP Manila, 623 Pedro Gil St, Ermita 1000 Manila.

Participant No.: _____

Part II: Documentation of Consent

Please check if you agree to the following:

_____ *I give consent to participate in this study.*

_____ *I agree that I cannot share or divulge what has transpired in the data collection.*

Part III: Documentation of Consent for Secondary Analysis

Please check depending on your choice:

_____ **YES**, *use the data shared for other related research studies*

_____ **NO, DO NOT USE** *the data shared for other related research studies.*

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks have been explained to my satisfaction. I understand I can withdraw at any time.
I was also given the opportunity to ask and clarify, and I was given appropriate and sufficient answers to my questions.

_____	_____
Signature of Study Participant/Legal Guardian	Date
_____	_____
Signature of Witness	Date
_____	_____
Signature of Investigator	Date

Use the left thumbmark when the respondent has no capacity to sign the document due to inability to read and write, and any other physical disability.

LEFT THUMBMARK

Key Informant Interview Guide

General Information:

1. Name of Facility:
2. Location/community:
3. Date of Interview:
4. Initials of the Interviewee:
5. Designation of Health Facility personnel being interviewed:
6. How long have you worked in this Health Facility?

For Service Provision Facilities:

1. What services are provided in this facility? (*Ask questions to fill in the table – ask to see records to back up the information*)

Type of service (e.g., growth monitoring, FP, antenatal counseling and testing)	Frequency of service	Type of clientele served (infants, elderly, etc)	Average # of Clients served per day	Cost of service (if free, indicate)

If there were records provided, list them

2. [*Observe type of posters and other IEC in the clinic and record content of messages*] Do you often get teenagers here requesting information on SRH? **Yes** **No**
   If yes, what is their most requested information? If no, why do you think that is?

3. [*Ask this question If antenatal services are mentioned as a service*] What is the average monthly number of clients the clinic serves that are aged below 20 years?
4. In your opinion, has this number been increasing, decreasing or remained the same since 2021? 2017?
5. What do you think are the reasons for the observed trend above?

6. As a health worker in this community, what is your opinion regarding young people using contraceptives?
7. Do you think there are cases where health workers may withhold sex-related health information or contraceptives from young people? **Yes** **No**
   If yes, why do you think that happens?

8. Does this Health facility provide health services that are tailor made for young people aged between 13-19? **Yes** **No**
   If yes, List them:

   If no, is this facility able to provide the following services to young people aged 13-19 years? What support will you require to provide these services?

Service	Type of support required to provide service	
	Facility/Equipment	**Human Resource, Training**
Family Planning		
Counseling and testing		
Sex-related Health Information		
Teen mothers support service		

9. Do you think there may be barriers to young people accessing sexual and reproductive health information and services at this clinic? **Yes** **No**
   If yes, what do you think these barriers are and why?

10. Would you classify this clinic as "youth friendly"? **Yes** **No**
    If yes, what makes it youth friendly?
    If no, please give information on why this is not a youth friendly facility?

11. Besides government support, are there any other organizations supporting this health facility? [*List them and indicate type of support, ex. NGO1 - drugs, equipment, training, etc.*]

For Educational Facilities:

1. How many dropouts do you get on average in a year? (*Students who leave before completing studies*) Boys___ Girls___
2. What are the average ages of students who drop out? What do you think are the reasons for the dropouts?
3. How many cases of teenage pregnancy has your school had this year and last year 2009? [*Ask to record to back up the answer*]
4. What were the average ages of teenagers who became pregnant?

5. In your opinion, what are the factors contributing to teenage sex/pregnancy?
6. Do you think the reasons girls engage in teenage sex is different from the reasons boys do it? How?
7. In your school, what happens to a teenage girl when she becomes pregnant?
8. What is the school official policy on teenage pregnancy?
9. Does your school allow back teen girls who have delivered and are willing to continue with their studies? **Yes** **No**
   If yes, do/how many come back?
   If not, why not?

10. In your opinion can schools do to prevent teenage pregnancy and support teenage mothers willing to return and complete studies?
11. If we were to start a programme for teenagers in your school, would you be willing to be part of it? **Yes** **No**
    If yes, in what capacity?
    If no, can you give a reason?

For <u>Both Facilities</u>:

1. Is teenage pregnancy considered a big problem by the community?
2. Does the RHU/LGU have any systems/activities in place to address the problem? **Yes** **No**
    If yes, please describe them:
    If no, does the DHMT have any future to address this problem?
3. What is the government policy regarding contraceptive use by adolescents?
4. What is the policy on provision of reproductive services to adolescents?
5. What can government units and other facilities do to meet the SRH needs of adolescents?
6. What kind of support is needed by the local health units to include youth friendly reproductive services?
7. In the past one year, how many cases of sexual abuse, physical abuse/assault, early marriages, etc. were reported?
    How many of these were prosecuted? Who were the perpetrators? Who was the complainant?
8. What services do you provide to those who have been sexually abused/assaulted/early marriages?
9. Are the services available often utilized by the complainant? **Yes** **No**
    If yes, which services in particular?
    If no, why do you think they are not utilized?
10. What challenges are you facing in providing services to victims of gender-based violence?
11. What do you think are the barriers to people (particularly teenagers) utilizing these services?

Concluding Questions:

1. In general, you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (*Wait for response*).
2. Are there important issues that we have not discussed?
3. Thank you very much for your time, it has been extremely valuable.

Informed Consent

Project Title:	**S**trategies on **TE**enage **P**regnancy (STEP): Analysis of Early Pregnancy Situation in the Eastern Visayas as a Basis for Multi-Sectoral Policies to Reduce Teenage Pregnancy in the Region
Institution/Sponsor:	University of the Philippines Manila – College of Public Health/World Vision Development Foundation, Inc.
Primary Investigators:	Ernani Bullecer, RND, MPH, DrPH; Kim Leonard dela Luna, RND, MSPH, PhD; Alvin Duke R. Sy, RN, MSPH

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- health care sector (midwife, nurse, doctor, BHWs), and
- service sector (barangay officials, city/municipal councilor for health, NGOs)

Around 10-20 participants will be included in the key informant interviews that will be conducted among the four provinces in the Eastern Visayas region.

C. Data Collection Procedures

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The interviewee is encouraged to ask questions and has a freedom to discuss whatever he/she wants to talk about. The discussion will be recorded electronically to capture everything that will be talked about. The interviewer will also be taking down notes of the interview, and be allowed to have copies of reports or records as consented by the interviewee.

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The results of the study may also serve as a basis for development or redesigning of regarding health care delivery services and interventions targeting adolescents.

G. Summary of the Participant's Rights

With your participation in this study, you are made aware that the result of this study could be published in local or international journals and give consent to this if your records will not be disclosed to anyone aside from the investigators and the Ethical Review Board members if they wish to examine the individual records of the study.

Your name, initials, institution, or anything that ties you with the discussion will not be written, used or shared to other people except for the investigators. We would be using a different name to protect your identity.

You do not have to participate in this study if you do not want to. Since engagement in the study is voluntary, you may withdraw from it at any time without consequences of any kind or loss of benefits to which you are otherwise entitled.

In addition, the information that you would be sharing cannot be used against you in any way. The transcriptions or forms can never be used as evidence in any trial or audit that may affect your employment status or reception of services.

Moreover, you cannot share or divulge what was done in the data collection to any other person aside from the investigators, or in any other place aside from the setting of the interview. Whoever will be found to breach this privacy and confidentiality clause will not be protected by this contract anymore.

The collected data will be stored in the primary investigator's laptop and kept under password-protected folders. Data encryption will be performed when sending information over the internet. Once data analysis has been done, records, raw data, and semi-processed data collected from this study will be deleted. All information that might contain important information or identity will be deleted immediately.

We assure you, as participants in the study, that we will act based on the Data Privacy Act of 2012. You can request to have access to your personal data, and have the right to ask for alteration or deletion of the shared data if you found any erroneous entry, or even consider removal of your data from the study.

As previously mentioned, the results of the study will be made available to you upon request, within three months from the final data collection. This will contain the summary of the key findings, as well as the conclusion and recommendations. However, the full breadth of results and the manuscript will not be accessible to the study participants.

H. Questions

The protocol of this study has been reviewed and approved by the college and the ethics review board. If you have any questions or concerns about your participation in this study or do not wish to continue, you may reach out to the investigators, Prof. Alvin Duke Sy via e-mail at arsy3@outlook.up.edu.ph, or Prof. Kim Leonard dela Luna via telephone at (02) 8526-0811 local 110 or 09088772876 for any concerns.

In addition, you may contact Dr. Cecilia Jimeno, Chair of the UP-Manila Review Ethics Board Panel 1, which is concerned with the protection of volunteers in research projects. You may reach the board office between 8:00 AM and 5:00 PM, Monday through Friday via phone at (+63 2) 85264346. You can also send an email at upmreb@post.upm.edu.ph or by writing at the University of the Philippines- Manila Review Ethics Board, Room 126, G/F, NIH Building, UP Manila, 623 Pedro Gil St, Ermita 1000 Manila.

