# Sociocultural Implications of Reproductive Health Programs in the Province of La Union, Philippines

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**Abstract:**
This study determined the sociocultural implications of RH programs in the Province of La Union, Philippines. Descriptive-correlational designs were utilized. Questionnaire, personal and phone interviews were used in the data gathering. Frequency and percentage, mean, Pearson r, Chi- square, t-test, ANOVA, and post hoc analysis were used to manage the data. Majority of the respondents are ages 19 to 40, females, have 2 to 4 children, high school graduate, with <P10, 481 income, Catholics, Ilokano are highly aware along all areas of assessment. Extent of practice revealed moderately practiced services along family planning information and services, prevention and management of STDs, and highly practiced services along maternal, infant and child health and nutrition, adolescent and youth RH education and counseling, and male responsibility and involvement in RH. Significant relationship exists between awareness and religion, ethnicity, and income, also, between practice, education, and ethnicity. No significant relationship exists between awareness and age, gender, number of children, and education, also, in practice and gender, number of children, income, and age. Significant difference exists in the awareness between gender, religion, number of children, ethnicity, and municipality. Also, it exists in the practice between gender, religion, number of children, and municipality. No significant difference awareness between age groups, education, and income, also, along practice between age, education, income, and ethnicity. Geographic accessibility tops the list of the barriers to services used.

## Chapter 1
## INTRODUCTION
### Situation Analysis

Health and well-being are the most important aspects of human life that sometimes people tend to neglect. Good health in its broadest sense can be improved in many ways including lifestyle modification. It constitutes activities of daily living, way of thinking, behavior, social interaction, and the like. One factor that affects this is the environment that people live in. How the environment change will certainly have an impact to one’s health.

The enactment of Republic Act No. 10354 or the Responsible Parenthood and Reproductive Health Law on December 18, 2012, has the goal of ensuring a healthy population at large. Most especially that number of people are accelerating rapidly, and several underlying effects associated with it are booming uncontrollably. The law which provides for a national policy on reproductive health products and services utilization has key elements which includes family planning information and services, maternal, infant, and child health and nutrition, adolescent and youth reproductive health education and counseling,

prevention and management of sexually transmittable infections, and male responsibility and involvement in reproductive health (Cabral, 2013).

Overpopulation is closely associated with the world's major problems and an issue that worsen as time passes. China has the largest population in the world with 1.3 billion people and growing by minutes (Verril, 2016) and is set to surpass India by as early as 2024 (Sofi, 2020). In South America, Brazil is currently the most populous country and the fifth-most populated in the world with 212.41 million people (Thelwell, 2019).

The provision of family planning services has important benefits for the health and well-being of individuals, families, communities, and the nation's economic development (Marcusa, et. al., 2020). Ethiopia is a developing country, second populous country in Africa with more than 112 million, but it is one of the Sub-Saharan countries trapped by poverty. The population is increasing at an average rate of 2.5 percent which resulted to dramatic increase of population, but economic growth has not kept in parallel with it (Life Water International, 2020). Such an unbalanced population size will inevitably have a negative impact on the wellbeing of the nation. Family planning is one of the strategies which is proving to be effective in tackling these problems (Kanem, 2018).

The utilization and acceptance of birth control pill as a family planning method worldwide is generally low. In the year 2018, Czechia and Portugal had the highest shares in Europe with only 54 percent and 48.3 percent respectively. In the Balkans, there is low usage of the birth control pill with less than two percent of women using the pill in Albania, Bosnia-Herzegovina, and North Macedonia (Stewart, 2019).

According to Hanafia, et al (2013), increasing age played a vital role in decision making, and gender disparities in formal schooling have been identified a fundamental structural factor in limiting effective sex education in South Asian countries. In poor countries, people's economic constraints affect their ability to buy contraceptives. Also, different ethnic groups face many barriers to accessing family planning services, because of their illiteracy, poverty, and low social status.

The result of the study conducted supported the claims of Al-Balushi, et. al., (2015). They mentioned in a micro-level analysis of marital fertility behavior in Tanzania that woman's education, religion, household income, and attitude toward family planning methods had significant impact on contraceptive use decisions. It was also noted that in Oman, the age of women, religion, number of living children, education, place of residence, and living arrangement had the most significant effects on contraceptive use among ever-married women. In rural areas of Bangladesh, the costs entailed in doing family planning and the distance of family planning clinics were also included and found that shorter distances to family planning clinics increased the prevalence rate or intention to use contraceptives.

Alongside with the ever- growing population of the globe, issues on communicable diseases are rising as well. The report of Global Health Policy (2019) reveals that 37.9 million people worldwide were infected with HIV and 23.3 million people were undergoing pharmacologic therapy. Meanwhile, the Joint United Nations Program on HIV and AIDS claimed that more than 95 percent of new HIV infections are in Eastern Europe and Central Asia, 95 percent are in Middle East and North Africa, 88 percent are in Western and Central Europe and North America, and 78 percent of new HIV infections are in Asia and the Pacific (Carlson, 2019).

The concern about adolescent sexual and reproductive health has grown due to unprecedented increasing rates of sexual activity, early pregnancies and sexually transmitted infections including HIV among adolescents which in turn negatively affect their health, productivity, and quality of life. A research conducted by Mangold, et. al (2018) indicates that increasing number of adolescents initiate sexual

activities early, with multiple partners, and inconsistently use condoms, and thus, remain highly vulnerable to HIV. The lack of female power in sexual relationships, threat of physical violence if condom use is requested, are among factors identified as potential barriers to its utilization. Condom use has also been associated with higher levels of education, and higher socioeconomic status. In addition, equating condom use with lack of trust have been shown to decrease the likelihood of use. They also found that young women who have regular partners, and older age, are those mostly not in the use of condom.

