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Perceived needs and recommendations on adolescent pregnancy-related services in the Philippines

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Abstract:

BACKGROUND: Adolescent pregnancy remains to be a significant social and public health problem in the Philippines, despite the widespread implementation of a comprehensive sexual and reproductive health (SRH) law. The current study explored the perceptions on teenage pregnancy and adolescent-oriented services across different views of stakeholders.

MATERIALS AND METHODS: Twelve focus group discussions involving sets of teenage boys and girls, teenage mothers, and parents of the teenage mothers were conducted. Data analysis using a descriptive qualitative approach adopting both inductive and deductive thematic analysis was implemented on the gathered data.

RESULTS: Four main themes emerged from the focus groups. First, discussants expressed community perceptions, emphasizing factors perceived to contribute to the occurrence of teenage pregnancy cases. Second, the adolescents expressed the coping responses they used or have observed in others to cope with teenage pregnancy, while the teenage mothers and their parents highlighted their immediate feelings toward the event. Last, the participants verbalized their perceptions of community services including criticisms and suggestions to improve the delivery of these services.

DISCUSSION: The findings underscore the importance of stratifying and customizing the delivery of adolescent services as well as the possibility of expanding the content and coverage of community actions. This study also suggests that there is a need to create local ordinances that are culturally specific based on the Republic Act 10354 or the Responsible Parenthood and Reproductive Health Act of 2012. These ordinances must be coupled with other programs on reproductive health including training of personnel, ensuring the availability of resources, and reframing service delivery to the needs of adolescents. Further research is needed to explore variability of perceptions across contexts and cultures and the need for more appropriate service delivery models, thus contributing to a better understanding of teenage pregnancy and more tangible impact toward its reduction.

Keywords:

Adolescent health services, focus groups, maternal health, public health, reproductive health

Introduction

Globally, the life expectancy continues to increase, but disparities between areas remain. Levels of adolescent fertility remain high in some countries, having an estimate of 10% babies delivered from mothers less than 20 years old worldwide.^[1]

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The Philippines is one of those countries where adolescent pregnancy remains to be a problem, with the prevalence of teenage pregnancy at 30 to 59 deliveries per 1000 women. Adolescent pregnancy, specifically complications from childbirth, being the most common cause of death in this age group, is what makes it a pressing important health problem.^[2] Aside from

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notable socio-economic consequences such as inability to access education, lack or unstable employment and subsequent health problems in later life can be experienced by the young parents and their children.^[3]

The local government has adopted policies and measures to reduce the number of teenage pregnancy cases alongside international guidelines^[4,5] and even declared it as a social emergency amid the coronavirus disease 2019 pandemic.^[6] A comprehensive law, the RH Law or the Responsible Parenthood and Reproductive Health Act of 2012, is being implemented to address the problem in a multi-dimensional and inter-agency approach.^[7]

However, it has been observed that the burden of adolescent birth is still high at 7–11% in the Eastern Visayas region of the Philippines,^[8] and the country's health-related outcomes of sexual and reproductive health programs appear to lag behind compared to other growing economies nations.^[9,10] This finding is indicative of a need to improve the delivery of these adolescent-targeted programs, though a formal evaluation of the implementation is still not available.^[11-13]

A common criticism about adolescent-related sexual and reproductive health programs across countries is that their delivery is only targeting already cases of teenage pregnancy and not customized with unique physiologic and psychosocial needs of adolescents.^[14] The literature also mentioned that addressing other adolescent-relevant issues must be addressed by such programs such as risky sexual behaviors, lack of contraceptive supplies, legal issues such as age discrepancies between couples and domestic violence, and lack of available livelihood programs for teenage parents.^[15] As a result, it has been noted that the target audience, adolescents, are reluctant or not very keen in accessing these services meant to address their needs.^[16]

The current study intends to explore the perceptions and experiences of teenage pregnancy and identify possible additions and improvements in the adolescent-focused programs currently implemented from the views of different stakeholders. The findings can be used to plan and design better targeted activities and interventions addressing different facets of this health problem and create a greater impact on reducing cases of adolescent pregnancy.