Participant No.: _____

Part II: Documentation of Consent

Please check if you agree to the following:

_____ *I give consent to participate in this study.*

_____ *I agree that I cannot share or divulge what has transpired in the data collection.*

Part III: Documentation of Consent for Secondary Analysis

Please check depending on your choice:

_____ **YES**, *use the data shared for other related research studies*

_____ **NO, DO NOT USE** *the data shared for other related research studies.*

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks have been explained to my satisfaction. I understand I can withdraw at any time.
I was also given the opportunity to ask and clarify, and I was given appropriate and sufficient answers to my questions.

_____	_____
Signature of Study Participant/Legal Guardian	Date
_____	_____
Signature of Witness	Date
_____	_____
Signature of Investigator	Date

Use the left thumbmark when the respondent has no capacity to sign the document due to inability to read and write, and any other physical disability.

LEFT THUMBMARK

Key Informant Interview Guide

General Information:

1. Name of Facility:
2. Location/community:
3. Date of Interview:
4. Initials of the Interviewee:
5. Designation of Health Facility personnel being interviewed:
6. How long have you worked in this Health Facility?

For <u>Service Oriented Personnel</u>:

1. What services in your community targets the youth? How about those activities targeting adolescent pregnancy? (*Ask follow-up questions or see records to back up the information*)

   If there were records provided, list them

2. Do you agree with providing sexual and reproductive health education among the youth? If yes, what information should be included in such activities? If no, what are the reasons for such reservations?

3. Do you think adolescent pregnancy is an important problem in your community? In your opinion, has the rate of teenage pregnancy been increasing, decreasing or remained the same in the past three years? Five years?

4. What do you think are the reasons for the perceived trend above?

5. What is your opinion about the use and availability of contraceptive-related services in the community? Is the delivery of such sexual and reproductive health education, and contraceptive services sufficient – and able to target the youth well? If yes, what is the reason to have such claim? If no, what are possible approaches to improve education and services?

6. Does the community provide services that are tailor made for young people aged between 13-19 years old? Can you give details about these services?

7. What do you think are possible barriers for teenagers to inquire and access sexual and reproductive health information and services in the community?

8. Would you classify your community as "youth friendly"? **Yes** **No**
   If yes, what makes it youth friendly?
   If no, please give information on why this is not a youth friendly community?

9. Besides government support, are there any other organizations supporting the adolescent or teenage members of the community? [*List them and indicate type of support, ex. NGO1 - drugs, equipment, training, etc.*]

For Both Facilities:

1. Does the RHU/LGU have any systems/activities in place to address the problem? **Yes** **No**
   If yes, please describe them:
   If no, does the government have any future to address this problem?

2. What is the government policy regarding contraceptive use by adolescents?
3. What is the policy on provision of reproductive services to adolescents?
4. What can government units and other facilities do to meet the sexual and reproductive needs of adolescents?
5. What kind of support is needed by the local health units to include youth friendly reproductive services?
6. In the past one year, how many cases of sexual abuse, physical abuse/assault, early marriages, etc. were reported?
   How many of these were prosecuted? Who were the perpetrators? Who was the complainant?
7. What services can the community provide to those who have been sexually abused/assaulted/early marriages?

8. Are the services available often utilized by the people involved in such situations? **Yes** **No**
   If yes, which services in particular?
   If no, why do you think they are not utilized?

9. What challenges are you facing in providing services to victims of gender-based violence?

Concluding Questions:

1. In general, you would describe your general feelings/attitudes as (reiterate the overall feeling obtained from the interview). Is that correct? (*Wait for response*).

2. Are there important issues that we have not discussed?

3. Thank you very much for your time, it has been extremely valuable!

Appendix D. Full Narratives of KII and FDG

CONSULTANCY SERVICES AGREEMENT

CONTRACT Ref.: WVDF-CSA-2022-08-001

KNOW ALL MEN BY THESE PRESENTS:

This Consultancy Services Agreement ("**CONTRACT**") is entered into by and between:

WORLD VISION DEVELOPMENT FOUNDATION, INC., a non-stock, non-profit, Christian, child-focused, relief, advocacy, and development organization duly registered and existing under and by virtue of the laws of the Philippines with principal office at 389 Quezon Avenue cor. West 6th St., West Triangle, Quezon City, Philippines, herein represented by its, **Operations Director**, **AJAB-ARAM R. MACAPAGAT** , hereinafter referred to as "**CLIENT**";

- and –

UNIVERSITY OF THE PHILIPPINES – COLLEGE OF PUBLIC HEALTH FOUNDATION, INC. a foundation duly registered and existing under and by the virtue of the laws of the Philippines with principal office at **625 PEDRO GIL ST., ERMITA**, Manila Philippines, herein represented by the Professor and Chair, Department of Nutrition , **ERNANI R. BULLECER, RND, MPH, DrPH,** hereinafter referred to as the "**CONSULTANT**".

WITNESSETH:

WHEREAS, **CLIENT** intends to engage the services of a Research Consultant to provide the KOICA Maternal, Newborn, and Child Health (MNCH) Project Team and other project stakeholders with a detailed overview of the Teenage Pregnancy situation, focusing on the interventions, advocacies, and policies in Samar, Western Samar, and Leyte.

WHEREAS, **CONSULTANT** is engaged into research, development and training projects/and or programs in various disciplines and specialties of public health and health related sciences and possesses significant training and/or experience related to health and nutrition assessment with different agencies and stakeholders that holds himself to the public as a professional consultant.

WHEREAS, the **CLIENT** desires to engage the **CONSULTANT** as an independent **CONSULTANT**, and the **CONSULTANT** agrees to be engaged as such by the **CLIENT**, pursuant to the terms and conditions set forth herein;

WHEREAS, **WVDF** is a Christian child-focused and community-based relief, development and advocacy organization dedicated to working with children, families, and communities to overcome poverty and injustice;

WHEREAS, **WVDF** is committed to safeguarding children and vulnerable adults it serves and is foundational to all its activities, programs, and Lines of Ministry (relief, development, and advocacy). Central to everything WVDF does is its commitment to first do no harm to children or adult beneficiaries, to respect the rights of all beneficiaries, and to uphold the best interests of children as a primary consideration in all actions and decisions;

WHEREAS, in alignment with the above commitment, the **CONSULTANT,** must adhere with the safeguarding management policy of WVDF;

WHEREAS, the **CLIENT** does not tolerate **CORRUPTION** under any circumstances and shall be a ground for termination if **CONSULTANT** engages on activities such as this;

NOW, THEREFORE, for and in consideration of the above premises and of the mutual covenants hereinafter set forth, the **CLIENT** and **CONSULTANT** do hereby agree as follows:

SECTION ONE
SCOPE OF THE SERVICE, PLACE AND LOCATION

1.1 The **CONSULTANT** agrees to perform, in a prompt and professional manner to the satisfaction of the **CLIENT** the following services:

a. The scope of the service, responsibilities and other matters are set out in the accompanying "Terms of Reference" (Annex 1) which is an integral part of this Agreement

During the term of this Agreement, **CONSULTANT**'S specialized knowledge, expertise and skills in the areas aforementioned shall be made available to the **CLIENT** at the latter's requests and at mutually agreeable times.

1.2 **CONSULTANT** will retain the exclusive right to determine the methods and means to be employed to perform the services contracted for under this Agreement free from the control of the **CLIENT** except as to the results thereof. **CONSULTANT** is not required to follow any particular routine or schedule, to perform services at any particular place or to report to work or be available to perform services at any particular time.

1.3 **CONSULTANT** warrants and represents that it complies with all applicable laws regarding business permits and licenses as well as the necessary credentials, qualifications, expertise, and experience required to carry out the work to be performed under this Agreement.

1.4 **CONSULTANT** further warrants and represents that is not a party to any agreement restricting its ability to enter into this Agreement, and that its performance of this Agreement does not require the consent of any third person or entity.

SECTION TWO
CONTRACT PRICE/MODE OF PAYMENT

2.1 In consideration of the services to be rendered by the **CONSULTANT** to the **CLIENT** during the term of the Agreement, the **CLIENT** shall pay the **CONSULTANT** the contract rate of One Million Pesos (Php 1,000,000.00 subject to government applicable taxes

Schedule of Payment is as follows:

- First Tranche – 35% upon approval of inception report including relevant methodology, tools for data collection and indicators to be used
- Second Tranche - 25% upon submission of the raw data and initial draft of the research study
- Third Tranche – 20% upon submission of final report draft
- Final Tranche – 20% upon submission and approval of the revised final report

Any billing shall be paid by the **CLIENT** within fifteen (15) days from the receipt of the billing statement. Payments to be made under this **CONTRACT** shall be in the form of demand drafts, checks or other cash equivalents, as may be agreed upon by the **Parties**.

