International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Factors that Influence Reproductive Health Decisions Among Low-Income Males Enrolled in an Anti-poverty Government Initiative in an Urban Community: A Qualitative Study Based on Thematic Analyses of Focus Group Discussions in Pasig, Philippines

Dominic Marcel A. Alfonso[1], David Sebastian D. Garcia[2], Christine Nicole G. Co[3], Aina Elise D.L. Sutingco[4], Joanna Marie B. Perez[5], Camille Andrea B. Malsi[6], Sarah J. Delos Reyes[7], Margarita Luisa A. Alfonso[8]

[1,2,3,4,5,6]Ateneo School of Medicine and Public Health
[7]Research Faculty, Ateneo School of Medicine and Public Health
[8]Clinical Faculty, Ateneo School of Medicine and Public Health

Abstract:
Poor family planning greatly impacts both maternal and child health outcomes. While legislation of the 2012 Responsible Parenthood and Reproductive Health Law increased the access and use of contraceptives, there is still an unmet need for family planning in terms of limiting and spacing of births especially in the lower economic quintiles within densely populated urban communities. Meanwhile, while other studies have shown that male involvement in family planning yields beneficial reproductive health outcomes, local reproductive health policies by the government targeting men have remained very minimal. Therefore, this qualitative study explored the factors that influence the reproductive health decisions among low-income males which may augment the local government in creating reproductive health policies that extend to these demographics. Using a modified qualitative knowledge, attitudes and practices framework, low-income 18-45 year-old males enrolled in an anti-poverty government initiative, the PantawidPamilyang Pilipino Program (4Ps), in Barangay, Pinagbuhatan Pasig City were included in this study. Four FGDs with 3-5 members recruited through purposive sampling were conducted between June 1-July 31, 2019. Thematic analysis was done using NVIVO software (ver. 11) and five themes emerged as the key factors that influence reproductive health decisions.Men enrolled in the 4Ps in Barangay Pinagbuhatan, Pasig City decide the contraceptives to use while their female partners use these contraceptives. (1)Safety issues and (2) compatibility on a contraceptive, (3) control over sex, (4) possible infidelity in marital dynamics, and (5) hegemonic masculinity are the five factors that influence their choice of family planning methods.

Keywords: *reproductive health, male involvement, family planning, contraceptives, safety, hiyang, control, hegemonic masculinity, infidelity, Philippines, qualitative study*

INTRODUCTION

Reproductive health (RH) is the state of complete physical, mental, and social well-being in all matters related to the reproductive system ("Reproductive Health", n.d.). Currently, RH in the Philippines is continuously evolving due to various changes in public policy such as the Responsible Parenthood and Reproductive Health law, which provides Filipinos with family planning services like ligation, vasectomy, and IUDs that are readily available in all government hospitals. The Demographic Health Survey done in 2017 showed that although the majority of women were aware of at least one contraceptive method, with oral contraceptive pills being the most popular of all the contraceptives, only a little over half of them currently use a method of contraception. Meanwhile, a study carried out in the Philippines provided an explanation regarding the apprehension of people towards using contraceptives - that it is due to the belief that birth control methods such as condoms diminish sexual satisfaction of men, and that vasectomy leads to males' loss of sexual performance (Parcon, 2010). Ultimately, a general observation was drawn wherein despite the majority of women having knowledge and are using family planning methods, there is still an unmet need for family planning in terms of limiting and spacing of births especially in the lower economic quintiles (PSA and ICF, 2018).

Exploring the attitudes and comprehension of males towards family planning is very important in understanding their role in reproductive health. Indeed, several studies have shown that, over the past decade, there has been heightened interest in male participation in the subject matter of contraceptive use and reproductive responsibilities (Amanta et al., 2013; Davis, 2016; Parcon, 2010). A qualitative study conducted in several countries in the Pacific showed that male involvement in the family planning decision process yields beneficial outcomes which are translated to an increase in access to contraception services, in male partner support and in uptake of services for sexually transmitted infections (STIs) (Davis et al., 2016). Moreover, a study carried out in the Philippines found that although the majority of the participants believe that family planning must vitally be discussed by both partners, more than half of them think that it is men who must still have the final decision (Amanta et al., 2013). In Bangladesh, a study found that there is a correlation in the proportion of males who are knowledgeable about the use of contraceptive methods and the proportion of couples who are accepting the use of family planning - a result which led to the conclusion that it is pivotal to strengthen male participation in reproductive health services in order to effectively lessen the unwanted pregnancies (Shahjahan, 2013). These studies fundamentally cement the idea that males' knowledge and attitudes on contraceptive use are essential in the overall decision and outcome of birth-prevention strategies by many families.

Furthermore, studies found that male participation in RH and family planning is limited in societies with culturally defined gender norms and roles, a problem that results in decreased patient education, and poor access to RH care (Amanta et al., 2013; Davis, 2016). In other words, men's influence on RH decisions are found to be fundamentally rooted in and are extensively affected by cultural beliefs and factors. Understanding these factors that shape decisions of men are thus essential to

explore in order to reveal its complex and dynamic effects on men's RH engagement and decision-making.

However, despite their importance, little research has been made regarding the factors that influence males' RH decision-making in the Philippines. Former studies have merely highlighted the knowledge, attitudes, and practices of men regarding family planning (Amanta et al., 2013, Davis, 2016) and have only ostensibly explained some demographic factors that affect reproductive decision-making of males (Parcon, 2010; Shahjahan et al., 2013). No study in the Philippines has qualitatively and thematically analyzed in-depth the factors that shape such decisions by males. This study therefore resorts to seeking and interpreting these factors in order to describe their interplay with males' decision-making process in regards to family planning. Moreover, results of this study may also be helpful in augmenting creation of RH policies that target men in poverty-stricken communities (Davis et al., 2016); a demographic where an unmet need for family planning still exists in third-world countries such as the Philippines (PSA and ICF, 2018). The findings of this research show information gathered from Pinagbuhatan Pasig, Philippines, it being one of the most densely populated localities and home to the largest number of indigents and dependent population (Pinagbuhatan, City of Pasig, n.d.) within the metro.

MATERIALS AND METHODS

General Design

The research employed aqualitative study designby extracting qualitative information using a modified knowledge, attitude, and practices (KAP) framework as seen in figure 1 and analyzed using a grounded theory approach. A qualitative KAP framework allows to uncover the unique experiences and context of each study participant, and provides the basis for behavioral interpretation and dissection that may characterize and explain the phenomena being studied (Werner, 1977; Launiala, 2009; Gumucio, 2011). A slight modification was done in the framework wherein, given a particular set of demographics, we included men's role in family planning as an integral part of the interaction and relationship between the respondents' knowledge, attitude, and practices. We think that given the specific points belonging to the respective constructs of the framework - i.e. the sub-topics under knowledge, attitude, and practices - and with careful assessment of this interplay, the role of men as well as the pivotal factors that influence males' RH and family planning decisions may effectively be surfaced and scrutinized.