In relation to these sustained issues of adolescent pregnancy in the country, there is a need to fully understand the felt needs and recommendations of different actors in the community that can inform the development and improvement of existing policies. As such, the current study looked at a more holistic

and encompassing view of the stakeholders and target population.^[7] Aside from looking at the views of teenagers who experienced pregnancy, the researchers wanted to look at the perspectives of adolescents who are at risk for these circumstances – and part of the target population for these programs and policies. Moreover, the study also included perspectives of “under-recognized” participants in teenage pregnancy who are the guardians and parents of teenage pregnancy cases. Such an approach will ensure that programs in place are aligned with the actual needs and preferences of the target population. This will also provide viable information on services that are most needed and desired by pregnant adolescents. Meanwhile, perceived needs can provide insights into areas where prevention and education efforts may be lacking. This information is crucial for designing effective awareness campaigns and educational programs to reduce the incidence of adolescent pregnancies.

Materials and Methods

Study design and setting

In an interest to understand more about one's behavior, motives, views, and barriers, a qualitative descriptive design was proposed using multiple qualitative lenses.^[17] A social generation lens referred to looking at a group of people born at a similar time with each other and the shared perspectives on socio-cultural and societal matters.^[18] Thus, focus group discussions were selected over in-depth interviews despite the sensitive topic.^[19] A theoretical lens was needed to explain a set of ideas and themes found in the study and contrasted against a previously identified theory.^[20]

Study participants and setting

The target population for the study was made representative and inclusive to gain comprehensive and varying perspectives to generate recommendations meant to improve delivery of adolescent health services. Hence, stratified purposive sampling incorporating intensity qualitative sampling was utilized.

Initially, four focus group discussions (FGDs) in select provinces of Eastern Visayas (i.e. Leyte, Samar, Eastern Samar, and Northern Samar) stratified between geographically isolated, disadvantaged areas (GIDA) and non-GIDA municipalities were planned. Each FGD was planned to have at least five participants – and the groups would be composed of 13- to 19-year-old adolescents (i.e. teenage girls without children; teenage boys without children, teenage mothers) and the parents or guardians of the teenage mothers.

The discussants were recruited using face-to-face and telephone scheduling. The inclusion criteria for FGD

participation were as follows: (a) shall be residing in the study areas for at least 1 year prior to the study, (b) their primary source of healthcare must be institutions under their respective local government units and/or the Department of Health, and (c) for participants less than 18 years old, permission was given by the parent or guardian. Consequently, discussants who are seeking medical and healthcare needs from private medical institutions, those who are part of any ethnic groups, or pregnant women who just migrated in the study sites were excluded to lessen the impact of cultural variations. Moreover, participants who were not able to finish at least 50% of the focus group were withdrawn in the study.

The pre-determined number of participants was initially set at 16 FGDs, but data saturation was reached after the ten FGDs. About 75% of the sub-themes were already repetitive, and no new information emerged from the two additional FGDs, merely adding descriptors for the sub-themes. The twelfth session validated that the sub-themes were repeated, after which the conduct of focus groups was terminated.

Data collection and tools

A set of semi-structured FGD guides was created for every group, composed of open-ended and probing questions. The questions covered a range of topics related to their perceptions on teenage pregnancy, contributors to teenage pregnancy, and impact of teenage pregnancy. Additional topics for the teenage mothers and their parents include experiences of receiving adolescent-aimed services and suggestions to improve the delivery of services.

The researchers developed the topic guide based on the literature and available documents on the delivery of these services. After this, these were shown to two experts in social science research, and the main suggestions on the initial tool were to improve the order of asking the questions, emphasis on questions that might be more appropriate for specific groups, and to use the Filipino version of the tool but with annotations in the local dialects (i.e. Bisaya and Waray), switching to the local dialect or in English only to facilitate understanding of the question.

Four individuals, all beyond 18 years, representing the sample population were interviewed to pilot test the instruments. The length of time for the pilot FGD is about 90 minutes and was audio-recorded. The participants recommended breaking some of the questions in two or more questions instead and give more time for the discussant to process some questions. They also added that “asking back” the questions can be performed to ensure that both the facilitator and discussant are talking about the same thing.