2.2 **CLIENT** shall not be liable to **CONSULTANT** for any expenses paid or incurred by **CONSULTANT** in connection with **CONSULTANT**'S provision of the services under this Agreement unless otherwise previously agreed in writing by an officer of the **CLIENT**. See Annex 1-F

SECTION THREE

INSURANCE & INDEMNIFICATION

3.1. The Consultant has the sole responsibility to obtain any other desired insurance coverage (liability, medical, travel, life, etc.) for its employees, and workers.

3.2. Consultant shall hold WVDF free and harmless from any claim or demand, or any obligation or liability it may incur in carrying out this Agreement regardless of its nature and source whatsoever.

3.3. Consultant shall hold WVDF free and harmless from any claim or demand which may be filed, including any judgment or award obtained, by the Consultant's workers and/or personnel against WVDF by reason of their employment, or assignment under this Agreement involving but not limited to violation of the Labor Code, and other labor laws, decree, order, rules and regulations, which are now in effect or which may hereafter be enacted, the intent and purpose being to absolve, free and discharge WVDF absolutely and unconditionally from any and all such claim, or demand.

SECTION FOUR
STANDARD OF PERFORMANCE

4.1 **CONSULTANT** shall comply with all applicable regulations and rules and all relevant industry standards of practice and ethical obligations in his performance of services under this Agreement. **CONSULTANT** will provide competent, complete and working data warehouse, business intelligence and organizational dashboard in a timely manner, and will refuse to undertake any project that **CONSULTANT** believes is beyond his capability.

4.2 **CLIENT** will provide **CONSULTANT** with a description of any specific **CLIENT** expectations for each assignment (including but not limited to any deadlines imposed by the **CLIENT** in advance of **CONSULTANT** accepting the assignment, and **CONSULTANT** will perform the assignment in accordance with these expectations.

CONFIDENTIALITY

5.1 **CONSULTANT** agrees that in the performance of his services, he will, both during and after the term of this Agreement, treat as proprietary and confidential (a) any information provided to **CONSULTANT** by **CLIENT** or a **CLIENT** of **CLIENT** in connection with the performance of the services; (b) any and all information developed by **CLIENT**, at the request of its **CLIENT**, which is designated as confidential (collectively the "Confidential Information"). **CONSULTANT** shall use such Confidential Information solely and exclusively in connection with the performance of services under this Agreement. Further, **CONSULTANT** will not disclose any such Confidential Information to any unauthorized party for any reason or purpose whatsoever without the prior written consent of **CLIENT**, unless **CONSULTANT** is legally required to disclose such information by law or in connection with any litigation or other legal proceeding, provided, however, that **CONSULTANT** will immediately notify **CLIENT** of any possibility that disclosure of Confidential Information may be required in connection with any such legal proceeding.

5.2 **CONSULTANT** agrees and confirms that all materials, reports, information, documentation, inventions or other work products ("Intellectual Properties") which the **CONSULTANT** may generate in the course and scope of its performance of services under this Agreement are the property of the **CLIENT**, and hereby assigns all rights, title, and interest in and to such Intellectual Properties to the **CLIENT**. **CONSULTANT** undertakes to sign a waiver of authorship of final output in favor of the **CLIENT**. **CONSULTANT** agrees for the **CLIENT** to be informed and notified in all reports to be published and disseminated related to the final output. **CONSULTANT** agrees that both the CLIENT and CONSULTANT will be duly recognized and acknowledged as co-authors in all reports to be published and disseminated related to the final output. During the journal publication process, the **CONSULTANT** agrees for them to be considered as the corresponding authors of the final output.

5.3 **Confidential Information** - Both parties to this contract warrant compliance with Republic Act No. 10173 or the Data Privacy Act of 2012 and agree to the following:

a. In compliance with said Data Privacy Act both parties shall use, transfer, store, and dispose any and all personal information acquired by the parties in connection with this agreement subject to the provisions provided under the law.
b. In the event of data breaches on the supplier's side, the latter must immediately notify the **CLIENT**. For any damages demanded by the owner of that data, the supplier shall be fully accountable to settle those damages.
c. The **CONSULTANT** and any of its employees shall not disclose any information given or obtained from the **CLIENT** without the express consent of the latter. Breach of this provision shall entitle **the CLIENT** to damages and other remedies as provided by law.

Emmi Bulleen

5.4 The **CONSULTANT** agrees to adhere to the **CLIENT's Safeguarding Policy** - In the course of performing this contract, **CONSULTANT** and **CONSULTANT's** employees will ensure that:

a. Any of their interactions with children or with adult beneficiaries, or with personal data about such persons, will comply with the attached CLIENT Safeguarding Behaviour Protocols, and with any other reasonable safeguarding measures that **CLIENT** may specify;
b. Any incidents of harm or risk of harm to children or to adult beneficiaries will be reported immediately to WV;
c. Any individuals with access to children or adult beneficiaries, or to personal data about such persons, will have a current clean criminal background check for offenses against children or abuse of adults, to the extent permitted by law (evidence of which will be provided to WV upon request); and
d. These safeguarding obligations will be clearly communicated to and acknowledged by, all employees who may have access to children or to adult beneficiaries, or to personal data about such persons,

and will be extended in identical form to any subcontractors (if any are authorized) engaged to perform this contract.

SECTION SIX
ASSIGNMENT

6.1 **CONSULTANT** acknowledges that the services to be rendered by **CONSULTANT** are unique and personal. Accordingly, the **CONSULTANT** may not assign any of his rights or delegate any of his duties or obligations, in whole or in part, under this Agreement. The rights and obligations of the **CLIENT** under this Agreement shall inure to the benefit of and shall be binding upon the successors and assigns of the **CLIENT**.

SECTION SEVEN
CANCELLATION AND/OR PERFORMANCE

7.1 It is mutually understood and agreed between the parties herein that should any one of the parties breach the terms of this Agreement, or should the **CONSULTANT** unreasonably fail or refuse to perform the work and services in such a manner consistent with the achievement of the result herein contracted, the aggrieved party at its option shall have the right to cancel this Agreement immediately upon giving the other party notice in writing, or to compel the other party to fulfill its obligations under this Agreement and pay all direct or indirect damages for the delay.

7.2 Should the **CONSULTANT** be at fault, the **CLIENT** shall likewise have the right to make other arrangements with respect to the work or service to be performed.

SECTION EIGHT
DURATION OF THE CONTRACT

8.1 This Agreement shall take effect for a period total of **130 days** covering the period from August 31 , 2022 to February 28, 2023. However, in the event that the deliverables has not been completed yet at the end of the contract due to fortuitous event or force majeure, **CONSULTANT** will still be allowed to finish the project subject to agreed time frame with the **CLIENT** without incurring any costs extension to the CLIENT.

8.2 This Agreement may be terminated by either party for any cause upon thirty (30) days prior written notice by one party to the other.

8.3 In the event of a termination due to force majeure, **CONSULTANT** shall be paid only the approved fees and expenses for services performed in accordance with this Agreement up to date of termination.

8.4 In any event of termination, **CONSULTANT** shall return to **CLIENT** all property of the **CLIENT** in the possession of the **CONSULTANT** within seven (7) days from the effectivity of such termination, without the need of further demand.

SECTION NINE
SECURITY AND EVACUATION

CONSULTANT services hereunder may be performed in an area with existing or potential political or social unrest **CONSULTANT** agrees to assume all risks, including damage to person and property, resulting from any such unrest **CONSULTANT** is solely responsible for the safety of **CONSULTANT's** property and employees, and for obtaining any desired insurance protections with respect to **CONSULTANT** work in such areas/location.

Should **CONSULTANT** be performing services in an area where WVDF has operations, **CONSULTANT** will coordinate with WVDF on security issues. WVDF may include **CONSULTANT** in the security and evacuation planning and procedures that WVDF conducts for its own staff, but **CONSULTANT** is responsible for assessing the adequacy of such plans and procedures to **CONSULTANT's** own satisfaction, and making alternative arrangements if judged necessary by **CONSULTANT**.

SECTION TEN
MISCELLANEOUS

10.1 **Governing Laws**. This Agreement is governed by and is to be construed in accordance with the laws of the Philippines. The parties agree that any action arising from, or in connection with this Agreement shall be filed only before the courts of Quezon City, Philippines, to the exclusion of all courts.

10.2 General Compliance with Laws. **CONSULTANT** warrants and agrees that it has complied and will comply with all applicable laws. **CONSULTANT** agrees to indemnify **CLIENT** and save **CLIENT** harmless from any claims, losses, damages, costs and legal expenses (including but not limited to attorneys' fees), resulting from **CONSULTANT**'s failure to comply with the foregoing, and in the event of such failure, **CLIENT** may, in addition to all other rights and remedies **CLIENT** may have pursuant to this Agreement or otherwise in law or in equity, immediately cancel this Agreement.

10.3 Notices. Any notice that is required to be issued by one party to the other shall be issued and sent to each of the parties at their addresses as indicated herein.

10.4 Headings. The insertion of headings and the division of this Agreement into sections are for convenience only and shall not affect the interpretation hereof.