A focus group discussion (FGD) was implemented as a form of data collection in order to observe the interactions and dynamic discussions between the participants, allow spontaneous dialogue and expression, and help recognize the participants' ideas as part of the collective consciousness of males in the community (Gumucio, 2011). Moreover, an FGD was favored over individual interviews in order to more easily recognize how intertwined their socio-cultural perceptions and beliefs are regarding reproductive health decision-making to their immediate surroundings and expand these from experiential information (Ochieng, et.al., 2018).

This process of obtaining the KAPs through FGDs ultimately provided the means to discover several key themes shaping men's family planning decisions which were then analyzed through the grounded theory qualitative approach.

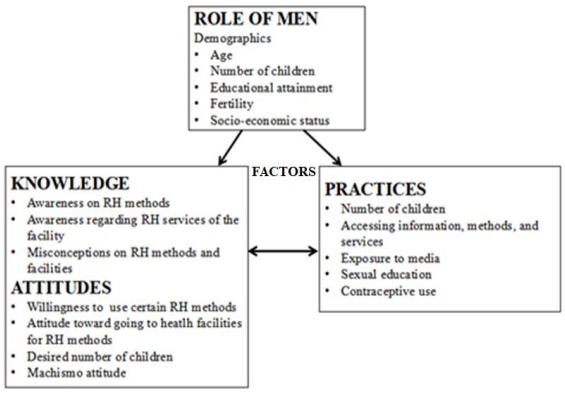

Figure 1. Modified KAP Framework on male involvement regarding RH decisions

The fieldwork took place between June and July of 2018 in Pinagbuhatan, Pasig City. Pinagbuhatan is the most densely populated neighborhood within the city and is home to the largest number of indigents (Pinagbuhatan, City of Pasig, n.d.).

The neighborhood of Pinagbuhatan has a considerable number of impoverished people who are members of an anti-poverty government initiative program called PantawidPamilyang Pilipino Program or 4P's ("Pinagbuhatan, City of Pasig", n.d.). This initiative is a human development measure sponsored by the country's Department of Social Welfare and Development (DSWD) that serves the poorest of the poor through conditional cash grants and proper support for families regarding RH concerns (Sasis et al., 2019). Therefore, given the considerable proportion of the dependent population in Pinagbuhatan, the numerous 4P's members, ("Pinagbuhatan, City of Pasig", n.d.), the need for family planning in the lower socioeconomic classes (PSA and ICF, 2018), and the potential for men to positively impact family planning decisions (Davis et al., 2016), this study was conducted on the 4P's members of this community.

Participant Selection

Eligible participants were heretosexual men aged 18 to 45 years old, Roman Catholic, sexually active, in a committed marriage or cohabitating relationship with a partner, members of the 4Ps, and residents of Pinagbuhatan, Pasig City.

We have employed a combination of purposive and snowball sampling techniques as local community health workers of Pinagbuhatan contacted eligible males face-to-face at their homes inviting them to participate in the study. Upon accepting the invitation, their contact details were given to the researchers and a date for the conduction of the FGDs was set.

A total of fourteen participants (n=14) were included in four FGDs, with each consisting of four to six participants, and all were conducted over the course of three days.

Data Collection

A semi-structured Filipino questionnaire, which was translated and compiled from several validated tools of the World Health Organization (WHO), was used to guide the researchers in conducting FGDs that consequently allowed obtaining information on men's KAPs regarding family

planning. To evaluate this method's validity, a pretest was conducted at Tumana Health Center in Marikina City on January 25, 2018.

The discussions took place at a local community center, which is just a short walk from most of the participants' homes. The community center was reserved exclusively throughout the duration of the FGDs thereby ensuring participant privacy and data collection integrity. On average, the discussions lasted between 60 to 90 minutes.

A vital consideration was assigning two male researchers as facilitators during the FGDs in order to reduce response bias. Moreover, the listening and communication skills of the male facilitators were considered as this encouraged spontaneous dialogue among the participants while still adhering to the topics from the validated questionnaire. This allows natural expression of ideas between the participants and is important in the analysis of data. Participants' responses were then documented using an audio recording device and were transcribed.

All participants gave their consent to the recording and use of data from the interview prior to each FGD. To ensure anonymity and confidentiality, pseudonyms were used to record and transcribe the discussions. Prior to the implementation of the study proper, the research protocol was reviewed and approved by the Ateneo School of Medicine and Public Health (ASMPH) and the University Research Ethics Office (UREO). Interviews were conducted in Filipino and analysis was done using the original Filipino text. The quotes present here were translated into English.

Data Analysis

The data gathered were read and explicated with the purpose of recognizing patterns and repeated topics, adhering to the inductive methodology of grounded theory research design. This approach improves analysis by generating theories that are obtained from and grounded in data, ultimately leading to a more comprehensive and integrated explanation that is related to a phenomenon (Tie et al., 2019).

The documented transcripts were collated and thematically analyzed using an NVIVO software (ver.11) and were then assessed further and refined independently by three researchers later to discuss and settle discrepancies with other members of the research team.

RESULTS

Demographic Characteristics of the Respondents

We initially tried contacting 20 participants in order to maximize participation of respondents. However, of the 20, only 14 became part of the FGDs. The remaining 6 did not show up on their scheduled FGD date or respectfully declined to be part of the study. Table 1 portrays the demographic information of the male participants who were part of the study (n=14). The age of the respondents ranged between 21 to 45 years old, averaged at 34 years old, and was found to be distributed relatively evenly across the age groups, with proportions at 36% for men aged 18-27 and 28-37 years and 28% for those between 38-45 years old.

Table 1. Male Respondents' Characteristics

		n	%
Total cases	Men	14	100

Age group (years)	18-27	5	36
	28-37	5	36
	38-45	4	28
	Average: 34 years; Range: 21-45 years		
Number of children	0	0	0
	1-2	4	28
	3+	10	72
Educational Attainment	Primary complete / Secondary Incomplete	9	64
	Secondary complete	5	36
	Tertiary complete / incomplete	0	0

Knowledge and attitude of males regarding several contraceptives

The summarized descriptive statistics for both the knowledge and attitude of the respondents towards contraceptives are presented in Table 2. Overall, men were generally aware and broadly knowledgeable in using and acquiring several contraceptives. However, this was not reflective in their attitude as there was a general hesitancy and vacillation in their willingness to use such methods of family planning. In line with this, and interestingly enough, men were more inclined to use female-specific contraceptives way more than male-specific ones.