A community based cross-sectional study design was conducted on selected adolescents from Debre Berhann, Ethiopia. Adolescents who have received at least one service out of the four identified RH services under the study which includes sexual and RH information and education service; modern contraceptive service; voluntary counseling and testing for HIV service; and sexually transmitted infections diagnosis and treatment service utilization were used by the adolescents. Respondents who had good knowledge of the services were only 54.9 percent, and only 68.5 percent of all adolescents have geographical accessibility to reproductive health service. The utilization of above-mentioned services in the study area were very low (Astawesegn, et. al., 2018).

Gender and magnitude of perception of risk for HIV were independently associated with the utilization of voluntary counseling and testing service. Males were 5.25 times more likely to ever use service compared to females and adolescents who were perceived themselves as high risk, and 8.22 times more likely to utilize compared to those perceived themselves as low risk for HIV/AIDS. Gender is an important predictor for the utilization of the service in this study. In general, males were more likely to use voluntary counseling and testing service as compared to females. This result is consistent with previous study done in North and South Nigeria.

In terms of maternal death issues, the World Health Organization (2019) reports maternal mortality as unacceptably high. About 295, 000 women died during and following pregnancy and childbirth in 2017. Most of these deaths, 94 percent, occurred in low-resource settings, and most could have been prevented. Sub-Saharan Africa and Southern Asia accounted for approximately 86 percent (254, 000) of the estimated global maternal deaths in 2017.

According to Mahajand and Sharma (2018), the risk of maternal mortality is highest for adolescent girls under 15 years old. Complications in pregnancy and childbirth are the leading cause of death among adolescent girls in most developing countries, including India. The inadequate knowledge about pregnancy care, breast feeding, and immunization leads them to complications of pregnancy and ill health of infants. The situation is more in case of first-time pregnant mothers because they have no previous experience of pregnancy. Their lower educational status and other social factors limit their access to proper antenatal care.

In Gambia, as part of the traditional practices, most women deliver at home under the supervision of a traditional birth attendant. There is only one in five women with obstetric emergencies reports to a medical facility for assistance which is a gross unmet need for emergency obstetric care. Women in Gambia has one in twenty-three lifetime risk of dying from maternity-related causes, and more than 50 percent of maternal deaths occur among women under 35 years of age. The low percentage of utilization of reproductive health products and services are closely associated with maternal age, wealth, education, parity, and urban residence. In Cameroon, the religion and cultural dimensions of gender roles blinded women from recognizing their right to maintaining good health. In Nigeria, an Islamic culture that undervalues women; a social need for reproductive health capacities to be under strict male control that

restrict woman's medical care; almost universal female illiteracy; marriage at an early age and pregnancy are harmful traditional medical practices strictly observed (Chen, et. al, 2016).

Majority of the people in Nicaragua maintain a strong religious conviction, and heath care seeking behavior is often attributed to fate. Their strong fatalistic beliefs were used to justify failure to seek care and reflected a sense of limited control over health outcomes. Meanwhile, it was stated by Akinyemi and Latuni (2018) that the low utilization of reproductive health products and services and health seeking behaviors are also affected by shared poor education; misconceptions that remained uncorrected, such as the benefits of the use of vaccines. Ochieng and Odhiambo (2018) also highlighted the lack of transportation to reach a health facility prevented some women from attending prenatal visits. In terms of gender and power issues, woman's lack of autonomy and mobility is illustrated by their need to receive permission from their bosses or partners to seek care. Some women were not permitted to seek care or chose not to in order to avoid potential violence or conflict. Because of the husbands' dominant role within the family, many women attributed poor maternal outcomes to the husbands' control over woman's health care utilization (Ganle and Obeng, 2015).

The statistics on child mortality is also alarming as report reveals that the world is currently far away from the sustainable goals for 2030. Globally, 3.9 percent of all children die before reaching the age of five, which means that an average of 15, 000 children die every day (Dadonaite, et. al, 2019). In the first three quarters of the year 2020, Nigeria recorded 59.19 percent, Pakistan has 59.11 percent, Cameroon has 58.31 percent, Angola has 58.24 percent, Lesotho has 57.54 percent, Mauritania has 51.35 percent, Zambia has 43.11, Sudan has 40.94 percent, Kiribati has 40.54, and Papua New Guinea has 39.81 percent (United Nations-World Population Prospects, 2020).

Irrespective of the continued global effort to reduce the infant and child mortality rates, the targets of Millennium Development Goals remained unattainable in many developing countries. Hunter (2018) highlighted an overwhelming 5.6 million of children still die worldwide due to vaccine-preventable diseases. According to Ketchell (2015), an estimated 19.9 million infants worldwide stay absent for routine immunization services. More than 40 percent– or more than 7.6 million – of these children were from sub-Saharan Africa. Others live in ten countries, mainly from South Asia including India.

Studies in India found significant gap in wealth-related, rural–urban, gender-related, maternal education, social class, proximity to a health facility, place of delivery, prenatal and postnatal checkup of mothers, and religion inequalities in immunization coverage. Apart from that, appropriateness of the timing of the vaccination due to poor health education is lagging in India and many states (Panda, 2020). In sub-Saharan countries, national immunization coverage of childhood vaccines is reported to be low. Associated factors for low vaccine rates include lack of knowledge of immunization, gender, beliefs, sociocultural factors such as language barrier, and inadequacy of human and infrastructure services, and supply of vaccines. (Bangura, et. al., 2020).