10.5 Severability. If any part, term or provision of this Agreement shall become invalid or unenforceable, the validity or enforceability of the remaining portions or provisions shall not be affected, and the rights and obligations of the Parties shall be construed as if this Agreement did not contain the particular invalid or unenforceable part, term or provision.

10.6 Waivers. The waiver by either party of any breach of any term, covenant or condition contained herein shall not be deemed a waiver of any other breach of the same or any other term, covenant or condition hereof.

10.7 Complete Agreement. This Agreement constitutes the complete agreement of the parties relating to the matters specified in this Agreement and supersedes all prior and contemporaneous representations or agreements with respect to such matters. No oral modifications or waiver of any of the provisions of this Agreement shall be binding on either party.

IN WITNESS WHEREOF, the parties have signed this Agreement on the date and at the place above-written.

WORLD VISION DEVELOPMENT FOUNDATION, INC.	**UNIVERSITY OF THE PHILIPPINES – COLLEGE OF PUBLIC HEALTH FOUNDATION, INC.**
By:	**By:**
AJAB-ARAM R. MACAPAGAT	**ERNANI R. BULLECER, RND, MPH, DrPH**

SIGNED IN THE PRESENCE OF:

Kim Leonard G. dela Luna, RND, PhD

ACKNOWLEDGMENT

REPUBLIC OF THE PHILIPPINES)
_____) S.S.

BEFORE ME, a Notary Public for and in the City of _____, this __ day of _____ 2022, personally appeared the following persons with the following identification documents:

Name of Representative	Government Issued ID (details)
AJAB-ARAM R. MACAPAGAT	
ERNANI R. BULLECER, RND, MPH, DrPH	PRC License No. 0011043

known to me to be the same persons who executed the foregoing instrument and acknowledged to me that the same is their own free and voluntary acts and deeds and that of the corporations herein represented.

This instrument consists of 8 pages including this page on which the acknowledgment is written and has been signed on the left margin of each page by the parties herein and their witnesses, and sealed with my notarial seal.

WITNESS MY HAND AND NOTARIAL SEAL on the date and at the place hereinabove written.

_____
Notary Public

Doc. No. _____;
Page No._____;
Book No. _____;
Series of 2022.

Ernani Bullecer

Annex 1: TERMS OF REFERENCE

Deliverable	Timeline	Remarks
Inception Report / Research Plan	31 August 2022	The research plan should not only contain the outline of the research but also the data collection plan/field visit plan/meeting with relevant stakeholders, including the budget plan; First tranche release – 35%
Inception Report / Research Plan Sharing Workshop	Within September 2022	The external consultant should arrange a workshop together with the project team members.
Initial Draft of Report	15 November 2022	Submission of raw data and initial draft report; Second tranche release – 25%
Final Report Draft	15 January 2022	Third tranche release – 20%
Final Report Sharing Workshop	Within January 2023	The external consultant should arrange a workshop together with the project team members.
Final Report Submission	15 February 2023	Both soft and hard copy should be submitted to WVDF; Fourth tranche release – 20%
Journal Publication	February 2023 onwards	The research will be published by the consultant in a local or international journal with support from WVDF;
Public Policy Consultation	February 2023 onwards	The research team may be invited by the project team to present the results to various stakeholders in Eastern Visayas.

Research Questions :

The research questions to be answered are the following:

1. What is the current prevalence of teenage pregnancy in the national, region, province and municipalities covered by the project?
2. What are the underlying causes of teenage pregnancy and to what extent does teenage pregnancy affect over health and well-being of teenagers?
3. To what extent does teenage pregnancy impact maternal, newborn, and child health mortality accounts in the project areas?
4. What are the existing policies at the provincial, municipal and barangay level related to teenage pregnancy?
5. How are these policies translated into programs, projects and activities? What are the lessons learned and good practices?
6. What are the existing teenage pregnancy interventions/programs by the national government being implemented? How are these being sustained?
7. How does teenage pregnancy being addressed at the different tiers of local government (i.e. regional, provincial, city/municipal and barangay level) in the project areas? How are these being sustained?
8. What is the contribution of the current initiative of DOH called "Adolescent-Friendly Health Facilities (AFHS)" to reduce teenage pregnancy and address the social stigma over pregnant teenagers and barriers to access to the health service required? In Eastern Visayas, how many (AFHF) level 1-3 there are?
9. How the current policy related to teen pregnancy at the local and national levels should be improved to address the issue?
10. Are there any other actors/organizations present in the areas focused in addressing the teenage pregnancy concern?
    - What are their intervention programs?
    - Were these efforts sustained after their project/program engagement? If yes, describe how?
    - What were the facilitating factors/good practices noted in the adoption of their program/s?
    - What were the key issues, challenges, constraints in terms of the adoption of their program/s?
    - How will the results achieved from the previous/current programs in the project areas be improved, sustained, and expanded?

Emmanuel Bulleza

11. What are the concrete recommendations (in terms of advocacy, policy, research, and implementation) need to be considered and prioritized by the project team for a successful implementation of intervention programs addressing teenage pregnancy in the project areas?

Methodology

The external consultant should utilize a mixed method approach to obtain different but complementary data on the same topic. At the minimum, the study design should include desk review of secondary data and qualitative and quantitative analysis of primary data. Any other mixed method study designs deemed appropriate to address the objectives and the research questions may also be proposed.

Operating Cost

Particulars	Unit Cost	Months/ Frequency	Total Cost
Principal Investigator	25000	6	150,000
Co-Investigators			
- Family, Health and Nutrition Specialist	20000	6	120,000
- Data Manager	20000	6	120,000
URA 1 (Science Research Specialist 1)	27608	5	138,040
Language transcriber/editor	20000	1	20,000
Data Collector (Project Assistant)			
x 1 x 18998/month. X 3 months	18998	3	56,994
x 3 x 18998/month. X 1 month	18998	3	56,994
Ethics review (UPM-REB)	30000	1	30,000
Transportation Allowances			
Airfare			
Project Staff/ 8000 RT (MNL - Tacloban) x 3	8000	3	24,000
Per Diem			
Project Staff/ 1000/day x 2 days x 4 pax	2000	3	6,000
Accommodation			
Hotel (2 nights) 3000/night x 3 visits	6000	3	18,000
Per Diem			
Data Collector (PhP 200 x 22 days)			
-URA (1)	4400	5	22,000
-Data Collector (1)	4400	3	13,200
Consultative Meetings (3 meetings)	5000	3	15,000
PPEs (face mask, alcohol)	5000	1	5,000
Tokens for participants			
Token- Focus Group Discussions (20 participants x 4 provinces= 80 participants)	400	80	32,000
Token- Key Informant Interview (6 Key Informants x 4 provinces= 24 participants	400	24	9,600
Token- Survey	200	270	54,000
Office Supplies			
Photocopy expenses	20000	1	20,000
Paper expenses and other Office Supplies	5000	1	5,000
Communication Allowance			
-URA (1)	500	5	2,500
-Data Collector (1)	500	3	1,500
Contingency fund			20,000
SUB-TOTAL			**919,828**
Administrative Fee (10%)*			**91,983**
TOTAL			**1,011,811**
Total Fees (Final)			**Php1,000,000.00**

Appendix F. Curriculum Vitae

Curriculum Vitae of

DR. ERNANI R. BULECER

PERSONAL INFORMATION

College/Institute	Department of Nutrition COLLEGE OF PUBLIC HEALTH University of the Philippines Manila
Present academic designation	PROFESSOR III and CHAIR, Department of Nutrition
Birthday/Birthplace	March 15, 1978/ Ilocos Sur
Contact	Office Tel No.: (+632) 8525-5858 Email Address: erbullecer1@up.edu.ph

PROFESSIONAL GROWTH

Degree(s)

Degree		Institution	Year obtained
Doctor of Public Health (Nutrition)		University of the Philippines Manila	2017
Master of Public Health (Nutrition)		University of the Philippines Manila	2009
Bachelor of Science in Community Nutrition		University of the Philippines Diliman	2001

PROFESSIONAL LICENSURE

Examination		Rating	Year obtained
Nutritionist-Dietitian Licensure Examination		First Placer 86.7%	2001

PUBLICATIONS

1. Sy DC, and **Bullecer ER**. Factors affecting intention of nutrition label use among selected adults in the Philippines. European Journal of Public Health, 30 (Issue Supplement 5):September 2020 ckaa166.242.