Table 2. Knowledge and Attitude on Several Contraceptives

Contraceptive	**Knowledge**						**Attitude**	
	Awareness on contraceptives (n=14)		**Use of contraceptives (n=14)**		**Acquisition of contraceptives (n=14)**		**Willingness to use contraceptives (n=14)**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Ligation	14	100	14	100	14	100	8	57
Condom	14	100	14	100	14	100	7	50
Withdrawal	14	100	14	100	-	-	7	50
Oral Contraceptive Pills	14	100	10	71	14	100	8	57
Calendar Method	14	100	2	14	-	-	6	43
Injectables	9	64	5	36	9	64	7	50
Vasectomy	7	50	7	50	0	0	0	0

Intrauterine Devices	5	36	3	21	5	36	1	7
Subcutaneous Implants	5	36	5	36	5	36	8	57

As regards knowledge, data show that while all of the participants (100%) are aware of several birth control methods namely, ligation, condom, withdrawal, oral contraceptive pills (OCP), and calendar method, only 64% know injectables, half (50%) for vasectomy, and a meager proportion of just slightly over a third (36%) are aware of both Intrauterine devices (IUDs) and Subcutaneous Implants. Interestingly, males' awareness of the calendar method is not translated to them knowing how to properly use this family planning method; with only 14% of the participants knowledgeable of the effective use of the calendar method. This therefore made this the most obscure of all the birth-preventive techniques. In terms of acquiring contraceptives, vasectomy was the least familiar among men as none (0%) of the participants knew where and how to get it.

As for the participants' attitudes, men were keener to opt for contraceptives that are used by women, with ligation, OCPs, and subcutaneous implants topping the list with similar proportions at 57%. On the other hand, male forms of contraceptives, such as condom use and the withdrawal method were less favorable for men as both stood equally at 50%. In line with this, none (0%) of the males were willing to undergo vasectomy mainly due to them explicitly expressing that this might lead to the loss of their manhood.

Practices

The descriptive statistics on the practices of using birth control methods among men are seen in table 3. In general, there are more males who are currently not using any form of contraception as compared to the past. In line with this, all forms of contraceptives saw a decrease in their use except for ligation.

In the past, 7 out of 10 males were using condoms as their birth control method, making it the most popular form of contraceptive. This was then followed equally by IUDs, injectables, and withdrawal, at 43%. OCPs, subcutaneous implants, and ligation were at 36%, 21%, and 14% respectively. While calendar method and vasectomy were 7% and 0% respectively, making them the least preferred form of contraceptive in the past.

On the other hand, the most popularly used contraceptives presently are withdrawal, OCPs, and ligation, where all stood at 14%. All the other forms of family planning saw a stark decrease in use, with proportions equalling naught (0%).

Surprisingly, more men tend to have sex without any form of birth control, with proportions increasing from 7% before to 36% now, as participants ironically calimed the unpredictability of the outcomes of several of the family planning methods and even described them, specifically the calendar the withdrawal method, as ineffective.

Table 3. Practices regarding birth control methods				
Contraceptive	**Used in the past (n=14)**		**Currently being used (n=14)**	
	n	**%**	**n**	**%**
Condom	10	71	0	0
Intrauterine Device	6	43	0	0
Injectables	6	43	1	7
Withdrawal	6	43	2	14
Oral Contraceptive Pills	5	36	2	14
Subcutaneous Implant	3	21	2	0
Ligation	2	14	2	14
Calendar Method	1	7	0	0
Vasectomy	0	0	0	0
None	1	7	5	36

Only one participant did not have any history of contraceptive use. While 35% of the respondents are not using any birth control methods at the time of the study period, the remainder are either using oral contraceptive pills (14%), ligation (14%), or withdrawal (14%). None of the participants used intrauterine devices, condoms, vasectomy, subcutaneous implants, and the calendar method at the time of the study. Vasectomy was abhorred and likewise not used by this group of cohorts.

Table 4 summarizes the current attitudes of the participants regarding several reproductive health topics. A comparison between the desired and actual number of children among the participants as outcome of current family planning method provided an initial basis for analysis between the interplay of attitudes and practices regarding family planning.

Table 4. Current Attitudes Regarding Reproductive Health			
		n	**%**
Total cases	Men	14	100
Desired vs Actual number of Children	Desired = Actual	8	57
	Desired > Actual	0	0
	Desired < Actual	6	43

Burden or responsibility in using contraceptives	Before prodding		
	Men	3	21
	Women	11	79
	Both	0	0
	After Prodding		
	Men	2	14
	Women	4	29
	Both	8	57
Men asking for consent before sex	With consent	6	43
	Without consent	8	57
Men's perception on youth's use of condoms	Agree	14	100
	Does not agree	0	0
Awareness on RH programs and pre-natal check-ups	Aware	6	43
	Unaware	8	57
Talking about sex	With friends	7	50
	With family	7	50
Primary decision maker on family RH issues	Before prodding		
	Men	8	57
	Women	0	0
	Both	6	43

	After Prodding		
	Men	6	43
	Women	1	7
	Both	7	50

Data show that more than half (57%) of the participants have convergence between their desired and actual number of children while the rest (43%) had more children than what they initially wanted.

Information on who is responsible for contraceptive use are also depicted in the table. Prodding, which looks into citing real-life examples and instances, was done by the researchers while asking the participants in order to compare and differentiate the males' ideal beliefs (*Who is supposed to be responsible*) versus their actual experience (*Who is the one actually responsible)*. This is to ensure output that could highlight the interplay between attitudes and practices.

When initially questioned on who would have the burden of responsibility in using contraceptives, the majority of the participants (78%) suggested that women should primarily be in charge of using contraceptives while none (0%) of them considered it to be a joint effort. Upon prodding however, more than half (57%) revised their answers pointing out that family planning is rather a joint responsibility between men and women, 29% mention that it was solely women's, and only a meager 14% said that it was entirely the men's.

The distribution of our respondents who asked permission before sex is also exhibited in this table and data showed that less than half (46%) of them viewed consenting from one's partner before sex as a form of respect and a privilege rather than a right. On the other hand, the majority (57%) found it unnecessary to ask permission, while believing that their partner's refusal would definitely lead to a conflict between them.

As regards RH program awareness, only 43% were aware of reproductive health programs and prenatal checkups attended by their partners while a dismal majority (57%) were heedless to all the ongoing RH programs in the health center. As cited by the participants, the primary reason for this unawareness to the RH programs is due to their "exclusive duty and paramount focus only on their job and occupation."

Regarding the matter about talking about sex between friends or family, the participants were equally split (50%) between discussing about it with either friends or family. Different points were brought up by the participants at this part of the dialogue, saying that discussing such matters with their family should even be a more private affair - exclusive between them and their spouse alone.

Similarly, men who talk about sex with friends are also cautious, sharing such discussions only with their closest friends, lest that they might be the topic of gossip in the community.

Overall, conversations about sex were viewed by the participants to be quite delicate and expressions of such must also be reserved regardless of whom they share it to.

As for the primary decision maker regarding reproductive health issues, prodding is once more utilized to differentiate perception (*Who is supposed to be the primary RH decision maker*) vs reality (*Who is the actual primary RH decision maker)*. Before prodding, a surprising group of answers were

seen where the majority of males, 57%, perceived that men alone should be the primary decision maker when it comes to RH issues. On the other hand, none (0%) saw it to be the woman's responsibility, while the remainder (47%), considered it to be a joint decision. After prodding, 43% answered that men are the sole decision makers, 7% thought that women should entirely be the one in charge, while half (50%) answered that both men and women must decide on family RH issues.