The focus groups lasted between 60 and 90 minutes. No discussant participated in more than one focus group, and none withdrew during the conduct of these discussions. The FGDs were facilitated by a male and female member of the research team who have sufficient training in performing qualitative research. These FGDs were conducted on a face-to-face basis, with permission for audio-recording during the discussions. Prior to the discussions, the facilitator provided an overview of the research activity and discussed the schedule of the interview. Field notes were also taken during the sessions to include observed gestures or facial expressions.

The interviews were conducted in a secluded activity room in the local government centers, free from any distraction, and appropriate to discuss the sensitive nature of the research topic. Debriefing after the FGDs allowing the discussants to express emotions or concerns or to clarify aspects of the study was performed. A few participants verbalized privacy and felt assured that their identity and shared information were dealt with utmost confidentiality. The investigators were also given the option to communicate with a member of the research team who is experienced in mental health counseling and assured that the investigators were available to be reached out by the discussants as needed.

Data analysis

The transcribed focus groups were repeatedly read thoroughly, and an inductive thematic approach was initially adopted to identify themes and sub-themes from codes based on the verbalizations of the discussants and summarized using a qualitative description of these perceptions.^[17]

A deductive content analysis approach was later used on the coded texts using the Theory of Collective Resilience from the Self-Categorization Theory, which was used as a theoretical lens to further organize and interpret the data.

Initial codes were identified by one investigator from repeated words and phrases and emphasized statements using QDA Miner Lite version 2.0.9 as software. Two other investigators categorized, compared, and contrasted these codes, and the emerging themes were compared across all the FGDs and arranged together to relate them with each other. The researchers validated the findings by separately reading and classifying the coding units, with disagreements settled via meetings to reach consensus.

Ensuring trustworthiness

Select measures to improve rigor and trustworthiness were implemented in analyzing the research findings. To improve transferability, using multiple data sources (i.e. transcription, field notes, group comparisons),

explicit description of the data collection process, and a purposefully diverse set of FGD participants were done by the researchers.

Prior to the focus groups, the moderator introduced each participant to each other and maintained an open environment to build trust and rapport with the discussants and eventually enhance authenticity. Similarly, comparing the FGD moderator's notes with the transcription and, during the FGD, reflecting the responses of the discussants and summarizing what was discussed were done to improve congruency and veracity. Participant checking was not conducted for all the groups due to resource constraints, and only the summarized results were provided to them, not the verbatim transcriptions of the focus groups.

Credibility was improved by quoting verbatim responses from the FGDs and side-by-side comparison of the transcripts to enhance the context of the identified theme. Furthermore, an audit trail and use of researchers' notes to clarify or discuss the identified themes were used to improve the confirmability and dependability of the findings. Keeping audio-taped and digital notes, bracketing, and iterative review of codes and noted themes addressed reflexivity.

Ethical considerations

An approval from an institutional ethics review board [UPMREB 2022-0474-01] was secured before any sampling recruitment or data collection. Informed consent and assent forms were secured from all participants and verbally reinforced prior to the focus groups.

Given the nature of FGDs, anonymity cannot be assured, but the discussants were strongly encouraged not to disclose what has been discussed or the persons involved in the activity among non-participants in the study. The researcher and discussants were encouraged to call each other using pseudonyms, and these were also used during data analysis. Information about the FGD participants is limited to members of the research team, and only a summary of findings was provided to select discussants during participant validation of the results. Pictures or video recordings were not taken during the data collection, but the audio-recording and other documentation during FGDs were explicitly written in the consent/assent.

Results

The number of respondents per focus group session ranged from four to eight persons, and the researchers conducted 12 focus group discussions with a total of 75 respondents participating in the study. No participants

refused or withdrew participation in the FGDs. The baseline characteristics of the participants are shown in Table 1. All adolescent participants (teenage boys and girls who are not cases of teenage pregnancy) have immediate families or close relatives who were teenage pregnancy cases. Hence, their responses contribute to the perceived impact of teenage pregnancy based on their experiences.