2. Estadilla, JO and **Bullecer ER.** Household Food Insecurity associated with overweight/obesity among adults in CALABARZON Region, Philippines. *Current Developments in Nutrition*, Volume 4, Issue Supplement_2, June 2020, Page 1632,

3. Dela Luna, KLG and **Bullecer ER**. Rural and Urban Differences in Household Food Insecurity and Diet Diversity of Preschool Children in Occidental Mindoro. Acta Medica Philippina, 2020;54(5):511-519.
4. Rivera AKB, **Bullecer ER** and Latorre AE. Factors Associated with Anemia among Selected Women of Reproductive Age in Tondo, Manila, Philippines. Acta Medica Philippina. 2020;54(5):520-527.
5. Sy DC and **Bullecer ER.** Prevalence and Factors Associate with Nutrition Label Use Among Selected Filipino Adults. Acta Medica Philippina. 2020;54(5):538-545.
6. Dela Luna FLG and **Bullecer ER.** Underweight Among Preschool Children as an Acute Consequence of Household Food Insecurity in Occidental Mindoro. *Philippine Journal of Science*. 2020;149(3):683-695.
7. Romero KMR, Landicho VTQ, Malipot JJC, Sagsagat MSJD, Sigue AMS and Bullecer ER. Relationship of frying temperature with frying life of selected oil types. *Philippine Journal of Health Research and Development. 2019; 23(2): 40-46.*
8. Dela Luna KLG and Bullecer ER. Household Food Security is Associated with Stunting among Preschool Children in Oriental Mindoro. *Philippine Journal of Health Research and Development*. 2018;22(3):67-76.
9. Bullecer ER and Develos MM. Use of Mini Nutritional Assessment (MNA®) as a Nutritional Screening Tool among Urban Older Adults in Pasay City, Philippines. *Acta Medica Philippina*. 2018;52(3):253-260.
10. Rama RLCM, Fabi JCQ, Mateo GCM and Bullecer ER. Protein Effi-ciency Ratio of Pigeon Pea (Cajanus cajan) and Lima Bean (Phaseolus lunatus): A Sprague-Dawley Rat Growth Assay. *Acta Medica Philippina*.2018;52(3):222- 231.
11. Ignacio MSE and Bullecer ER. Assessment of the Philippine Plan of Action for Nutrition (PPAN) Localization in Selected Municipalities in Ifugao, Bulacan and Siquijor, Philippines. *Southeast Asian Journal of Tropical Medicine and Public Health*. 2016; 47(4):852-867.
12. Parco JP, Martinez REC and Bullecer ER. Assessment of the Capacity to prevent and Manage Major Non-Communicable Diseases in Primary Health Care Centers in Pateros, Metro Manila, Philippines. *Philippine Journal of Health Research and Development*. 2015; 19(3):20-30.
13. Quiambao-Pablo MLC, Tiangson-Bayaga CLP, Bullecer ER and Gabriel AA. Handler Hygienic Practices and Aerobic Plate Counts of Blenderized Whole Food Tube Feedings among selected tertiary and specialty hospitals in the National Capital Region, Philippines. *Acta Medica Philippina*. 2015;49(3):39- 48.
14. Cokieng CB, Gutierrez LA, Manaloto AN, See JP, Tan JH and Bullecer ER. Validity of Dietary Diversity Score as an Indicator of Nutrient Adequacy among Older Adults in Pasay City, Philippines. *Acta Medica Philippina*. 2014; 48(3):58-65.
15. Guevarra JP, Oidem MG, Estrada JA, Bertuso AG, Borja MP, Bullecer ER, et al. Partnership for Health Development through the Field Practice. *Acta Medica Philippina*. 2014; 48(3):66-71.
16. Bullecer ER, Rabuco LB, Aninao DA, et al. Dietary Diversity Score as an Indicator

of Nutritional Adequacy among 16-19 year-old adolescents. *Acta Medica Philippina*. 2012; 46(1):28-33.

17. Bullecer ER, Pangan MRL, Arcegono MS and Agaton KS. Validation of Dietary Diversity Score as an Indicator of Nutritional Adequacy of Diets among selected group of adults in a university campus in Manila, Philippines. *Journal of the Nutritionist-Dietitian's Association of the Philippines*. 2012; 26(1&2):21-31

ACCOMPLISHMENTS IN RESEARCH

1. **Bullecer ER** and Ignacio MSE. Monitoring and Evaluation of the contribution of food banking systems in improving the dietary iversity and caloric intake of household beneficiaries in Bacolod and Tagui City. 2019-2021 [on-going], funded by DOST-PCIEERD.

2. Lopez JL and **Bullecer ER**. Stunting (Co-I) Review and Analysis of health System Gaps Linked with Stunting in the Philippines: Implications for Policy and Action. 2020-2021 [on-going]

3. Rivera AB and Bullecer ER. Factors associated with anemia among non- pregnant women in Tondo, Manila. 2020. UPM-NIH funded. [completed]

4. Corpuz, JM and **Bullecer ER.** (2020) Association of Dietary Diversity and Nutritional Status among non-pregnant women aged 20-29 years old in rural barangays in Infanta, Quezon. [completed]

5. Payumo, AR and **Bullecer ER.** (2020) Development and Validation of a Semi-Quantitative Food Frequency Questionnaire as an assessment tool for Iron intake of filipino women of reproductive age. [completed]

6. Manlapid JM, Chua, GM. **Bullecer ER** et al. (2019) Association of Dietary Energy Density with Dyslipidemia Status Among Adults in Isabela Province, Philippines. [completed]

7. Baidiango, Leeyhen Marie, **Bullecer E**R et al. (2019). Assessment of the Dietary Energy Densities, Contribution of Food and Beverage Groups to Total Energy and Nutrient Adequacy among adults in a selected barangay in Pasay City. [completed]

8. Caballero, NM and **Bullecer ER.** (2019) Food Waste Generation and Management of Selected Barangays in Quezon City. [completed]

9. Salunga,Daniel and **Bullecer E**R. (2019) A study on the knowledge, attitudes and practices of barangay nutrition scholars on the 2012 Operation Timbang Plus Implementing Guidelines in Malabon City, Philippines.[completed]

10. Santos, NL. and **Bullecer ER(**2019). Validity and Reproducibility of a Semi-Quantitative Food Frequency Questionnaire to estimate Sodium intake in a selected group of filipino adults. [completed]

11. **Bullecer ER.** Association of Dietary Diversity Score with Anemia Status among nonpregnant women in Pasay City, Philippines. 2018. [completed]

12. **Bullecer ER.** Association of Dietary Diversity Score and Dietary Energy Density with Dyslipidemia among Adults in Bicol Region, Philippines. 2017. [completed]

13. **Bullecer ER.** Sarol LD and Quizon RR. Evidence-based planning for resilient local health communities in Typhoon Haiyan corridors in the Philippines. 2016, funded by UNICEF Philippine

ACCOMPLISHMENTS IN THE SERVICE OF THE COMMUNITY, COUNTRY, AND THE PROFESSIONS

Technical assistance, or other service	Beneficiary	Year
Resource Speaker and Coordinator Course on Food Safety offered by the UPM College of Public Health	RNDs, Food technologists, Microbiologist	2007-present
Resource Speaker, Dietary assessment Intensive training Course on Assessment of Nutritional Status offered by the UPM CPH-DON	Nutritionist-dietitians	2018-2019
Project Coordinator National Public Health Emergency Management in Asia and the Pacific (PHEMAP) Training Course	DOH Health Emergency Management Bureau (HEMB) personnel	2013-2018
Resource Speaker/Coordinator Health Leadership and Management Program for the Poor (HLMP) offered by DOH	4th to 5th class municiplaities Rural Health Physicians and Mayors	2014-2018
Resource Person Nutrition in Emergency Management Training Course	Asian Disaster Preparedness Center countries	2018
Development of Policy Recommendation on reducing Population Salt Consumption	WHO Philippines	2015
Project Coordinator Evidence-based Planning for Resilient Local Health Systems in Typhoon Haiyan corridors.	UNICEF Philippines	March 2015-March 2016
Consultant Leadership and Advocacy in the NCD Prevention and Control in NCR Cities, Philippines	WHO-WPRO	March 2014

Consultant/Visiting Professor on Health and Nutrition Project and Program Planning	SEAMEO-RECFON University of Indonesia	November 2013
Project Co-Leader. Development of a User-Friendly Pocket Manual Guidelines for "Nutrition in Emergency"	DOH-Health Emergency Management Staff	Feb 2012- Oct 2013
Consultant. Ensuring Food Security and Nutrition among children 024 months of age on the Philippines: MDGF 2030 Endline Survey	UNICEF	July- December 2012
Member, Guidance Committee (Thesis panel) MS Applied Nutrition Program	Institute of Human Nutrition and Food-UPLB	June 1, 2012-May 31, 2014

Membership in Technical Review/Expert Panels

Technical Review/Panels	Year
Member, Technical Panel for exposure Assessment, DOST-PCIEERD	2019-2020
Member, Technical Panel Effect of Quality Snacks, DOST-PCHRD	2018
Member, Technical Panel for Philippine Nutrient Profile Model, DOST-FNRI	2020-on going
Member, Technical Panel for Risk Profiling Project, DOST-PCIERRD	2019-on going
Member, Technical Panel for Total Diet Study, Year 1 and 2, DOST-PCIERRD	2018-on going

Membership in academic, professional, scientific or arts organizations (national and international)

Organization and position, if any	Year
Vice President, Philippine Society of Nutritionist-Dietitians, Inc.	2021-2022
Auditor, Philippine Society for Nutritionist-Dietitians, Inc.	2019-2020
Board of Director, Nutritionist Dietitian's Association of the Philippines	2013-2015 2015-2017
Member, Nutritionist-Dietitian's Association of the Philippines	2001-present