When it comes to teenage pregnancy, nearly 1,000 births in Bulgaria and Romania in 2015 were girls ages between the ages of 10 to 14. Bulgaria had nearly 300 of the young mothers – representing nearly five percent of all the country's teenage births. Hundreds of girls of the same age gave birth in Germany, France, and the United Kingdom. In around half of European Union countries, girls who give birth at this age do not even reach double figures, notably in Scandinavia. While overall teenage births fell in every European Union country over the decade in 2015, the 10 to 14 age group was far more stubborn. Slovakia, France, Austria, Italy and Romania all had more teenage mothers in 2015 than a decade earlier. Bulgaria, Romania, Hungary, Slovakia, Lithuania, Latvia, and Poland are all among the Europe's worst when it

comes to young mothers (Harris, 2017). Along the utilization of condoms in 2018, Finland had the prevalence rate of only 31 percent in Europe for clients aged 15 to 49 years old using the male condom as main form of contraception. Additionally, Spain and the United Kingdom had a 28.4 and 27 percent share respectively. In Albania, only four percent used condoms to avoid pregnancy and sexually transmitted infections (Stewart, 2020).

Hadi and Violita (2019) pointed out that in Indonesia, teenage reproductive health issues were a huge challenge despite national efforts to control the problem. The utilization of adolescent reproductive health services tends to be low. Sixty two percent of adolescents have never utilized any services intended for them and 53.5 percent have never taken advantage of the established risky behavior prevention program for adolescents by the government. The low utilization is closely associated with knowledge and awareness level; individual perceptions on susceptibility, severity, and seriousness; perceived benefits and barriers, played an important role. Awareness is believed to be one of the driving factors in behavioral change. The study conducted has shown that adolescents with good knowledge of RH will benefit from available services. On the other hand, adolescents with poor awareness tend not to utilize the services due to lack of information.

In Nepal, compulsory education was seen as an effective option to postpone marriage and thus, delay pregnancy. In Nigeria, education was positively correlated to delaying the first childbirth. Several correlations of higher education attainment, noted as educational empowerment with lower chances of adolescence pregnancy. A study involving Canadian adolescents reported that, improving the content and delivery of sexual education might act as a facilitator to a safer sexual health. In Sweden, sex education sessions and gender related messages in the school curricula may help to empower young women and promote avoidance of risk-taking during sexual activity. Sex education programs have been further noted in previous studies as fundamental in reducing adolescent pregnancy (Estinfort, et al., 2020).

With regards to the possible issues on male reproductive health, Kumar, and Singh (2015), reported that in India, 40 percent of infertility cases were related to men, 40 percent to women and 20 percent to both sexes. Fifty percent of infertility is related to the reproductive anomalies or disorders in the male. Increasing incidence of abnormalities of the male genital tract including testicular cancer and cryptorchidism in various countries poses a higher risk. Twelve to eighteen million couples in India are diagnosed with infertility every year. They have reported that males' exposure to high temperature at their workplace like welders, dyers, blast furnace workers and those employed in cement and steel factories were more prone to infertility.

The utilization of male sterilization method specifically vasectomy worldwide is only 2.4 percent. Men generally lack knowledge about vasectomy, posing a major demand-promotion barrier. Awareness of vasectomy as a family planning method ranged from 15.6 percent in Ethiopia to 39.6 percent in Turkey. Inaccurate knowledge often fuels erroneous assumptions about how vasectomy affects men physiologically and psychologically. In Ghana and India, participants perceived that vasectomy hurt a man's pride or caused a man to lose masculinity. In Indian study, 68 percent of men found vasectomy acceptable, but only 34 percent suggested they would adopt it (Packer, et. al., 2016). The claims were supported by the research conducted by Achola and Barone (2015), it revealed that levels of knowledge on male sterilization among men and women of reproductive age ranging from 10 to 50 percent only. Only in Rwanda, Malawi and Uganda were the levels of knowledge on male sterilization is over 50 percent.

In terms of male responsibility and involvement in reproductive health, more than contraception, it has been recognized the positive role men can play in family planning and reproductive health as far as

decision making is concern. In many countries, men have dominated household decision making around family size, contraception, and access to health services. This has furthered harmful gender inequities and left women unable to make family planning decisions or access services without their male partners' permission or financial support. Engaging men as supportive partners can lead to improvements in couple decision making and better health outcomes for men, women, and their families (Kali, 2018).

One of the many strategies the World health Organization initiated to counteract the effects of the emerging issues of concern in health and well-being of the people is the Sustainable Development Goals (SDG) of 2030. It recognizes the interdependence of health and development and present an ambitious, comprehensive plan of action for the people and prosperity, as well as for addressing the inequalities that drive poor health and development results. SDG 3 aims to secure the health and well-being of all, including a bold commitment to eliminate AIDS, tuberculosis, malaria, and other communicable diseases by 2030. It also strives to establish universal health coverage in order to meet the overall health goal by ensuring that everyone has access to safe and effective medications and vaccines (World Health Organization-Regional Office For Southeast Asia, 2017).

A closer look at the Philippine setting, a research conducted by Uy (2016) revealed that the population of Philippines grew from 92.34 million to 100.98 million from year 2010-2015. The United Nations Population Fund also reported that the population growth rate is 1.6 percent annual change (Mercado, 2019). As expressed at the World Population Prospects 2017 revision by the United Nations population estimates projections, the Philippines ranked thirteenth in the most populated nations around the globe and ranked seventh among Asian nations.

A report from the Department of Health on Responsible Parenthood and Reproductive Health revealed that 2.3 million women of reproductive age were not provided with modern family planning, which translates to 835,000 unintended pregnancies that could have been avoided, 492,000 possible abortions prevented, and 440 maternal deaths that could have been averted. The challenge of reducing the gaps in linking demand generation to service delivery remains. A total of 2, 424, 876 were listed to be "drop-outs", as far as family planning is concerned (Epidemiology Bureau- Department of Health, 2018).