ThematicAnalysis

Five key themes were gathered from the knowledge, attitudes, and practices of men regarding RH and family planning decisions namely, safety, "*hiyang*" (compatibility), control, machismo, and hegemonic masculinity.

A. Safety takes many different meanings which must be satisfied for any contraceptive method to be considered "safe".

Safety as health

Safety can connote lack of medical consequences, such as absence of undesired side effects on the body. Contraceptives generally pose few serious health risks and the benefits outweigh these potential adverse effects (Trussell, 2008). The variety of available family planning methods provides freedom to choose a method suitable for one's needs and preferences.

A study from the International Planned Parenthood Federation (2012) demonstrates the importance of safety through the use of the withdrawal method. Since this method uses no exogenous substances and has no side effects, its use is extremely popular albeit an unreliable contraceptive method.

Contraceptives not only prevent unplanned pregnancies but also protect against sexually transmitted diseases.However**,** only one participant is aware of this benefit.This demonstrates the fact that knowledge about other benefits of contraception are not widely recognized.

Safety as efficacy

The efficacy of a contraceptive lies in its ability to prevent pregnancy. When evaluating efficacy, correct and consistent use must be highly emphasized, e.g. daily intake of pills. Majority of the participants (71.4%) are aware of the correct use of pills, but some complained regarding difficulty in compliance, resulting in contraceptive failure, "*Even if the pills are already hung on the bedpost, the doses are still missed*." Contraceptive methods with a high inherent efficacy, with a long duration, requiring little to no daily or coital adherence, such as sterilization, will usually be chosen (Trussell, 2008). However, this was not observed in this study since fewer couples use sterilization. For men, the permanence and irreversibility of vasectomy were equated to losing one's masculinity (Kabagenyi et al., 2014). This implies that there are other factors that are taken into consideration when choosing contraceptives**.**

Safety as familiarity

Fear is a veil through which rational objectivity cannot penetrate. To quote the participants, *"I won't agree to it, I haven't tried it yet."* or "*I will agree to it only if it is explained properly."* Couples only subscribe to methods that they are familiar with. Moreover, lack of education forms a barrier against proper access and usage of effective and safe contraceptive methods. One must assuage these fears borne of misconceptions and unfamiliarity before completely commiting the use of contraception.

B. "Hiyang" influences the RH decision of men by opposing the use of family planning methods that cause side effects, by showing reluctance to other methods once the hiyang method has been tried, and by taking "control" over the RH of the couple.

Hiyang, translated into English, means "compatibility" or "suitability" and is usually in relation to food, company, and medicines. One is *hiyang*to a particular drug depending on their perceived efficacy of the drug, usually indicated by its lack of side effects (Hardon, 1992). Women's compatibility to a particular contraceptive method is attributed to regular menstrual cycle, weight gain, and lack of headache, dizziness and impetuousness (Henry, 2001). The irony is that although weight gain is an acknowledged side effect, poor families usually equate it to good health and is therefore perceived as something they are *hiyang* to (Tan, 2008).

The most commonly experienced side effects noted in this study are headache, allergies, and irregular menses. Contraceptives are judged based on their side effects rather than their actual efficacy. Many men were unwilling to use contraception after their wives reported experiencing side effects, to quote, *"No, we don't use it because my wife doesn't like it"* and "*...Not anymore, because my wife wasn't compatible with it.*", even if such contraceptives were proven to really be highly effective in preventing pregnancy. Women are initially free to choose what contraceptive method to use; men's decision-making influence only settles after the wives report having side effects (Henry, 2001). Although men show concern for their wives, they are still unwilling to carry the physical burden of using contraceptives themselves. This is supported by our data that none of the participants currently use condoms and approve of vasectomy and that only 14% use withdrawal. Those not using any contraceptives are not consistent with their attitude towards family planning and instead claim that they themselves will stop the impulse and desire - *"I will be the one to control the urge instead."*

Meanwhile, some men dismissed the idea of using other contraceptives once their wives finally found a method they are *hiyang* to. When asked about willingness to use the implant, a participant responded, "*...maybe we won't use it anymore, because right now, my wife is compatible with the pills"*

C. Control means the use of modern contraceptive methods and as abstinence from sex.

For the purposes of this study, control is defined as: (1) the use of modern contraceptive methods, and (2) abstinence from sex.

Most of the time, participants defined "control" as the ability to avoid pregnancy through modern contraceptive methods, *"She already has control, she's ligated."* Family planning is usually regarded by the participants as belonging to a women's domain, which is why more women use contraceptives than their male partners. Since the burden of contraception is usually put on women, men believe that it is the woman's responsibility to control pregnancy. This was observed as participants mentioned that *"It is up to women if they want to become pregnant or not, it's in [their] control"* Women who value their marriage will likely use a contraceptive that their husbands consented to (Avila & Wong, 2001). This highlights that reproductive health decision-making should be a joint process. This may also explain why men in this study said, *"I am and will be the one to control it instead."* when their wives experience side effects when using certain contraceptives.

Some men also claim having the "control," which pertains to successful withdrawal before ejaculation or complete abstinence from sex. Some men would reason out that they can control when and where to ejaculate, and therefore do not need contraceptives, *"For us men, that is something you*

can stop, so why use a safety net [contraceptives]?" While men are convinced that withdrawal is ineffective, *"It's dangerous, because you can't be sure if you were able to withdraw in time - it's not something you can stop when it happens."* They also think there is a lack of trust when their wives do not consent to withdrawal, *"It irritates me, as if she doesn't trust my capabilities."*

Meanwhile, few men used "control" as abstinence, especially when their wives refuse sex, *"[I will] practice self-control instead."* Men believe that they could control their sexual urges by engaging in sport *"I will play basketball instead to keep my mind off it"* or by keeping themselves busy *"...I will do other things instead."* . However, men can have difficulty controlling sexual urges especially during their partner's fertile days which can potentially result to marital strains due to unavailability of sex (Laing, 1987).

D. Infidelity is influenced by the concept of "machismo", and consequently affects marital dynamics and reproductive health practices.

Infidelity is defined as the breaking of marital vows, which range from casual relationships to the keeping of a "*querida"* or mistress. This also exists within couples not legally married, as breaking of emotional confidence. Despite the strong religious culture in the Philippines, infidelity remains widespread (Bost, 1995). One factor which drives its persistence in the Philippine culture is typical machismo behavior and its characteristics of which are: (1) male dominance, (2) possessiveness, (3) suspicion of infidelity, (4) viewing women as property, (5) conscious acceptance of double standards in sexual behavior, (6) gender-role rigidity, (7) vengefulness, and (8) a constant need for respect (Feehery-Simmons, 2002).