Title of award	Awarding body	Year
One UP Professorial Chair Award (Outstanding Achievements in Research and Public Service in Public Health Nutrition)	UP System	2016-2018 2019-2021
UP Manila Centennial Professorial Chair Award	UP Manila	July 2018-June 2019
UP Manila Professorial Chair Award	UP Manila	Jan 2013-Dec 2013
Peer Reviewer, Philippine Journal of Science	Philippine Journal of Science	2018-present
Peer Reviewer, Acta Medica Philippina	Acta Medica Philippina	2012-present

TRAININGS ATTENDED

Certificate/course	Institution	Inclusive dates
Seminar Workshop on Test Construction and Instructional Design	UP Manila Board Room	Sept. 7, 2007
Training Workshop on Developing a Strategic Communications Plan: The Spitfire Strategies Smart Chart Approach	Fersal Hotel Quezon City	Oct. 11-12, 2007
Sartorius Mechatronics Seminar on Moisture Analysis and Water Detection Systems	Mandarin Hotel Makati City	Nov. 29, 2007
Staff Development for SEAMEO TROPMED Partner Centres Teaching and Facilitating Skills.	Bangkok, Thailand	June 3-6, 2008
Orientation on being Caring and Nurturing Faculty in the Context of UP's Academic Excellence	UPM Social Hall	Sept. 19, 2008
8th National Public Hlth Emergency Management in Asia and the Pacific (PHEMAP) Training Course	City State Tower Hotel, Mabini Manila	Nov. 17-28, 2008
Asia Pacific Academic Consortium for Public Health (APACPH) Early Career Network. Regional Workshop on Health Advocacy and Policy Related to Non-Communicable Diseases	Special Conference Room, CPH, UP Manila	Aug. 12-14, 2009
Scientific Seminar on Food Safety: Challenges and Opportunities	ILSI-SEAR EDSA Shangrila	Sept. 18, 2009
Updates in Biotechnology for Food and Medicine	Biotechnology Coalition of the Philippines and CPH	Sept. 26, 2009
7th Southeast Asian Nutrition Leadership Program	Jakarta, Indonesia	Nov. 1-7, 2009
Health, Nutrition and Food Biotechnology	Rm. 407, CPH, UP Manila	Oct. 22, 2010
Propensity Scores: A Path to Causality	Press Room, CPH, UP Manila	June 15, 2011

48th Asia Pacific Academic Consortium for Public Health Conference		Teikyo University, Tokyo, Japan	September 16-19, 2016
15th World Congress on Public Health		Melbourne, Australia	April 3-7, 2017
5th Seoul International Congress of Endocrinology and Metabolism		Hotel Walkerhill, Seoul, South Korea	April 27-29, 2017
6th Seoul International Congress of Endocrinology and Metabolism		Hotel Walkerhill, Seoul, South Korea	April 19-22, 20118
Nutrition Epidemiology Short Course		National University of Singapore	June 2018
International Conference on Diabetes and Mellitus		Grand Hilton Seoul Hotel	October 10-12, 2019

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kgdelaluna@up.edu.ph

OBJECTIVES

Looking for a challenging career in an institution where I can effectively exploit my knowledge, skills and abilities that will facilitate to have a constructive contribution to the organization.

WORK EXPERIENCES

ASSOCIATE PROFESSOR III — University of the Philippines Manila
625 Pedro Gil St., Malate, Manila
March 18, 2022- present

INSTRUCTOR III — Batangas State University-ARASOF Nasugbu Campus
R. Martinez St., Brgy. Bucana, Nasugbu, Batangas
August 8, 2016- June 30, 2019

Positions Held:

1. Faculty, In- Charge, Nutrition and Dietetics Department (August 2017- June 2019)
2. OJT Coordinator, College of Nursing and Allied Health Sciences (January 2018- June 2019)
3. Head, Food Service and Student Residential Housing (January 2019- June 2019)
4. Adviser, Philippine Association of Nutrition- Delta Epsilon Chapter (August 2017- June 2019)

NUTRITIONIST- DIETITIAN II — Our Lady of Caysasay Medical Center, Inc.
V. Illustre, Ave., Lemery, Batangas
October 2011- July 2014

Positions Held:

1. Consultant/ (On- Call) Nutritionist- Dietitian (July 2014- October 2019)
2. Member, Disaster and Risk Management Committee (June 2012- July 2014)

OTHER RELATED EXPERIENCES

Presenter/ Lecturer — PUP In- House Review for BSND Students
Polytechnic University of the Philippines (Sta. Mesa, Manila)
July 25-26, 2015/ October 15-18, 2021

EDUCATIONAL BACKGROUND

POST GRADUATE EDUCATION	Doctor of Philosophy in Human Nutrition University of the Philippines-Los Baños 2019-2022
GRADUATE EDUCATION	Master of Science in Public Health (Nutrition) University of the Philippines-Manila 2014- 2017
COLLEGE EDUCATION	Bachelor of Science in Nutrition and Dietetics Polytechnic University of the Philippines Sta. Mesa, Manila 2007- 2011

ORGANIZATION/ AFFILIATION

Member	Philippine Society of Parenteral and Enteral Nutrition November 2012- present
Member	Nutritionist Dietitian Association of the Philippines- Batangas Chapter June 2012- present
Member	Nutritionist Dietitian Association of the Philippines August 2011-present
Member	Philippine Association of Nutrition- Alpha Epsilon Chapter 2007-2011
Member	Federation of Alumni Association of PUP, Inc 2011-present
Member	Philippine Society of Nutritionist- Dietitian, Inc 2015-present

EXAMINATION TAKEN

Passed	2011 Nutritionist- Dietitian Licensure Examination (81.95%) Philippine Regulation Commission July 2011

SKILLS AND KNOWLEDGE

- Exceptional Written and Communication Skills (Filipino/English)
- Very good interpersonal skills and ability to work effectively with variety of people.
- Very good interpersonal and communication skills when dealing with patients, families and other healthcare team members.
- Skills in training and staff orientation about the current standard procedure and protocols set by the institution.
- Updated regarding current nutrition and dietetics practices and principles in the hospital setting.

RELATED TRAININGS

Trainee	Philippine Heart Center (200 hours) East Avenue, Quezon City

Trainee	Dads KamayanSaisaki (200 hours) Buffet Attendant and Kitchen Helper EDSA Ortigas
Trainee	Nutrition Foundation of the Philippines (240 hours) E. Rodriguez Sr., Quezon City

TRAININGS/ SEMINARS/ CONVENTIONS ATTENDED

- **2020 Philippine Society of Nutritionist-Dietitian Online Convention**
  PUSH Nutrition: PSND Unravels Solutions for Health and Nutrition (November 5, 12, 2021)
- **65th Nutritionist-Dietitians' Association of the Philippines Annual Convention**
  Conrad Hotel, Pasay City (February 27-28, 2020)
- **Introducing Calorie Labeling in Food Service Establishments to Support Healthy Diets**
  NDAP Foundation, Focus Group Discussion
  Conrad Hotel, Pasay City (February 26, 2020)
- **65th Nutritionist-Dietitians' Association of the Philippines**
  Conrad Hotel, Pasay City (February 27-28, 2020)
- **Updates on Intervention on Micronutrient Malnutrition and Agriculture-Nutrition Links**
  University of the Philippines Los Banos (January 17, 2020)
- **National Conference on Family Ecology**
  Development Academy of the Philippines (November 27-29, 2019)
- **Bridging the Nutritional Gap with Innovations: 2nd Nutrition Summit**
  The Medical City, Ortigas Avenue, Pasig City (October 22, 2019)
- **2019 Comprehensive Education Course for Asian Diabetes Educators**
  Grand Hilton, Seoul, Korea (October 13, 2019)
- **2019 International Congress of Diabetes and Endocrinology**
  Grand Hilton, Seoul, Korea (October 10-12, 2019)
- **2019 Philippine Society of Nutritionist Dietitian, Inc Annual Convention**
  Manila Marriott Hotel, Pasay City (September 11-12, 2018)
- **Nutrition and Dietetics: A Sustainable Profession Across Horizon**
  Mary Mediatrix Medical Center (July 20, 2019)
- **7th Seoul International Congress of Endocrinology and Metabolism**
  Sheraton Hotel, GrandeWalker Hill, Seoul, Korea (April 18- April 21, 2019)
- **Strategic Planning Workshop**
  Batangas State University Main I Campus (March 22, 2019)
- **Women Inspiring Women: Forum on Health and Wellness**
  Batangas State University Main I Campus (March 20, 2019)
- **Orientation Seminar on Fire Exit Drill**
  Batangas State University ARASOF Nasugbu Campus (March 12, 2019)
- **Training-workshop on Enhanced Gender Mainstreaming Evaluation Framework and BatSateU Gender Audit**
  Batangas State University Main I Campus (August 6-7, 2018)
- **2018 Philippine Society of Nutritionist-Dietitian Convention**
  Diamond Hotel, Pasay City (September 19-20, 2018)
- **In-House Seminar/ Workshop in Outcomes-Based Education through Evolving Pedagogies**
  Batangas State University ARASOF Nasugbu (July 18-19, 2018)
- **ISO 9001:2015 Quality Management System Awareness Seminar**
  Batangas State University Main I Campus (May 15, 2018)
- **6th Seoul International Congress of Endocrinology and Metabolism**
  Sheraton Hotel, GrandeWalker Hill, Seoul, Korea (April 19- April 22, 2018)