As far as family planning methods utilization is concerned, contraceptive prevalence rate (CPR) in the Philippines in the year 2017 was estimated to be 40 percent among married women of reproductive age, and 17 percent among unmarried sexually active women. The CPR increased only 2 percent between 2013 and 2017, with rates being much lower in some populations. Forty-six percent of married women used no contraceptive method in 2017 and 14 percent a traditional method, only 10 percent of women used long-acting contraceptives such as Intra Uterine Devices (IUDs) and implants. Among sexually active unmarried women, traditional methods were used by 15 percent (Bellizzi, et. al., 2019).

According to Miradora (2017), most empirical studies in the Philippines on fertility behavior identified the following as the key determinants on family planning methods used such as socioeconomic characteristics, fertility preferences, and access to family planning services. Some studies also attempted to establish links between individual and community-level characteristics and how these affected family planning methods use. Among the significant findings in Bicol region were the link between local labor market conditions– such as wage rate- the direct influence of income-earning opportunities for women on contraceptive use, and the positive effect of the availability of family planning services in the community on the use of contraceptives.

Research conducted by Plecher (2018) reveals that infant mortality rate in the Philippines from 2015 to 2018 are almost the same. The year 2015 reported 23.7 percent per one thousand live births. In the year

2016, it was 23.4 percent, followed by 22.9 percent and 22.5 percent in the years 2017 and 2018. The Commission on Population and Development (POPCOM) in the Philippines has also raised the alarm about the growing number of pregnancies among teenagers as young as ten years old, amid the government calling teen pregnancy a “national social emergency.” There is an average of 530 teenagers that get pregnant daily, and the figure has stayed above 500 since 2010. The number hit high in 2017, when the agency recorded about 574 teen pregnancies per day. The agency said 16 percent of these are “repeat pregnancies.” They attributed this trend to the Supreme Court’s decision to remove a provision in the Responsible Parenthood and Reproductive Health Law, which allowed minors who had miscarriage to receive family planning services without their parents’ consent (Peralta, 2019).

In a more serious look, in June 2019, there were 1,006 newly recorded HIV-positive individuals reported to the HIV/AIDS and ART Registry of the Philippines. Nineteen percent had clinical manifestations of advanced HIV infection at the time of diagnosis (Epidemiology Bureau- Department of Health, 2019). Chua (2018) mentioned that only one out of 10 Filipinos use protection when having sexual intercourse. Since 2017, the Philippines has had the lowest condom use in Asia. Condom use declined in older population, especially for those in the 40 to 50 age range. Only 12 percent of men and women whose age ranges from 31 to 40 used condoms against sexually transmitted diseases (STDs) while 14 percent said they did to prevent pregnancy (ABS CBN, 2019). Only 0.10 percent or an equivalent of 2,445 were subjected themselves with vasectomy or male sterilization (Epidemiology Bureau- Department of Health, 2018).

In the Cordillera Administrative Region, the use of modern methods of family planning which include sterilization, intrauterine device, injectables, implants, pills, standard days method, lactational amenorrhea method, and condom used were at 43.5 percent in 2017. This increased by 37.8 percentage points from 31.8 percentage recorded in 2003. But there was a slight decrease from the 44.0 percent recorded in 2013. Meanwhile, the use of traditional methods of contraceptives which include calendar, withdrawal, and folk methods were at 6.5 percent in 2017. This decreased by 55.1 percentage points from 14.5 percent in 2003 and decreased by 62 percentage points from 17.2 percent in 2013 (Philippine Statistics Authority- Cordillera Administrative Region, 2018).

The Philippine Statistics Authority- Ilocos Gender Watch Report released last March 5, 2020, reveals that women ages 15 to 49 years old has problems in accessing health care due to the following reasons: distance to health care facility has 22 percent, not wanting to go alone; 21 percent, getting money for treatment; 45 percent, getting permission to go for treatment listed 9 percent, and at least one problem accessing health care were 54 percent (De Guzman, 2020). Overall, Ilocos Region has 71.68 percent which translates to 458, 259 users. Contraceptive prevalence rate in Region I for the year 2018 are the following: Ilocos Norte recorded 68.6 percent, Ilocos Sur has 79.2 percent, and Pangasinan listed 73.5 percent.

There were 78 infants who died in the year 2018 at 8.69 percent in the Province of La Union and 33 infants at 23.24 percent in the City of San Fernando. Along maternal mortality rate, La Union listed 11 and San Fernando had 1, at 122.60 percent and 70.42 percent, respectively (Epidemiology Bureau- Department of Health, 2018). In the Province of La Union, CPR were 72.46 percent. In the City of San Fernando, CPR were recorded at 83.29 percent or equal to 12, 918 users. Specifically, La Union has 22.16 percent or 12,175 females for bilateral tubal ligation (BTL), 0.05 percent or 30 males recorded for vasectomy, 37.52 percent or 21, 532 females for pills, 3.69 percent or 2,120 females for intrauterine device, 22.69 percent or 13, 023 females for injectables, 0.54 percent or 312 females for calendar method. In the City of San Fernando, there were 16.60 percent or 2,148 females who underwent BTL, 0.26 percent or 34 males

recorded for vasectomy, 59.85 percent or 7,745 females using pills, 1.01 percent or 131 females had intrauterine device, 9.24 percent or 1,196 females who are using injectables, and zero for natural family planning- calendar method (Epidemiology Bureau- Department of Health, 2018).