There is also a double standard attitude in the Philippine culture on infidelity as it becomes largely tolerated as a male tendency (Gonzales et al., 2004). When taken into context of the marital dynamics, this paints the husband as both a dominant (overprotective) while at the same time, wife-avoidant (withdrawn) person (Gonzales, 2004). In other words, the husband would far less-likely feel the negative social repercussions of infidelity due to the presupposed double standards of them being withdrawn in the first place despite their overprotective nature. This becomes a natural hinge by which the women would then view men as automatic "suspects of infidelity". This in turn, provides means for men to get insulted especially when their female partner suggests to use contraceptives (Lee, 1999). The use of contraceptives is seen therefore as a sign of mistrust and disrespect, as seen in the participants' responses: *"Why use contraceptives? It is as if you don't trust me."* or *Yes! We will get irritated when asked to use contraceptives because that is how we are as men [capable of controlling it]"* The use of contraceptives or even the suggestion of their use, is interpreted as an affront to the husband's masculinity, a blatant disrespect to the dominant or overprotective archetype of the husband. Marital interactions are therefore evident in this as it tends to be curved and shaped by the underlying cultural belief about infidelity operating within the confines of behavioral machismo. Ultimately, this may provide overall discouragement to the use of contraceptives.

The easy accessibility of contraceptives has also contributed to the increasing prevalence of infidelity by taking away the repercussions of sex.Getting sterilization procedures has encouraged some men to think that it is an opportunity to get away with sex with people other than their partners. One participant said that a reason he chose not to undergo vasectomy was, "*To discourage myself to cheating and get someone else*" or deprive himself the choice of having sex with anyone anytime he wants.

More into the behavioral machismo as well as the marital dynamics and RH practices, one participant, when asked if he asks permission before using contraception, said *"It [asking permission before sex] is not something you need to ask permission for."* He does not need to ask his partner for permission when using protection because he just says so - a manifestation of characters of machismo as male dominance. This is also a corollary of the "machismo" attitude where males feel disrespect from the mere idea of the wife having a part in decision-making (Heise, 1997) as well.

E. Hegemonic masculinity is inherent and covert within the context of family decision-making.

A key insight that was not initially expected by the group was the unique male-to-male interactions provided by the FGD format. A gender order theory called hegemonic masculinity sheds light on these peculiar interactions.

There exists a dominant form of standards and expectations that apply to men, known as "hegemonic masculinity." This is institutionalized in social structures and ideologies that favour men, including men's health practices such as risk-taking sexual behaviours (Sabo & Gordon, 1995; Connell & Messerschmidt, 2005). Hegemonic masculinity embodies the currently most honored way of being a man; it requires all other men to position themselves in relation to it. This idea of masculinity as inherent in many different societies bridges the perspective of this also being evident within the Filipino context. For example, men were expected to fish, which was deemed a 'tough' job while women's chores at home were 'light' and 'easy' (Turgo, 2014). This *pattern of practice* has been continuously embedded into their lives by positioning male dominance in accordance with the competitive, homo-social nature of hegemonic masculinity (Cornwall & Lindisfarne, 1994; Mckay, 2007).

An aspect of machismo influence with regards to who should make family decisions was asked during the FGD. One participant answered with conviction *"...of course, it should be the men [who must make the decisions]. She [the wife] can leave if she wants to be the one in charge."* When asked why women cannot make decisions, he answered *"It doesn't look nice if women are in charge…other people will think low of you [men]. Besides, wives are easy to change…"* Initial impressions about his answer were reflected upon the faces of the other participants. The interviewer then listened to the answers of the next participant who apprehensively answered *"Yes, Men too should be the one deciding for the family."* When asked why, he hesitantly answered, ``*...Because for me, if I want something, I [just] want it to be followed."* The first participant paved the way into surfacing the concept of hegemonic masculinity. Being the first one to answer, the 'ideal man' has been brought about and significantly swayed the answers of other male participants. It has become the very basis of how other participants made their answers favor men in making family decisions.

In another FGD, when asked why he said the husband should make the family decisions, a participant mentioned. *"...Because as a man, my children also have to respect me. If their mother is also the one in charge, then what will be left of my reputation to them?"*This further highlight how a man and woman should be distinguished and respected differently. These answers were said in a manner that showed how these participants actually had a different or even opposite answer. The other participants' answers being swayed by the first participant is an exemplification of hegemonic masculinity as a standard and as a homosocial interplay influencing participants. Through this conversation, masculinity has become a predominant pattern of living that highlight and continuously perpetuates male-dominance in accordance to a standard abided by and expected to be followed by men. This masculinity that embodies the ideals of patriarchy without the show of violence and secures its power through persuasion

is what is known as hegemonic masculinity (Connell, 1995; Cornwall & Lindisfarne, 1994; Turgo, 2014).

This study has observed that men have influenced other men to give answers that are more aggressive, male-dominant, and male-centric. These "masculine" men have swayed the other participants into practicing and expressing this form of masculinity as reflected in their thoughts, words, and beliefs confined within the standards and ideals of hegemonic masculinity.

DISCUSSION

Our study showed that men enrolled in the 4Ps initiative are adequately knowledgeable in the array of available modern family planning methods. In line with this, they are also familiar with each of the contraceptives' purpose and side effects. Moreover, they have a positive attitude and willingness towards the use of such, so much as even advocating the youth to use condoms. However, this willingness to use these family planning methods are heavily skewed towards contraceptives that are merely applicable to women. Participants were mostly unaware of the ongoing RH programs within the locality and that family planning is low as evidenced by a large number who do not use any contraceptives. Furthermore, a significant proportion of them have more children than initially intended or desired. This study also saw that the participants are more likely to decide the family planning method to be used by their partner. And yet, considers that women should primarily be the one responsible for carrying out these responsibilities. Therefore, this study observed that the role of men in RH decision making and family planning emerges as that of a decision maker with little to no responsibility. Additionally, our study supports the conclusion mentioned from prior published materials indicating that overall adequacy of awareness and willingness on contraceptive methods does not necessarily reflect in its general effective utilization (Nsubuga et al., 2015; Davis, 2016). The probable reason that shapes this paradoxical role and the lack of translation from knowledge and attitudes into practices can be due to another cause such as socio-cultural factors (Nsubuga et al., 2015).