- **63rd Nutritionist-Dietitians' Association of the Philippines Annual Convention**
  SMX Davao Convention Center, Davao City (February 22-23, 2018)
- **2017 Observance of the 18-Day Campaign to End Violence Against Women**
  Batangas Sate University ARASOF Nasugbu (December 22, 2017)
- **Seminar on Outcomes Based Learning and teaching Approach and Assessment**
  Batangas State University ARASOF Nasugbu (November 23-23, 2017)
- **BatStateU Triangular Research Conference 2017**
  Batangas State University ARASOF Nasugbu (November 21, 2017)
- **Gender Mainstreaming in the Academe: GAD Orientation for New Faculty and Employees**
  Batangas State University Main I Campus (November 15, 2017)
- **3rd International Research Conference on Innovations in Engineering, Science and Technology**
  Batangas State University Main I Campus (September 27-28, 2017)
- **International Symposium on Realizing the Full Cycle of Research and Development: From Bench to Community**
  Taal Vista Hotel, Tagaytay City (September 21-22, 2017)
- **2nd International Science Graduate Scholars' Conference**
  Philippine International Convention Center, Pasay City (May 24-25, 2017)
- **5th Seoul International Congress of Endocrinology and Metabolism**
  Sheraton Hotel, GrandeWalker Hill, Seoul, Korea (April 27- April 30, 2017)
- **2017 National Women's Month Celebration: We Make Change for Women**
  Batangas State University ARASOF Nasugbu (March 28, 2017)
- **62nd Nutritionist-Dietitians' Annual Convention**
  Marriott Hotel Manila, Pasay City (March 9-10, 2017)
- **Seminar on Anti-Sexual Harassment Act of 1995 (RA7877 & RA 7610)**
  Batangas State University ARASOF Nasugbu (November 25, 2016)
- **4th Seoul International Congress of Endocrinology and Metabolism**
  Sheraton Hotel, GrandeWalker Hill, Seoul, Korea (April 25- May 1, 2016)
- **Health Care Social Media Summit 2016**
  Philippine International Convention Center (April 21, 2016)
- **1st International DOST-SEI ASTHRDP-NSC Scholars' Conference**
  Philippine International Convention Center (April 7-8, 2016)
- **62nd NDAP Convention: Served with Passion Towards a Nourished Nation**
  Royal Garden Convention Center, Jaro, Iloilo City (February 23-25, 2016)
- **International FORUM for Research**
  Philippine International Convention Center, Pasay City (August 24-28, 2015)
- **8th National Medical Writing and 1stWriteshop for Young Researchers**
  Sofitel Philippine Plaza, Pasay City (August 28, 2015)
- **PSND Convention: Taking Nutrition Into Greater Heights**
  Vigan City (June 21-23, 2015)
- **DOH Updates on Rabies Management**
  Our Lady of Caysasay Medical Center (April 17, 2015)
- **Managing Diverse Workforce**

Our Lady of Caysasay Medical Center (May 9, 2014)

- **Infection Control Symposium**
  Our Lady of Caysasay Medical Center (June 20, 2013)

- **Diabetes One on One Training Year 4**
  One Tagaytay Place, Tagaytay City (March 20, 2014)
- **59th NDAP Annual Convention: We Learn, We Grow Through Research**
  Crowne Plaza Galleria, Mandaluyong City (February 26-27, 2014)
- **9th PHILSPEN Convention: Medical Nutrition Therapy: The Missing Piece in Clinical Practice**
  DusitThani, Makati City (October 22-23, 2014)
- **58th NDAP Annual Convention: LEAP FORWARD**
  Nutritionist Dietitian Annual Convention 2013
  Manila Hotel (February 21-23, 2013)
- **8thPHILSPEN Annual Convention: Goal Directed Nutrition Therapy**
  Manila Diamond Hotel (November 13-14, 2012)
- **11thDiabetes Forum**
  Hotel Ponte Fino, Batangas City
  October 19, 2012
- **The Go Giver: Getting More in Business and Life**
  Our Lady of Caysasay Medical Center (July 3, 2012)
- **Learn Hospital 5S**
  Our Lady of Caysasay Medical Center (May 28, 2012)
- **The Power of a Vision**
  Our Lady of Caysasay Medical Center (April 24, 2012)
- **Personality Plus (Understanding Different Perosnalitiies)**
  Our Lady of Caysasay Medical Center (February 27, 2012)
- **3rd Total Nutrition Therapy Training**
  Taal Vista, Tagaytay City (November 15-16, 2011)

SPEAKERSHIP/S

- **Think before you Drink. Is there a recommended limit of added sugar to beverages?**
  Saana ko Nagkulang? Saan ako Sumobra?
  1st NDAP Camarines Sur Webinar Conference
  Resource Speaker (October 16, 2021)
- **Malnutrisyon Patuloy na Labanan, First 1000 days Tutukan!**
  Ka-CHS, Healthy ka pa ba kahit may Pandemya? Quirino State University
  Resource Speaker (July 28, 2021)
- **3rd NDAP Batangas Annual Conference: Advancing the ND Practice in the Region**
  Resource Speaker (July 17, 2021)
- **Honing the Writing Skills: The Basics of Allied Health Research**
  First Asia Institute of Technology and Humanity Colleges, College of Allied Health Sciences
  Facilitator/ Resource Speaker (July 15-16, 2021)
- **Responsible Consumption and Nutrition-Sensitive Agriculture: Key Concepts of the Sustainable Development Goal**

Batangas State University ARASOF Nasugbu
Resource Speaker (June 15, 2021)

- **Flexible ND Curriculum: Coping with the Demands of the Better Normal**
  Moderator (June 12, 2021)
- **2nd NDAP Batangas Annual Conference: Moving Forward: Continuing Professional Education through Science-Based solutions**
  Resource Speaker (August 8, 2020); Moderator (July 25, 2020)
- **3rd NDAP South Luzon Convention 2019: Mainstreaming Nutrition and Dietetics through Evidence-Based Practice**
  Moderator (December 7, 2019)
- **Nutrition and Dietetics: A Sustainable Profession Across Horizons**
  Resource Speaker (July 20, 2019)
- **Basic Nutrition: Merging Principle to Practice**
  Resource Speaker (July 10, 2019)
- **Converging Communities through Quality Multidisciplinary Research Collaboration**
  Presenter (November 21, 2017)
- **Nutri-Caravan Health and Wellness Program**
  Resource Speaker (August 28, 2016)

RESEARCH INVOLVEMENT/S

Full Research Implementation

- **Capacity Building on Nutrition-sensitive Agriculture among Local Agriculture Planners in CALABARZON**
  January 2021- January 2022
- **Factors Affecting the Nutritional Status of School Children Belonging to Agriculture Households in the Philippines**
  March 2020-August 2020
- **Association of Household Food Security Status and Nutritional Status Among Preschool Children in Occidental Mindoro**
  Main Author, *June 2016-June 2017*
- **Effect of Shiftwork in Clinical Performance and Stress among Medical Interns: Proposal**
  Contributing Author, *May 2015*
- **Comparison of Nutrient Intake among Working and Non- Working Student of College of Nutrition and Food Science**
  Co-Author, *March 2011*

RESEARCH PRESENTATIONS

Poster Presentations

- **Glycemic Control and Depression as Mediated by Food Insecurity among Diabetic Patients in Low-Income Countries: Review Article as a Basis for Local Studies in the Philippines**
  2019 International Congress of Diabetes and Metabolism
  Grand Hilton Seoul Hotel, Korea (October 10-12, 2020)
- **Increasing Trend of Overweight and Obesity in CALABARON (Cavite-Laguna-Batangas-Rizal-Quezon), Philippines as a Result of Nutrition Transition: A Review Article**
  2019 International Congress of Diabetes and Metabolism
  Grand Hilton Seoul Hotel, Korea (October 10-12, 2020)
- **Knowledge and Usage of Qualitative Tools in Nutrition among Barangay Nutrition Scholars (BNS) in Nasugbu and Tuy, Batangas; Baseline for the Development of a Training Program**
  7th Seoul International Congress of Endocrinology and Metabolism (SICEM 2019)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea (April 18-21, 2019)