The verbatim data were initially extracting 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. The sub-nodes were further re-classified into six theme nodes and four main themes (indicated in bold) surfaced based on the stakeholders' perceptions and experiences of adolescent-targeted services. A summary of the key themes and sub-themes can be found in Table 2. These key themes include the following: (1) immediate feelings, (2) coping responses, (3) community perceptions, and (4) perception of community services.

Minor themes were also identified by the researchers, and themes that appear to have consistently similar elements were later grouped together for a better understanding of the perceptions on incident reporting among nurses. The hierarchy of themes and codes used for the said study can be seen in the table below.

For the immediate feelings, it focused on the response and reaction of the teenage pregnancy case and their families. The exemplified feelings of *being betrayed or lied to* and *frustration* particularly among parents of a teenage pregnancy case were observed. Discussants stated that:

"The early pregnancy of my daughter broke my heart because she lied to me." [ID 61, 42 years old, mother of a teenage parent]

"I told her that she should learn from my experience that marrying early is a very hard. She assured and listened to me, but still she got pregnant early." [ID 19, 56 years, mother of a teenage parent]

Statements from both teenage parents and mothers of teenage parents reported feelings of life plans being derailed due to the pregnancy. They have mentioned that:

"I felt bad when she told me of the situation, I felt that even if I did everything to take care of them my daughter got pregnant early. 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].

Table 1: Sociodemographic profile of the FGD participants (n=75)

Characteristics	Teenage Boys	Teenage Girls	Teenage Mothers	Guardians or Parents
Number (%)	23 (30.67%)	17 (22.67%)	21 (28%)	14 (18.66%)
Age during FGD				
13-19 years	23 (100%)	17 (100%)	15 (71.43%)	-
20-25 years	-	-	6 (28.57%)	-
26 years and above	-	-	-	14 (100%)
Educational attainment				
Elementary Level	-	-	3 (14.29%)	6 (42.86%)
Elementary Graduate	-	-	-	1 (7.14%)
High School Level	18 (78.26%)	16 (94.12%)	2 (9.52%)	-
Senior High School Level	5 (21.74%)	1 (5.88%)	11 (52.38%)	3 (21.43%)
High School Graduate	-	-	-	-
College Level	-	-	5 (23.81%)	3 (21.43%)
Vocational Graduate	-	-	-	1 (7.14%)
College Graduate	-	-	-	-
Marital Status				
Single, with partner	-	-	16 (76.19%)	2 (14.29%)
Single, without partner	23 (100%)	17 (100%)	5 (23.81%)	-
Married	-	-	-	11 (78.57%)
Separated	-	-	-	1 (7.14%)
Employment				
Employed, part time	-	-	-	2 (14.29%)
Self-employed	-	-	-	1 (7.14%)
Not employed	23 (100%)	17 (100%)	21 (100%)	11 (78.57%)

Table 2: Identified themes and sub-themes from the FGDs

Main Themes	Codes
Immediate Feelings	Being Lied To Frustrated Derailed Plans
Coping Responses	Setting Negative Feelings Aside Fear of Further Harm Handling Marital Issues Learning from the Incident
Community Perceptions	Parental Shortcomings Family Background Technology Friends/Peer Pressure Invincibility Consequences to Cases
Perception of Community Services	
Facilitators of Access to Services	Sex Education Supportive Family
Barriers of Access to Services	Inadequate Supplies/Information Approach of the Public Servants Religious Influence Irregular or Infrequent Activities
Limitations to Current Services	Lack of Tailored Activities Economic Support Unclear School Policies Lenience from Teachers Counseling and Mental Health Dissemination of Services Parenting Support

“When my mother found out that my sister got pregnant, she cried since my sister is the only hope of the family to have a better future.” [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 following statements exemplify how parents of the teenage pregnant tend to set negative feelings aside to focus on the situation and prevent further harm especially on the pregnant adolescent:

“When I found out about the pregnancy, I initially got angry but there is nothing that I can do about it. At present, she listens to our advice more frequently that dampens my anger towards her.” [ID 60, 41 years old, mother of a teenage parent]

“We were afraid since a similar incident happened when a girl committed suicide because the parents kept on getting angry at her because of the pregnancy. Hence, we tried to support our daughter 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 the following verbalizations:

“My husband told me that the young couple are always fighting. Initially, I was very angry with the partner

of my daughter because he does not have enough money". [ID 61, 42 years old, mother of a teenage parent]

"As much as possible, we 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 is now more careful with boys courting her." [ID 20, 41 years old, mother of a teenage parent]

"My daughter was ashamed of the situation because she did it and has to be accountable for the consequences" [ID 60, 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 teenage pregnancy. Other people think that this reflects their parenting style and 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*, peer pressure, and environmental issues related to reproductive health. Discussants stated that:

"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 mobile phones." [ID 19, 56 years, mother of a teenage parent]

"I had sexual intercourse without regard whether it is right or wrong because I was too drunk around the time that I did it. It seemed normal between most people

our age, and I just got along with what my friends are doing." [ID 12, 18 years old, teenage mother]

"When I was younger, I tend 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]

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, reported teenage pregnancy are 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." [ID 46, 15 years old, teenage girl]

"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. [ID 9, 14 years old, teenage boy]

The different responses and perceptions mentioned previously interplay to create a perceived idea of the situation. 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." [ID 10, 16 years old, teenage boy]

"In school and barangay, 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 themselves of these services. [ID 8, 13 years old, teenage boy]

It 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

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to avail community services as noted in the following verbalization:

“From my side, my family supported our decision to move in together because I was already pregnant. Our parents were initially angry but eventually accepted our fate.” [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 centre or the side effects.” [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. Moreover, 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 centre is because they keep on scolding us. For me, it’s alright since you understand where they come from and given our situation.” [ID 34, 15 years old, teenage mother].

The RH Law of 2012 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. 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:

“My family is now 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, and they will not teach it. According to them, 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 not consistent. 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:

“Even 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 preaching about abstinence that it was 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 or similar social concerns:

“Like if I experience abdominal pains, I and other people do not know what to do and the school nurse will have to refer us to the midwife or the centre doctor.” [ID 34, 15 years old, teenage mother]

“From the cases that we know, teenage pregnancies were the result of abuse like rape. Girls are 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.” [ID 45 and 46, 17 and 15 years old respectively, teenage girls].

The third sub-theme comprised 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 has 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.” [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 circulating rumours about them. There should be school policies against rumourmongers.” [ID 9 and 10, 12 and 16 years old respectively, teenage boys].

The teenage mothers and their parents appreciated the lenience from teachers as exemplified in the statements below. However, the decision of the faculty is still on a case-to-case basis and no clear document or ruling supports these decisions. It was mentioned that:

“When she was 15 years old, she decided to transfer schools because of the situation. 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].

The discussants also mentioned services that are lacking, such as counseling or mental health services, parenting support, and dissemination of reproductive health services.

“There are non-government organizations that offer counselling services for teenagers but not regularly. I think it would be great if there is a focus on teenage pregnancy cases such as a written and consistent guide to handle different issues that come along with this situation.” [ID 60, 41 years old, mother of a teenage parent]

“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.” [ID 5, 17 years old, teenage mother]

From the perspective of the discussants, community perceptions on socio-demographic characteristics attributed to teenage pregnancy as well as the perceived consequences contribute to the immediate feelings and concerns felt by the adolescents 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 researchers reached out to two sets of teenage mothers and their parents to verify if the identified themes captured the essence of the focus groups, but only a pair participated. They agreed with the identified themes, and no revision or comments were expressed. However, they emphasized that societal norms and a lack or limited support also had possibilities to decrease resilience and produce negative feelings. They further added that their suggestions to improve the community services need to be highlighted in the study as well. Resource constraints limited access to the teenage boys or girls.

Discussion

UNESCO^[21] has reinforced that all levels of governance and relevant sectors play a responsible role in providing the adolescents and youth with the highest standard of health. The research findings showed that different stakeholders have varying perceptions on the needs of adolescents as well as variations in the perceived or experienced impact of teenage pregnancy.