Our study has come across five important elements that were found to mainly influence reproductive health and family planning decisions among men. First is **safety**. Participants in our study are more willing to use family planning methods that are effective, that they are more familiar with, and don't pose any undesirable side effects. Second, the contraceptive method must be **'hiyang'** or compatible with the respondents. In other words, the relative compatibility or suitability of the contraceptive methods - as defined by the interplay of the participants' perceived efficacy of the contraceptive, its side effects, as well as their idiosyncratic tolerance towards the side effects - are taken into account in the family planning decision. Third would be the concept of **control**. The participants' family planning decisions are shaped by three ideas of control over the outcome of sex - one is through the use of modern contraceptive methods, another is having a successful withdrawal method, and lastly, control is abstinence from sex. However, participants still predominantly perceived control using modern contraceptive methods. Fourth, the **'machismo'** behavior embedded in the male psyche makes them unwilling to accept contraceptive methods which, upon using it, might insinuate their infidelity to their partners. Our study has found this factor to be noteworthy as it contributes to the low number of contraceptive use among the participants. As such, social and community RH activities may need to target male demographics more than just merely females. Lastly, and most importantly, **hegemonic masculinity** is a covert and underlying factor that greatly sustains the pervasive machismo behavior

thereby transforms masculinity as a predominant pattern of living, perpetuates male-dominance in accordance with the standards abided by and expected to be followed by other men, and may ultimately act as a barrier for a more effective RH and family planning decision-making. Our study has deemed this to be the main factor that largely affects the participants' RH decision-making, ultimately leading to less use of contraceptives despite the overall adequate knowledge and positive attitude. Because of the masculinity that imbibes the ideals of patriarchy without showing any form of violence but secures its vigor and capacity through male-to-male persuasion, we think that the male participants were thoroughly influenced by each other's practices formed by machismo and masculinity. This is similar to the life of living in a community where interactions with one another is pivotal and that culture tends to be ingrained within one's practices and actions.

Our study has several limitations that need to be addressed. First, our participants were chosen through a purposive, sampling technique and thus is very prone to researcher bias. Second, although there was a recognized benefit of using an FGD as part of our data collection, such as recognizing socio-cultural perceptions or beliefs through spontaneous interactions between the participants, there may be group bias or group effect that tampered with the data obtained. Third, we were not able to completely represent the males belonging to the 4Ps program within the community due to the low number of participants. Although we included information regarding the knowledge, attitude, and practices of the male participants, the data obtained were related and interpreted qualitatively and thus was primarily analyzed using a qualitative grounded theory design. Finally, factors influencing reproductive health decision-making among males belonging to the 4Ps is context-specific. This study does not represent all conditions and circumstances.

CONCLUSION

Socio-cultural factors such as safety, *hiyang* or compatibility, control, machismo, and the pervading hegemonic masculinity, are five of the factors that influence reproductive health decision among low-income males enrolled in the PantawidPamilyang Pilipino Program. Of these, machismo and hegemonic masculinity are two of the most important factors that sway males to not use contraceptives despite their adequate knowledge and willingness to use them.

Communities with similar demographics - i.e. low to middle income communities that are combating overpopulation - may capitalize on the aforementioned factors by making government policies that encourage, educate, and train husbands and fathers in family planning through peer counseling. The Department of Social Welfare (DSWD), as a lead implementer of the 4Ps program, can also provide additional guidelines that can further refine the 4Ps program to include male participation in reproductive health talks and activities as part of the requirement of being retained in the 4Ps program. This may contribute as a form of stimulus and further motivation for men to attend talks concerning reproductive health. Furthermore, local government units (LGUs) must be called to create more activities that may encourage male participation in several RH programs. For instance, instead of having RH conferences or symposia on a normal workday during work-hours, the timing can be shifted during the weekends when the majority of males are not preoccupied at work. Additionally, public representatives that may champion and promote more male involvement in reproductive health must also be males in order to more effectively influence fellow men, given a very patriarchal society. LGUs may

therefore opt to train males that could invite other men within the community to partake in local RH activities. As regards to monitoring the effect of the policies, DOH must be able to constructively measure the outcome of said policies over time by interpreting data trends that may favorably show increasing male participation in RH activities in relation to a corresponding improvement in the use of contraceptives to combat overpopulation.

Overall, the government and health organizations must be able to clearly communicate with males, females, and families within the community their intentions of providing a more proper and holistic approach in reproductive health by increasing involvement of males in its RH programs.

REFERENCES

1. Amanta, J. G., Amit, J. L., Amparado, K. F., Anchores, A. A., Andal, M. A., Andrade, L. R., Ang, C.S., Angulo, P.C., Añover, A.A., Aquino, E.M., Aquino, J.S., &Juangco, J. G. (2013). Awareness, attitudes and practices of Filipino fathers in artificial family planning: A descriptive study. *UERM Health Sciences Journal, 2*(1), 12-17. https://library.uerm.edu.ph/kohaimages/UERM/repository/Health%20Sciences%20Journal/Vol2%20No1%20January-June%202013/HSJ%20vol.2%20no.1%202013-12-17.pdf
2. Avila, J. L., & Wong, E. L. (2001). When fate and husbands prevail: Dynamics of decisions and behavior regarding family planning in Cebu, Philippines. *Philippine Quarterly of Culture and Society, 29*(1/2), 79-104.
3. Bost, L.D. (1995). *Fertility control in the Philippines: The deterring forces.* (Thesis). https://openresearch-repository.anu.edu.au/bitstream/1885/9817/9/Bost_L.D._1995.pdf
4. Cabral, E. (2013). Reproductive Health Law in the Philippines. *Journal of the ASEAN Federation of Endocrine Societies, 28*(1), 26–29. https://doi.org/10.15605/jafes.028.01.06
5. Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. SAGE open medicine, 7, 2050312118822927. https://doi.org/10.1177/2050312118822927
6. Connell, R.W. (1995). *Masculinities*. (2nd ed.). Polity Press.
7. Connell, R.W. &Messerschmidt, J.W. (2005). Hegemonic Masculinity. *Gender & Society, 19*(6), 829–59.
8. Cornwall, A. & Lindisfarne, N. (1994). *Dislocating masculinity: comparative ethnographies.* Routledge.
9. Feehery-Simmons, J. (2002).Exploring the Dimensions of Culture. *Journal of Promotion Management, 8*(2), 97–122.
10. Davis, J., Vyankandondera, J., Luchters, S., Simon, D., & Holmes, W. (2016). Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific. *Reproductive health, 13*(1), 1-11.
11. Gonzales, T.P., Greer, J., Scheers, N.J., Oakes, E., Buckley, J. (2004). Sources of resilience in the Filipino wives responses to spousal infidelity. *Philippine Journal of Psychology, 37*(1), 74–103.
12. Gumucio, S.; Merica, M.; Luhmann, N.; Fauvel, G.; Zompi, S.; Ronsse, A.; Courcaud, A.; Bouchon,
13. M.; Trehin, C.; Schapman, S.; et al. Data Collection Quantitative Methods, the KAP Survey Model
14. (Knowledge, Attitude and Practices); IGC communigraphie: Saint Etienne, France, 2011