Along areas of maternal health care and nutrition, pregnant women with four or more prenatal visits, received two or more doses of tetanus toxoid, and given complete iron with folic acid vitamins, the Province of La Union, it recorded 44.78 percent or 8,304 mothers, 23.74 percent or 4,403 mothers, and 45.83 percent or 8,498 mothers, respectively. In the City of San Fernando, it listed 46.80 percent or 1,590 mothers, 21.78 percent or 740 mother, and 43.71 percent or 1,485 mothers, respectively. In terms of postpartum mothers who initiated breast feeding, received Vitamin A and iron supplementation, in La Union it has 47.58 percent or 8,822 mothers, 45.41 percent or 8,421 mothers, 45.53 percent or 8,442 mothers, respectively. Meanwhile, San Fernando listed 41.62 percent or 1,414 mothers, 42.56 percent or 1,446 mothers, and 41.62 percent or 1,414 mothers, respectively (Epidemiology Bureau- Department of Health, 2018).

In the area of child nutrition, the Province of La Union registered 68.63 percent, or 6,354 infants aged 6 to 11 months old received vitamin A supplementation, and 35.53 percent or 26, 355 infants were given the same supplementation for ages 12 to 59 months old. San Fernando recorded 79.35 percent, or 1,348 infants aged 6 to 11 months old received Vitamin A supplementation, and 39.07 percent or 5,309 infants were given the same supplementation for ages 12 to 59 months old. Along exclusive breastfeeding until 6 months of age, the province has 49.60 percent and San Fernando has 46.83 percent of all eligible infants. In terms of iron supplementation, La Union noted only 22. 46 percent or 2, 082 infants' 6 to11 months old, and 23.13 percent or 393 for San Fernando. A record of only 2.42 percent or 1,797 children aged 12 to 59 months old and 3.83 percent or 527 children of the same age received iron supplements in La Union and San Fernando City, respectively. In terms of provision of micronutrient powder (MNP), La Union has 4.44 percent or 412 infants, while San Fernando has 24.61 percent or 418 infants for ages 6 to 11-month-old. Along provision of deworming syrup, La Union listed 29.81 percent or 22,111 recipients, while San Fernando had 22.86 percent or 3,106 children recipients (Epidemiology Bureau- Department of Health, 2018).

The Expanded Program on Immunization is a government program to avoid child mortality, in the Field Health Services Information System, it recorded a 66.18 percent which translates to 1,897,115 children nationwide were fully immunized in the year 2018 only. Ilocos Region contributed only 91,616 children, in which Ilocos Norte recorded 59 percent or 7,884 children, Ilocos Sur has 67.58 percent or 10,766 children, Pangasinan has 68.72 percent or 45, 588 children, and a total 53.95 percent or 9,837 children were from the Province of La Union, from its nineteen municipalities, and 47.24 percent or 1,605 children from the City of San Fernando. Others are from the remaining seven more component cities in the region (Epidemiology Bureau- Department of Health, 2018).

Specifically, in the Province of La Union, 48.34 percent or 8,964 children were given Bacille Calmette-Guerin (BCG), 48.13 percent or 8,924 received Hepatitis B1 vaccine within 24 hours after birth, and 0.17 percent or 31 children were given Hepatitis B1 vaccine more than 24 hours after birth. In the City of San Fernando, 41.71 percent or 1,417 children were given BCG, 41.80 percent or 1420 children received Hepatitis B1 vaccine within 24 hours after birth, and no child were given Hepatitis B1 vaccine more than 24 hours after birth (Epidemiology Bureau- Department of Health, 2018).

Along Oral Polio Vaccination (OPV), La Union registered 50.31 percent, or 9,329 children were given the OPV 1 vaccine, 52.33 percent or 9,703 children received OPV 2, and 52.55 percent or 9745 children

were given OPV 3. In the City of San Fernando, 46 percent or 1563 children were given OPV1, 47.77 percent or 1623 children received OPV 2, and 47.62 percent or 1,618 children were given OPV 3. In terms of Measles-containing Vaccines 1 and 2, La Union registered 53.33 and 50.01 percent which translates to 9,889 and 9,274 children respectively. San Fernando City recorded 47.24 and 45.86 percent which translates to 1605 and 813 children respectively. In terms of ROTA vaccines 1 and 2, La Union registered only 0.06 and 0.09 percent or equal to 12 and 17 children respectively, while the City of San Fernando has zero reported children who received the vaccine (Epidemiology Bureau- Department of Health, 2018). According to the Commission on Population- Region I, total of twenty-six new cases of HIV was recorded in October 2018 in the Ilocos Region. The said figure is nine cases higher compared to the cases recorded in November 2017. The province of Pangasinan has the highest case while the province of Ilocos Norte recorded the lowest case in Region I. The Philippine National Demographic and Health Survey 2017 reported that in Ilocos Region, only 53.3 percent women mentioned that they know where to get an HIV test. Also, only 3.3 percent were tested and received results, and 96.4 percent were never tested of HIV. People in the lowest quintile group and no education were among those who not knowledgeable about the service and were never tested or screened with the disease. Cultural taboo on sex, gender, and sexuality remains prevalent (National Council of Churches in the Philippines, 2018). Religious and traditional family values were also cited as contributing to the care and support of the victims of HIV and their families. Many places indicated that cultural practices and norms and inflexible religious interpretations encouraged the stigmatization of people living with HIV and AIDS.

The growing HIV epidemic has been fueled by a legal and policy environment hostile as evident on the based policies and interventions proven to help prevent HIV transmission. Such restrictions are found in government policies and are compounded by the longstanding resistance of the Roman Catholic Church to sexual health education and condom use. Government policies create obstacles to condom access and HIV testing and limit educational efforts on HIV prevention (Conde, 2016). Meanwhile, those people with college education and those in the wealthiest households are more likely to have been tested than in other categories. Along condom utilization, only 2.01 percent, and 3.86 percent was noted in La Union and San Fernando City, respectively. Meanwhile, nobody wassubjected for male sterilization/ vasectomy in La Union and 5 were noted in San Fernando (Epidemiology Bureau- Department of Health, 2018).