A consistent finding across the different discussant groups is the need for a more comprehensive and less judgmental delivery of sexual and reproductive health (SRH) services and further backed by availability of supplies and skilled personnel.^[2] However, the findings mentioned the perceived impact of technology and peer pressure not only in contributing to the occurrence of cases but also on controlling the narrative of teenage pregnancy which later affects the impact of the said event.

The finding corresponds with previous studies showing that teenagers learn about sexuality and gender relationships from other sources than parents and schoolteachers.^[22] It has been mentioned in the literature that teenagers can be empowered to make better informed decisions given sufficient literacy in SRH. These peer relationships can be used for peer education, which has been shown to positively influence SRH literacy among adolescents.^[23,24] Previous study mentioned that both teenagers and service providers report more positive outputs when the parent or family is not involved in such activities and underscores the developmental need of teenagers for privacy.^[25]

The FGDs also suggested that the delivery of adolescent services should be customized and varied based on their sex, experience, or lack of, in teenage pregnancy, and degree of involvement (i.e. parent, partner, support system). Previous studies noted that such tailor-made delivery can be in the form of making modifications to cater the audience's needs or in implementing more specific guidelines in rendering these services.^[26] Evidence has shown that adolescents are the most vulnerable to reproductive health problems such as exploitation, abuse, contracting sexually transmitted infections, poor healthcare access (e.g. unsafe abortion or delivery) and economic impacts such as illiteracy, social isolation, lack of income, and further poverty.^[27]

The focus groups mentioned that engaging in unprotected and pre-marital sexual practices are viewed as normal, with adolescent males participating in such acts viewed as more virile and superior, and female adolescents face the negative stigma of being promiscuous, being isolated by families and peers and yet carry the burden of unplanned pregnancy. Several studies also mentioned how older men tend to make sexual advances to these adolescent women, with the exposure increased among those who had been pregnant and should be discussed in SRH education putting the context of their pregnancy status while delivering the intervention.^[16] Thus, adolescent females are the more severe and common recipients of the impact of teenage pregnancy, as mentioned by other studies.^[28,29]

Likewise, adolescent males also agreed that specific materials and concerns are also lacking in the currently available services, with one study suggesting that teenage boys can be empowered through knowledge of risky sexual behaviors and personal skills development aligned with culturally appropriate ideologies of manhood values.^[30] This could potentially address long-held and problematic concepts of masculinity such as dominance, sexual drive or virility, lack of consent, and experimentation without accountability that has also influenced the persistence of adolescent pregnancies.

Teenage mothers and their parents expressed in the FGDs that the former should undergo training or preparation on pregnancy, immediate postpartum, and childcare. This coincides with other studies proposing that a comprehensive SRH program should include maternal role training for adolescent mothers to alleviate anxiety and frustration and improve capability to take a better care of their children.^[31] Likewise, the adolescent mothers also mentioned that their parents and families would benefit from similar services. Maternal figures are viewed as highly important in ways like giving advice and emotional support, providing information, and even keep them connected to community and other resources amid the stigma of teenage pregnancy.^[25]

The literature supports the remarks of teenagers in the FGDs on how the delivery of SRH education tends to be limited to abstinence and warnings, while those who actually inquired for contraceptive services in the community experienced issues such as lack of parental consent, lack of supplies, and lack of a safe and private space to discuss such services.^[22,25] A similar study in Africa also corroborated that adolescents tend to be reluctant in participating and accessing SRH interventions due to the perceived negative attitude of service providers toward them,^[28] especially when seeking for contraceptives or family planning methods. As much as one's norms and beliefs are to be respected, these should get in the way of rendering services, studies have shown that training and reinforcement of health workers and other providers in adolescent-friendly and sensitive approaches are effective in increasing the utilization of these interventions among adolescents.^[32]

Another unclear aspect of teenage pregnancy is the guidelines on continuing education for these women. A study in Lao PDR mentioned that the limited number of in-school adolescent pregnancies in their study can be attributed to some schools implementing expulsion among students who engaged in such activity.^[22] There was no mention of school sanctions in the focus groups, but contributors to the lack of desire to continue education among pregnant teenagers include a sense of guilt, fear of being shamed or disgraced by peers, and limited resources financially, mentally, and physically.^[33] This is an important public health and socio-economic issue since the cycle of poverty and vulnerability can repeat among the offsprings of teenage parents due to inability to find decent work and employment from limited educational backgrounds.