15. Hardon, A. P. (1992). That drug is Hiyang for Me: Lay perceptions of the efficacy of drugs in Manila, Philippines. *Central Issues in Anthropology, 10*(1), 86-93. https://doi.org/10.1525/cia.1992.10.1.86.
16. Heise, L. L. (1997). Violence, sexuality, and women's lives. In R. N. Lancaster & M. Di Leonardo (Ed.), *The gender/sexuality reader: Culture, history, political economy.* Routledge.
17. Henry, R. (2001). *Contraceptive practice in Quirino Province, Philippines: Experiences of side effects*. Calverton, Maryland, USA: University of thePhilippines Population Institute, University of La Salette, and Macro International Inc. https://dhsprogram.com/publications/publication-qrs1-qualitative-research-studies.cfm
18. International Planned Parenthood Federation. (2012). *Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia*. https://eeca.unfpa.org/sites/default/files/pub-pdf/Rep_Keyfactorsinflcontractusein7ctries_Dec2012.pdf
19. Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J., &Atuyambe, L. (2014). Barriers to male involvement in Contraceptive uptake and reproductive health services: A qualitative study of men and women's perceptions in two rural districts in Uganda. *Reproductive Health,11*(1). https://doi.org/10.1186/1742-4755-11-21.
20. Laing, J. E. (1987). Periodic abstinence in the Philippines: New findings from a national survey. *Studies in Family Planning, 18*(1), 32-41. https://doi.org/10.2307/1966419
21. Launiala A. How much can a KAP survey tell us about people's knowledge, attitudes and practices? Some observations from medical anthropology research on malaria in pregnancy in Malawi. Anthropol Matters (2009) 11:1758–6453.
22. Lee, R.B. (1999). Men's involvement in women's reproductive health projects and programmes in the Philippines. *Reproductive Health Matters, 7*(14), 106–117.
23. Mckay, S.C. (2007). Filipino seamen: Constructing masculinities in an ethnic labour niche. *Journal of Ethnic and Migration Studies, 33*(4), 617–633.
2. Nsubuga, H., Sekandi, J.N., Sempeera, H. et al. Contraceptive use, knowledge, attitude, perceptions and sexual
1. behavior among female University students in Uganda: a cross-sectional survey. BMC Women's Health
2. 16, 6 (2015). https://doi.org/10.1186/s12905-016-0286-6
3. Ochieng, NT, Wilson, K, Derrick, CJ, Mukherjee, N. The use of focus group discussion methodology: Insights from two decades of application in conservation. Methods EcolEvol. 2018; 9: 20– 32. https://doi.org/10.1111/2041-210X.12860
4. *PantawidPamilyang Pilipino Program* (n.d.). Official Gazette of the Philippines. https://www.officialgazette.gov.ph/programs/conditional-cash-transfer/#:~:text=The%20Pantawid%20Pamilyang%20Pilipino%20Program,of%20children%20aged%200%2D18
5. Parcon, CF. (2010). *Men, Family Planning and Contraceptive Use in Western Visayas*. University of the Philippines Visayas, Iloilo.
6. Philippine Statistics Authority (PSA) and ICF. (2018). *Key Findings from the Philippines National Demographic and Health Survey 2017*. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF. https://www.dhsprogram.com/pubs/pdf/SR253/SR253.pdf

7. Philippine Statistics Authority (PSA) and ICF. (2018). *Philippines National Demographic and Health Survey 2017*. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF. https://dhsprogram.com/publications/publication-fr347-dhs-final-reports.cfm
8. *Pinagbuhatan, City of Pasig*. (n.d.) PhilAtlas. https://www.philatlas.com/luzon/ncr/pasig/pinagbuhatan.html#sources
9. *Reproductive Health.* (n.d.). World Health Organization. https://www.who.int/westernpacific/health-topics/reproductive-health
10. Sasis, P. ,Pelenio, E. &Dalde, M. D.. (2019). The Impact of PantawidPamilyang Pilipino Program (4Ps) to its Beneficiaries. *SMCC Higher Education Research Journal (Business Administration Journal), 1(1)*. http://ejournals.ph/form/cite.php?id=14409
11. Sabo, D.F. & Gordon, D. (1995). *Men's health and illness: gender, power, and the body*. Sage Publications.
12. Shahjahan, M., Mumu, S.J., Afroz, A. *et al.* Determinants of male participation in reproductive healthcare services: a cross-sectional study. *Reprod Health* 10, 27 (2013). https://doi.org/10.1186/1742-4755-10-27
13. Tan, M. L. (2008). *Revisiting usog, pasma, kulam*. University of the Philippines Press.
14. Trussell, J. (2008). Choosing a Contraceptive: Efficacy, Safety, and Personal Considerations. In R. A. Hatcher, D. Kowal, F. H. Stewart, W. Cates Jr., A. L. Nelson, J. Trussell (Authors), *Contraceptive Technology* (19th ed., pp. 19-47e). Ardent Media.
15. Turgo, N.N. (2014). Redefining and Experiencing Masculinity in a Philippine Fishing Community. *Philippine Sociological Society, 62*, 7–38.
16. Werner PD. Implications of attitude-behavior studies for population research and action. Stud Fam Plann (1977) 8:294–9. doi:10.2307/1966280
17. *What is reproductive health?* (n.d.). Department of Health. https://doh.gov.ph/node/1376

APPENDIX

Table 1. Tagalog Version of the Semi-structured Questionnaire

A.3	**ATTITUDES TOWARDS RH**
	Ilang anak ang naismongmagkaroon?
	Ilang anak ang meron kayo? Kung hinditugma, bakit?
K.5	**ASSESSING KNOWLEDGE**
	Ano ang mgamaaaringmangyarikapaghindigumamit ng proteksyonbagomakipagtalik?
K.1	May kaalaman po ba kayo sa RH Bill? Ano po ang mgaalamniyotungkoldito?
K.5	Saan niyo po ito (RH Bill) narinig? Anu-ano ang mganarinigmonamga contraceptives? (FGD facilitator will probe on the different contraceptive methods using the guide below when possible)
K.2 K.3 A.4	Alam niyo po ba kung ano ang **condom**? (show photo of condom to participants) Kailan at saaninilalagay ang condom? Payag ka bang gumamitnito? Pwedemo bang sabihin kung bakit? Saan o kaninomaaaringmakakuha ng condom?

	Alam niyo po ba kung ano ang pills o oral contraceptive pills **OCP**? (show photo of OCPs to participants) Araw-araw po bang iniinom ang OCP? Payag ka bang gumamitnito angiyong partner? Saan o kaninomaaaringmakakuha ng OCP?
	Alam niyo po ba kung ano ang intrauterine devive or **IUD**? (show photo of IUD to participants) Payag ka bang gumamitnito and partner mo? Bakit Saan o kaninomaaaringmagpalagay ng IUD?
	Alam niyo po ba kung ano ang **Subcutaneous Implant**? (show photo of subcutaneous implants to participants) Payag ka bang gumamitnito and partner mo? Saan o kaninomaaaringmakakuha ng implant?
	Alam niyo po ba kung ano ang **Injection/Injectables**? Payag ka bang gumamitnito ang partner mo? Bakit? Saan o kaninomaaaringmagpa-injection?
	Alam niyo po ba kung ano ang **Vasectomy**? (FGD facilitator will describe a vasectomy) Payag ka bang magpatali? Saan o kanino ka maaaringmagpatali?
	Alam niyo po ba kung ano ang **Ligation o Pagpapatali**? (FGD facilitator will describe ligation) Payag ka bang magpatali ang partner mo? Saan o kanino ka maaaringmagpatali?
	Alam niyo po ba kung ano ang **Natural Method**? Maaari bang maiwasan ang pagbubuntissamgaaraw ng nag-oovulate ang isangbabae? Payag ka bang gumamitnitongparaan?
	Alam niyo po ba kung ano ang **Withdrawal Method**? Tuwing kailan baginagamitito? Payag ka bang gumamit ng ganitongparaan?
	May alam pa bakayongibang contraceptive methods?
P.1	**SEXUAL PRACTICES**
	Sa kasalukuyan, gumagamitba kayo ng iyongasawa/kinakasama ng contraceptives? Gaanokadalas?
	Anong contraceptive method ang pinakamadalasnaginagamitniyo ng iyongasawa/kinakasama? (FGD Facilitator may ask the each method to generate a response and expound on it)
	● Condom
	● Oral Contraceptive Pills