- **Rural and Urban Differences in Household Food Security (HFI) and Diet Diversity of Preschool Children (PSC) in Occidental Mindoro, Philippines**
  7th Seoul International Congress of Endocrinology and Metabolism (SICEM 2019)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea (April 18-21, 2019)
- **Sunlight Exposure, Vitamin D Intake and Physical Activity among Rehabilitation Medicine Patients: A Baseline for Developing a Holistic Care Management Program**
  7th Seoul International Congress of Endocrinology and Metabolism (SICEM 2019)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea (April 18-21, 2019)
- **Obesity, Cognitive Performance and Food Security among Children: A Review Article**
  7th Seoul International Congress of Endocrinology and Metabolism (SICEM 2019)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea (April 18-21, 2019)
- **Awareness and Sources of Information about FAD Diets Among Senior High School (SHS) Students in, ARASOF, Nasugbu, Philippines: A Basis for Formulation of Nutrition Education Plan**
  6th Seoul International Congress of Endocrinology and Metabolism (SICEM 2018)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea (April 20-21, 2018)
- **Comparison of Dietary Diversity Score Between Rural and Urban Communities in Occidental Mindoro**
  5th Seoul International Congress of Endocrinology and Metabolism (SICEM 2016)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea (April 27- 30, 2017)
- **Association of Household Food Security Status and Nutritional Status Among Preschool Children in Occidental Mindoro**
  2nd International Science Graduate Scholars' Conference
  Philippine International Congress of Endocrinology and Metabolism
  May 24-25, 2017
- **Effect of White Kidney Bean Intake on Weight and Protein Consumption: An Experimental Study on Sprague- Dawley Rats**
  4th Seoul International Congress of Endocrinology and Metabolism (SICEM 2016)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea
  April 25- May 1, 2016
- **A Case Report on Patient with Chronic Kidney Disease (CKD) Practiced Alternative Medicine and Nutrition Treatment**
  4th Seoul International Congress of Endocrinology and Metabolism (SICEM 2016)
  Sheraton Hotel, Grande Walker Hill, Seoul, Korea
  April 25- May 1, 2016

Oral Presentations

- **Effect of Sugar-Sweetened Beverages (SSBs) and Artificially Sweetened Beverages (ASBs) in Cardiovascular Events: A Narrative Review**
  Asia-Pacific Consortium of Researchers and Educators (APCORE) 2020 International Conference
  December 4, 2020
- **Environmental Influences on Adolescent Behavior as Consumer: A Mixed Method Study Design**
  Asia-Pacific Consortium of Researchers and Educators (APCORE) 2020 International Conference
  December 4, 2020
- **Household Food Security is Associated with Stunting Among Preschool Children in Occidental Mindoro**
  3rd International Research Conference on Innovations in Engineering, Science and Technology
  Batangas State University (September 27-28, 2017)

- **Bakit Parating ako'y Kulang? A Qualitative Study on Single-Parenting, Child-rearing, Feeding in Nagcarlan, Laguna**
  National Conference on Family Ecology (November 27-29, 2019)

RESEARCH PUBLICATIONS

dela Luna, K.L.G., & Marinay-Atienza, L. (2021). Effects of Sugar-sweetened (SSBs) and Artificially Sweetened Beverages (ASBs) in Cardiovascular Events: A Narrative review. Asia Pacific Journal of Management and Sustainable Development, 9(2), 122-130.

dela Luna, K.L.G., & Talavera, M.T.M. (2021). Factors Affecting the Nutritional Status of School-aged Children Belonging to Farming Households in the Philippines. Philippine Journal of Science, 150(6B), 1627-1639.

dela Luna, K.L.G., and Martinez G.C.G (2020). Household Food Security and Diet Diversity among Preschool Children of Farming and Fishing Households in Batangas. Nutritionist-Dietitian's Association of the Philippines Journal, 34 (1), 1-15.

dela Luna, K.L.G., and Bullecer, E. R. (2020). Underweight Among Preschool Children as an Acute Consequence of Household Food Insecurity in Occidental Mindoro. Philippine Journal of Science, 149 (3), 681-693.

dela Luna, K. L. G., & Bullecer, E. R. (2020). Rural and Urban Differences in Household Food Insecurity and Diet Diversity of Preschool Children (PSC) in Occidental Mindoro. *Acta Medica Philippina*, *54*(5). DOI: https://doi.org/10.47895/amp.v54i5.2254

dela Luna, K.L.G., Ostonal, J.M. and Orillo, A.T. (2020). Dietary Diversity as a Component of Food Security among Households with Preschool Children in a Coastal Municipality in Batangas, Philippines. Asia Pacific Journal of Multidisciplinary Research, 8; (3), 63-75.

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dela Luna, K.L.G. and Bullecer, E.R. (2018). Household Food Security is associated with Stunting among Preschool Children in Occidental Mindoro Philippine Journal of Health Research and Development J, 22 (3), 67-76.

SCHOLARSHIP/ RESEARCH FUND GRANT/S

Scholar	Master's Degree. Department of Science and Technology-Accelerated Science and Technology Human Resource Development Program. 2014-2016
Grantee	Master Thesis Graduate Assistance Program. University of the Philippines Manila 2016-2017
Scholar	PhD Degree. Department of Science and Technology-Accelerated Science and Technology Human Resource Development Program. 2019-2022
Grantee	Dissertation Grant. Philippine Council for Agriculture, Aquatic and Natural Resources Research and Development

December 2021-May 2022

PREVIOUS POSITION HANDLED

Regional Vice President	Nutritionist Dietitian Association of the Philippines 2021- present
President/ Secretary	Nutritionist Dietitian Association of the Philippines- Batangas Chapter 2019- 2021/ 2015- 2019
Secretary	Philippine Association of Nutrition- Alpha Epsilon Chapter June 2010- May 2011

STUDENT EXCHANGE PROGRAM

Delegate	Japan-East Asia Network for Students and Youths Japan-ASEAN Students Conference: Sustainable Development Goals 2030 Tokyo and Osaka, Japan (February 9-18, 2020)

CHARACTER REFERENCES

Available upon request.

I hereby certify that the above information is true and correct to the best of my knowledge.

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Summary

Applied researcher specializing in biostatistics with interests focused on diagnostic and biomarker studies; community health and training; and perinatal epidemiology. Well-versed in planning and designing of biomedical research, management, and analysis of public health data; and conducting statistical review and evaluation of studies. A clinical nurse experienced in adult, obstetric, and pediatric emergency management of patients.

Experience

Assistant Professor - 02/2022 to Present
Department of Epidemiology & Biostatistics, College of Public Health, University of the Philippines Manila

Biostatistician - 08/2020 to Present
Expanded Hospital Research Office (EHRO), UP - Philippine General Hospital

Staff Nurse - 04/2012 to 06/2020
Division of Nursing Services, UP – Philippine General Hospital

Education

Master of Science: **Public Health (Biostatistics)** - 2021
University of the Philippines Manila

Bachelor of Science: **Nursing** - 2011
University of the Philippines Manila

Skill Highlights

- **Data Presentation** using MS Word, MS PowerPoint
- **Data Management** using MS Excel, and Epi Info©
- **Data Analysis** using SPSS, JASP, Stata, RevMan, MedCalc

Eligibility

Licensure Examination: **8th Place (86.20%)**, Professional Regulatory Commission – Board of Nursing

Select Publications

- **Sy ADR**, Gonzales MKD, & Rodriguez RCC. Work-related quality of life and performance appraisal among nurses in a tertiary hospital in the Philippines. Journal of Integrative Nursing. 2023 (*in press*)
- Espiritu AI, Bravo SLR, Sombilla HAA, Tantengco OAG, Sy MCC, **Sy ADR**, Anlacan VMM, Jamora RDG. Clinical Outcomes of COVID-19 Infection in Pregnant and Nonpregnant Women: Results from The Philippine CORONA Study. *Vaccines*. 2023; 11(2):226. https://doi.org/10.3390/vaccines11020226
- Velayo CL, Reforma KN, Sicam RVG, Diwa MH, **Sy ADR**, Tantengco OAG. Diagnostic Performances of Ultrasound-Based Models for Predicting Malignancy in Patients with Adnexal Masses. *Healthcare*. 2023; 11(1):8. https://doi.org/10.3390/healthcare11010008
- Velayo CL, Reforma KN, Sicam RVG, Diwa MH, **Sy ADR**, Tantengco OAG. Improving diagnostic strategies for ovarian cancer in Filipino women using ultrasound imaging and a multivariate index assay. *Cancer Epidemiology*. 2022 Sep 28; 81: 102253
- **Sy ADR** & Asaad AS. Propensity Score Approaches in Quantifying Effects of Treatment from Observational Data. *Acta Medica Philippina*. 2022;56(16):96-107
- **Sy ADR** & Asaad AS. Average Treatment Effects of a Single-dose Antenatal Corticosteroid on the Respiratory Morbidity of Filipino Preterm Neonates. *Acta Medica Philippina*. 2022;56(16):71-77
- Novero, VM, Yu, ML, Gamilde, A, Berramende R, **Sy ADR**. Age Specific Serum Anti-Mullerian Hormone Reference Range for Infertile Filipino Women in a Tertiary In-Vitro Fertilization Center in the Philippines. *Philippine Journal of Obstetrics and Gynecology*. 2021 March-April; 45(2): 68-75

KOICA
Korea International Cooperation Agency

World Vision

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