Aside from trainings, stakeholders' meetings are also recommended to reduce the stigma and increase community awareness on the negative effects of social stigma on adolescents, especially teenage pregnancy cases.^[26] The focus groups further suggested that the frequency and consistency of structures and interventions should be maintained to promote uptake of these adolescent-targeted services and put the needs of teenagers (e.g. privacy, non-judgmental approach, simplicity) as a primary consideration in designing these programs.

The FGD transcripts from the different groups were organized and summarized to provide a representation of how the different perceptions of what predisposes teenage pregnancy, the perceived and felt impact of teenage pregnancy, and perceptions of community adolescent-related services guided by the dimensions of the Theory of Collective Resilience [Figure 1]. This behavioral theory can be used to provide a framework

on the different facets where adolescent health can be addressed.

The theory suggests that group behavior in certain emergencies, such as teenage pregnancy, is influenced by shared identity and shared experience can strengthen social bonds and lead to collective resilience or action^[34] and can be moderated by means of communication. Thus, adolescent-friendly interventions and programs, which include all stakeholders, can be developed using this conceptual model, such as by sensitizing the community members to this health problem affects its shared impact, and contribute to the collective resilience and action to reduce the cases and consequences of adolescent pregnancies. Making use of various modes of communication not only aggravates or reduces the weight of the shared consequences and characteristics of the adolescents and subsequently contributes to resilient responses toward teenage pregnancy.

Thus, using the resilience model has potential to make the delivery of adolescent-related services empowering the youth and not just by equipping them with knowledge and a more positive attitude to SRH needs, which would shape their subsequent behaviors as long as supported by different sectors of the community and including government support.^[35]

The strength of the study is the use of a qualitative methodology allowing in-depth examination of unique and sensitive perceptions of adolescents and their guardian on the various aspects of teenage pregnancy. The involvement of different stakeholders allowed for a more varied and nuanced set of perceptions, while the use of both male and female data facilitators who can speak with the vernacular language bridges communication and improves rapport during the focus groups. However, the major limitation of the study

is the lack of representation of adolescents and their guardians in other areas as well as inability to account for contextual factors, thus hindering the generalizability of the findings to a larger population. In addition, the authors also felt that the sensitive nature of the topic may have led to information bias in the form of hesitation and limited disclosure of some participants despite obvious strategies done by the researchers.

Conclusion

The current study has aimed to explore and improve the understanding of how teenage pregnancy is perceived by the community and experienced by adolescents and families involved. The findings have highlighted that each stakeholder has unique and special perspectives on the sexual and reproductive health needs that must be addressed and provided by the community. The implications of these variations would be in the designing and delivery of gender-sensitive, socially responsive, and accommodating interventions taking into consideration these needs and the presence of structures or supplies for these programs.

The findings underscore the need for key implementers to be trained, not only in delivering these services but also in using a more positive approach among in and out-of-school adolescents. Program managers also need to ensure the availability and accessibility of these services for the different categories of adolescents and their families, such as in our study. Furthermore, policymakers, educators, and non-government organizations should be able to design laws and guidelines that can accommodate the SRH and related needs of adolescents.

Importantly, the study findings and the proposed conceptual model provide important information