For the local government units' performance for the four quarters of the year 2020, records from the Provincial Health Office of La Union (2020) showed a total of 72, 751 residents are currently using contraceptives services as of December 2020. Of the twenty local government units, the City of San Fernando recorded the highest number of users with 12, 806 residents currently using the service. This was followed by Agoo with 6841, Bauang with 6152, Rosario with 5810, and Naguilian with 4825. The Municipalities of Santol, Bagulin, and Burgos ranked 18$^{th}$ to 20$^{th}$ with 1176 users, 1080 users, and 706 users, respectively. Meanwhile, the City of San Fernando ranked first recording 52.86 percent of the eligible population currently taking oral contraceptive pills. This was followed by Naguilian with 46.82 percent, Agoo with 32.60 percent, Rosario with 37.28 percent, and Bauang with 3472 percent. The municipalities of Bagulin, Sudipen, and Burgos ranked the lowest with 30.00 percent, 29.45 percent, and 28.47 percent respectively placing them to 18$^{th}$ to 20$^{th}$ spots in the ranking.

Along the area of tubal ligation, San Fernando ranked first with 2358 residents who had the surgery, 1561 for Bauang, 1039 for Naguilian, 823 for Bacnotan, and 765 for Balaoan. In the lowest groups, Pugo recorded 298 recipients, 243 for Bagulin, and 186 for Burgos. For male sterilization or vasectomy, San Fernando recorded 23 beneficiaries, 8 from Rosario, 3 each from Pugo, Tubao, Bagulin, 2 from Caba, and

1 each from Naguilian, Aringay, and Santol. The rest does not have any recorded vasectomy acceptors as of the fourth quarter last year.

For injectables, Rosario was listed the highest with 2278 users. This was followed by Agoo with 2175, San Fernando with 1744, Bauang with 1446, and Aringay with 1250. The lowest groups are Bagulin with 185, Santol with 133, and Sudipen with 128 users. Along implant utilization, San Fernando got the highest with 403 users. This was followed by 219 from Bauang, 200 from Aringay, 184 from San Gabriel, and 132 from Luna. The bottom groups are Santo Tomas with 14 users, Burgos with 6, and Bangar with only 2 users.

Along the use of condoms, Bangar ranked the highest with 333 registered users. Next is San Fernando with 261, and this was followed by Agoo with 205, Rosario with 188, and Luna with 129 beneficiaries. Naguilian, Bacnotan, and San Juan ranked the lowest with 19 users, 18 users, and 13 users respectively. Along intrauterine device used, Luna got the highest with 497 users. This was followed by Balaoan with 360, San Fernando with 166, Bangar with 134, and Bauang with 76 beneficiaries. In the lowest groups, Burgos only had 14, Rosario had 5, and Caba does not have any service users.

Along the area of antenatal care, Bacnotan recorded 87.43 percent of its eligible population who had the service, Agoo had 64.05 percent, San Gabriel had 64.41 percent, Balaoan had 60.77 percent, and Tubao had 59.29 percent. Meanwhile, for the lowest groups, Nagulian had 30.53 percent, Luna had 28.33 percent, and Santo Tomas had 17.48 percent. Along pregnant women screened for gestational diabetes mellitus, Bacnotan had 48.60 percent, San Gabriel had 46.13 percent, San Fernando had 33.97 percent, Sudipen had 33.49 percent, and Luna had 19. 24 percent. Meanwhile, for the lowest groups, Rosario had 0.67 percent, Santo Tomas had 0.14 percent, and Bagulin does not have any patient who had the service.

Along the area of iodine capsule provision to pregnant women, Tubao ranked first with 37.74 percent against its eligible population. This was followed by Bangar with 32.97 percent, San Gabriel with 31.73 percent, Bagulin with 21.82 percent, and Balaoan with 21.53 percent. Meanwhile, for those pregnant women assesed for complete blood count and was diagnosed with anemia, Luna had 8.05 percent against its eligible population. This was followed by Balaoan with 5.59 percent, Bauang with 5.48 percent, Agoo with 5.37 percent, Sudipen with 4.70 percent, and Aringay with 4. 61 percent. For the lowest groups, the municipalities of Bacnotan, Bagulin, Bangar, Burgos, and Caba had no reports who availed the service.

On the aspect of deworming, Nagulian had 59.08 percent against its eligible population. This was followed by San Gabriel with 43.48 percent, Santol with 35.09 percent, Tubao with 33.64 percent, and Burgos with 31.77 percent. Meanwhile, for the lowest group, Agoo had 0.67 percent, and both Bacnotan and Bauang recorded zero beneficiary along this area. Along HIV screening for pregnant women, Bacnotan got the highest with 84.63 percent of its eligible population. This was followed by Tubao with 4.28 percent, San Fernando with 38.62 percent, Luna with 37.58 percent, and Naguilian with 35.94 percent. In the lowest group, Burgos, Santo Tomas, and Sudipen recorded zero on this aspect.

Along area of syphilis screening, Bacnotan ranked first with 85.01 percent against its eligible population. This was followed by Luna with 51.30 percent, San Gabriel with 49.07 percent, Sudipen with 47.89, and Bangar with 41.59 percent. For the bottom group, Balaoan had 7.77 percent, Pugo with 5.69 percent, and Santo Tomas with 4.64 percent. Meanwhile on the aspect of hepatitis B screening, Bacnotan ranked first with 78.54 percent against its eligible population followed by San Gabriel with 49.07 percent, Tubao with 47.76 percent, Sudipen with 46.64 percent, and Agoo with 43.17 percent. The three municipalities who had the lowest results includes Santo Tomas with 5.60 percent, Balaoan with 2.72 percent, and Bagulin who did not have any patient who availed the service.