	● Withdrawal
	● Vasectomy
	● Ligation
	● IUD (Intrauterine Device
	● Injectables
	● Subcutaneous Implant
	● Natural Methods
	● Iba pa
	Saan niyonakukuha o nabibili ang contraceptive method naito? (FGD facilitator may give the choices and ask respondents to elaborate on their source of contraceptive)
	● Tindahan
	● Bilihan ng gamot (Mercury, Watsons, etc.)
	● Government clinic/Health center/Hospital
	● Private doctor/nurse/clinic
	● Kaibigan
	● Iba pa
A.4	**WILLINGNESS TO USE RH METHODS**
	Mas gusto mo bang gumagamit ng proteksyontuwingnakikipagtalik?
	Bakit o bakithindi?
A.2	Sino ang kadalasang responsible sapaggamit ng proteksyon? Bakit?
	Sa iyongpananaw, kaninongresponsibilidad**dapat** ang paggamit ng proteksyon? Bakit?
P.1	Nagpapaalam po ba kayo saasawaniyotuwingbibili or gagamit ng contraceptives? Bakit?
A.3	Sa inyongopinyon, katanggap-tanggapba ang paggamit ng condoms samgakabataangwala pang asawa?
A.1	May mgainaalok bang programa ang inyong health center para sa reproductive health?
	Alam moba kung gaanokadalasmagpatinginsa health center simisistuwingsiya'ynagbubuntis?
	Sinasamahanmobapumunta ng health center ang iyongasawa/kinakasama?
A.3	Komportable (malaya) ka batuwingnakikipag-usaptungkolsa sex at iba pang kaugnayna RH issues kasama ang iyongmgakaibigan?
	Tuwingnapapag-usapan, madalas bang mgakaibigan ang kausapmo? Mag-isa lang bakayong nag-uusap o kasama ang grupo? Paano niyoitopinag-uusapan (seryosongusapan/pabiro)?

A.2	**MACHISMO INFLUENCE**
	Sa iyongpananaw, mas nasusunodbadapat ang lalaki o babaesamgadesisyon ng pamilya?
	Sa kasalukuyan, ganoon po ba ang nangyayari?
A.3	Gaanokahalaga ang pakikipagtaliksaisangrelasyon? Ano ang nakukuhaniyosapakikipagtalik? Ano ang kahalagahan ng pakikipagtalik para sakanila (asawa/kinakasamamo)?
	Natatanggihan ka ba ng iyong partner/asawa/kinakasamasamakipagtalik? Kung OO, ano ang ginagawaniyokapagtumatanggisimisis? Pinipilitniyaba ang paggamit ngproteksyon?

Table 2. English Version of the Semi-structured Questionnaire

A.3	How many children do you *plan* to have?
	How many children do you actually have? If there is a difference, why?
K.5	**ASSESSING KNOWLEDGE**
	What are the possible consequences of having sex without using protection?
K.1	Do you know the RH Bill? What do you know about this?
K.5	Where are your sources of information regarding this bill? What kinds of contraceptives have you heard of? (FGD facilitator will probe on the different contraceptive methods using the guide below when possible)
K.2 K.3 K.4	Do you know what a **condom** is? (show photo of condom to participants) When and where do you put a condom? Are you willing to use this method? Where or from who can you avail a condom?
	Do you know what an **OCP** is? (show photo of OCPs to participants) Are OCPs taken everyday? Are you willing to use this method? Where or from who can you avail OCPs?
	Do you know what an **IUD** is? (show photo of IUD to participants) When can a woman get an IUD? How often should a woman replace her IUD? Are you willing to use an IUD? Where or from who can you obtain an IUD?
	Do you know what a **subcutaneous implant** is? (show photo of subcutaneous implants to participants) Does an implant have to be replaced every 3 years? Are you willing to use an implant? Where or from who can you get an implant?

	Do you know what an i**njection/injectable** is? Do women have an injection every two to three years? Are you willing to use injections? Where or from who can you have injections?
	Do you know what **vasectomy** is? (FGD facilitator will describe vasectomy) Would you be willing to have a vasectomy? Where or from who you could obtain this method?
	Do you know what **ligation** is? (FGD facilitator will describe ligation) Are you willing to have your partner ligated? Where or from who could obtain this method?
	Do you know what **natural method** is? Can pregnancy be prevented when a female is ovulating? Are you willing to use this method?
	Do you know what **withdrawal** is? When is this method used? Are you willing to use this method?
	Do you know/use any **other methods** of contraception?
P.1	**Sexual Practices**
	Currently, do you and/or your partner use contraceptives? If YES, how often?
	What is/are the contraceptive methods that you use often with your partner? (FGD Facilitator may ask the each method to generate a response and expound on it)
	• *Condom*
	• Oral contraceptive pills
	• Withdrawal
	• Vasectomy
	• Ligation
	• IUD (Intrauterine Device)
	• Injectables
	• Subcutaneous implant
	• Natural Methods
	• Others
	Where do you usually get contraceptives? (FGD facilitator may give the choices and ask respondents to elaborate on their source of contraceptive)
	• Convenience Store
	• Drugstore (Mercury, Watsons, etc.)

	• Government clinic/health center/hospital
	• Private doctor/nurse/clinic
	• Friends
	• Others
A.4	**WILLINGNESS TO USE RH METHODS**
	Do you prefer using contraceptives during sex?
	Why or why not?
A.2	Who is normally responsible for contraception and protection? Why?
	In your opinion, who *should* be responsible? Why?
P.1	Do you consult your partner before you buy or use contraceptives? Why?
A.3	Do you think the use of condoms in unmarried youth is acceptable?
A.1	Does your health center offer options for reproductive health?
	How often does your partner go to the health center whenever she is pregnant?
	Do you accompany your partner to the health center?
A.3	Are you comfortable talking about sex and other RH related issues with your friends?
	When talking about sex and RH issues, Is it usually with friends? In person or in groups? How do you approach the conversation (seriously or jokingly)?
A.2	**Machismo Influence**
	Who do you think should be more favored in making family decisions? Currently, is that what happens?
	How important is sex in a relationship? What do you get out of having sex? What is the importance of sex to your partner?
	Is your partner able to refuse you if you want sex if she does not want? If YES, what do you do when your partner refuses? Does your partner insist on using contraception?