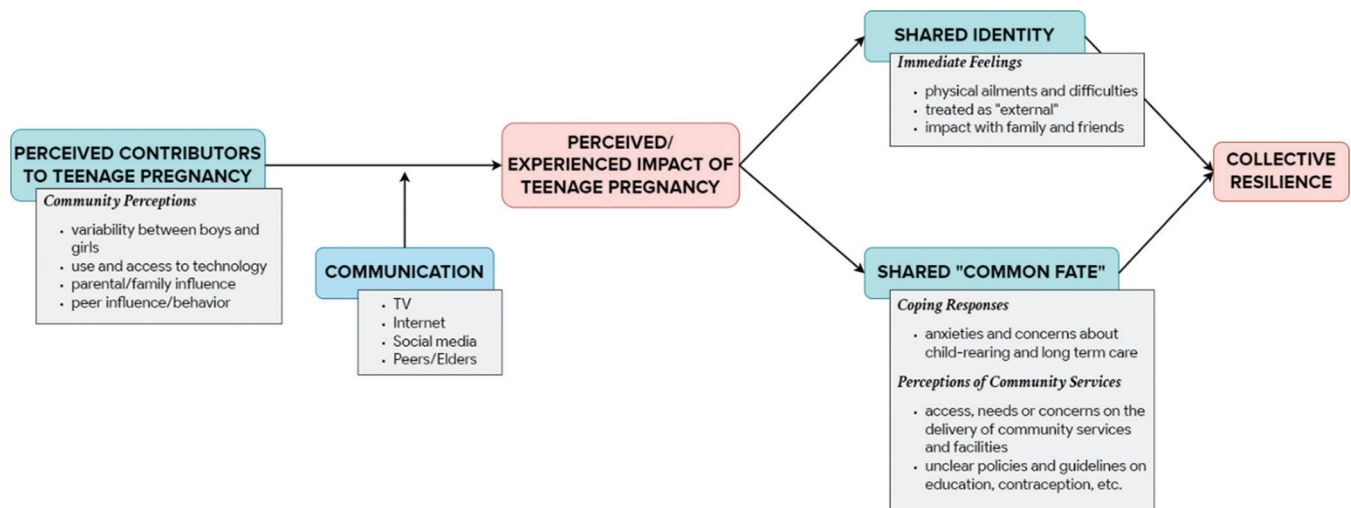


Figure 1: Conceptual model of the stakeholders' perceptions on teenage pregnancy

that can be used to improve the design and coverage of the currently implemented comprehensive sexual and reproductive health strategies. The creation of adolescent-sensitive and adolescent-appropriate materials as well as maintaining a space or appropriated budget provides these services proactively.

The use of inductive and deductive approaches to organizing and analyzing the findings also provided a more comprehensive view of these perceptions, while the utilization of a theoretical lens allowed the gathered findings to be communicated using a more grounded model. The conduct of this study sheds light on the gaps and challenges in implementing the Responsible Parenthood and Reproductive Health Act of 2012 in the Philippines, particularly in low-resource setting areas. Understanding the perceived needs and recommendations related to adolescent pregnancy services is crucial for ensuring the effective implementation of the existing policies on reproductive health for adolescents. It was also observed that aside from this national policy, there is a need to create services that are age-appropriate, culturally sensitive, and effective in addressing the unique challenges faced by this demographic. Notably, there is a need to have inclusive local ordinances that will cater to the diverse needs of this group, considering factors such as socio-economic status, cultural background, and geographical location. Hence, this research is valuable for making data-driven adjustments and improvements in terms of the existing programs and project related to the Responsible Parenthood and Reproductive Health Act of 2012.

Also, it has been repeatedly mentioned that there is no “one size fits all” adolescent-oriented services – but there are culturally and contextually appropriate programs – which the study findings can contribute on. The research supported the creation of target group-specific strategies and interventions which subsequently promote an enabling and non-judgmental environment for teenagers to inquire and utilize SRH information and services. Moreover, the findings also emphasize the need for more inclusive services such as maternal role training for teenage mothers and psycho-social or economic assistance to families of the adolescent parents.

Future studies can be done to explore if similar perceptions exist in other parts of the Philippines as well as create more extensive exploration of variations in these perceptions and a more detailed evaluation of the currently implemented sexual and reproductive health services. Moreover, it is recommended that more qualitative investigations, single studies, or meta-synthesis be done to eventually develop a more encompassing and appropriate model toward

addressing risk factors and managing the impact of teenage pregnancy and eventually address the burden of adolescent pregnancy.^[8]

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Ethical considerations

The original study protocol was approved by the University of the Philippines Manila – Review Ethics Board (UPMREB 2022-0474-01).

Consent to participants

Written informed consent and assent, as well as reinforced verbal consent, have been obtained from the participants during the conduct of data collection for this research.

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Conflicts of interest

There are no conflicts of interest.

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