For the Pentavalent 1 vaccination, Bacnotan ranked the highest with 83.37 percent children vaccinated against its eligible population. This was followed by Tubao with 82.70 percent, Santol with 77.89 percent, Caba with 77.52 percent, and Bagulin with 77.37 percent. For the lowest groups, San Fernando had 63.56 percent, Burgos with 62.88 percent, and Pugo with 61.82 percent. Along pentavalent 2 vaccination, Tubao ranked the highest with 87.35 percent children vaccinated against its eligible population. This was followed by Santol with 80.88 percent, Rosario with 77.79 percent, Bagulin with 74.59 percent, and Caba with 74.37 percent. For the lowest groups, Burgos got 64.86 percent, Santo Tomas got 63.51 percent, and Sudipen got 62.92 percent. For the pentavalent 3 vaccination, Tubao ranked the highest with 87.53 percent children vaccinated against its eligible population. This was followed by San Juan with 80.69 percent, Rosario with 79.14 percent, Bacnotan with 78.29 percent, and Bagulin with 76.97 percent. For the lowest groups, Luna had 63.38 percent, San Gabriel had 60.52 percent, and Sudipen had 59.48 percent.

Along the aspect of Oral Polio 1 vaccination, Bacnotan ranked the highest with 83.37 percent children vaccinated against its eligible population. Tubao had 82.70 percent, Santol had 80.88 percent, Bagulin had 76.97 percent, and Caba had 75.10 percent. For the bottom group, Burgos had 62.88 percent, Naguilian had 62.73 percent, and Pugo had 62.10 percent. For the Oral Polio 2 vaccination, Tubao ranked first with 87.35 percent children vaccinated against its eligible population. This was followed by Santol with 81.31 percent, Rosario with 77.79 percent, Caba with 74.37 percent, and Bacnotan with 73.72 percent. For the bottom group, Santo Tomas had 63.51 percent, San Fernando had 62.20 percent, and Nagulian had 62.14 percent. For the Oral Polio 3 vaccination, Tubao ranked first with 87.53 percent children vaccinated against its eligible population. This was followed by Bagulin with 87.29 percent, San Juan with 80.69 percent, Santol with 79.60 percent, and Rosario with 79.14 percent. For the bottom group, San Fernando had 63.47 percent, Luna had 63.38 percent, and Sudipen had 62.29 percent.

With the rising emerging issues of concerns in the country, the government launched the “AmBisyon Natin 2040”. It is the Filipino people's collective long-term vision and ambitions for themselves and the country for the next twenty-five years. It describes the type of life people wish to live and the state of the country in 2040. It is a vision of the future, a set of personal and national objectives. It is not the same as a plan, which lays out the strategies for achieving the goals. It is like a destination that answers the question “Where do people want to be?”. A plan defines how to get to a specific location; AmBisyon Natin 2040 is the country's vision for the future and the cornerstone of its plans. Along areas of health and well-being, this initiative envisions new products and procedures that are safer and cleaner, and that undoubtedly promote good health. To ease the strain on people's health, policies that encourage work-life balance will be developed. Filipinos must have access to affordable and high-quality healthcare in the event of illness (National Economic Development Authority, 2016).

The Responsible Parenthood and Reproductive Health Law is rooted on the human rights of the people including their right to equality and nondiscrimination, the right to sustainable human development, the right to health including RH, the right to education and information, and the right to choose and make decisions for themselves in accordance to their religious convictions, ethics, cultural beliefs and the demand of responsible parenthood (POPCOM, 2016). Generally, the provisions of the RH Law are to ensure, protect and strengthen the family as a basic autonomous social institution and equally protect the life of the mother and the life of the unborn from conception, instill health consciousness among them and shall likewise advance the right of families to a balanced and healthful environment in accord with the rhythm and harmony of nature (Benigno, 2012).

Meanwhile, the Supreme Court of the Philippines issued a status quo ante or restraining order against the RH Law for 120 days (Center for Reproductive Rights, 2014). During which period, it would review the petitions challenging the new law itself; oral arguments before the Supreme Court begun on June 18, 2013, or six months since the enactment by Congress (Calonzo, 2013). It has been almost three decades since the proposal to the House of Representatives and numerous debates have been going on ever since the law were passed whether it would really benefit the country and the people. The Catholic Bishops' Conference of the Philippines, the whole Roman Catholic Church and religious groups strongly protest it's passing because of the strong belief that it is immoral, and according to them it will set the stage for other anti-life laws so-called DEATH Bills (acronym for death, euthanasia, abortion, two-child policy and homosexuality (Robles, 2012).

Though the Reproductive Health law has proven to be effective and beneficial to other countries, up until now, it is not yet fully implemented due to some objections of population themselves and the churches. The late American President Abraham Lincoln stated that a house divided cannot stand; referring to the political divisions present in each country (Little, 2019). This for almost every century, conflict arises which divides the people in times of relative peace. One of the main issues because the Reproductive Health law is not fully utilized by the people is the serious dispute among Filipinos; conflict that is especially present between the government and the church (Baring and Batalla, 2019).

Prominent legislators and political personalities blatantly opposed RH law. One of them is the former Senator Francisco Tatad, who together with colleagues, argued before the high court that said law rest on a flawed premise; it is unnecessary, unconstitutional, oppressive, and destructive in religious beliefs, public moral, and values. Furthermore, the former senator emphasized that it is an act of genocide, an attack on human life, the family, and the countries' social and cultural values as it does not equally protect the right of the mother and right of the unborn and denies the basic right of married couple to procreate on their own free will, but simply put the family under state supervision and control (Tupas, 2013). Meanwhile, the Department of Health implements easier access to birth control in which the church claims a step not to protect family as the foundation of the nation (Domonoske, 2017).

Everyone has been talking about this RH law. Everyone may benefit and for some, it may bring into some point that it may trigger to do such thing that will ruin someone's life. But as the saying goes, that every little thing that is too much is not good. So, it depends on how people will take it and treat it as long as they are only motivated to do well and focus only to what could bring them a healthy and happy life.

**Framework of the Study**

Ronald M. Andersen's Behavioral Theory of Health Care Utilization is a conceptual model aimed at demonstrating the factors that lead to the use of health services. In this model, usage of health services which include inpatient care, physician visits, dental care, among others are determined by three dynamics: predisposing factors, enabling factors, and need. Predisposing factors are demographic and social factors such as race, age, and health beliefs. Enabling factors are economic which includes family support, access to health insurance, and community, among others. Need represents health outcome factors both perceived and actual need for health care services (Feng, et. al., 2016).

This theory gave light and direction in this study because it investigated the relationship between the age, gender, number of children, educational attainment, income, access to media, religion, ethnicity, health-seeking behavior, pregnancy and birth beliefs/ practices, and superstitious beliefs of the respondents as factors to the level of awareness and their extent of practice on the available reproductive health services

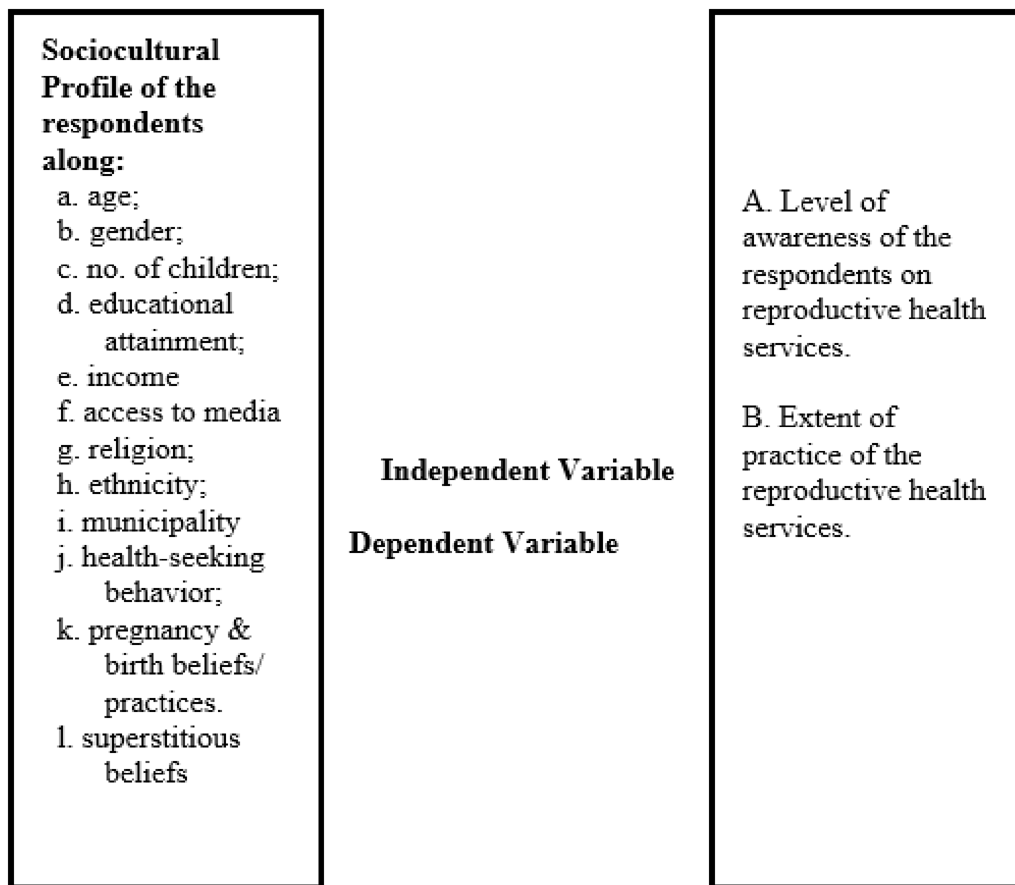
provided by the government. The researcher investigated the association between these variables as the focus of this study.
Hochbaum Rosenstock's Health Belief Model also strengthened this study. It is a theoretical model that can be used to guide health promotion and disease prevention programs. This model helps to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection and prevention of illness. It is also used to explain and predict individual changes in health-seeking behaviors. The model describes the key factors that influence health-seeking behaviors as an individual's perceived threat to sickness or disease / perceived susceptibility, belief of consequence/ perceived severity, potential positive benefits of action/ perceived benefits, perceived barriers to action, exposure to factors that prompt action/ cues to action, and confidence in ability to succeed/ self-efficacy (LaMorte, 2019).
This theory was practically applied in this study because it is closely associated with some possible predictors on the extent of practice of the reproductive health services which include individual's view or health belief of perceived vulnerability to illness, perceived efficacy and benefits of health care associated with preventive health behavior, and perceived seriousness of symptoms.
Madeleine Leininger's Transcultural Care Theory sets on the premise that to improve the health status of the community, cultural factors affecting health behavior and health care services need to be clearly recognized. Cultural variables which include socioeconomic status, gender roles and responsibilities, sexual behavior, pregnancy and birth practices, general health regulations, professions, religion, habits, self-healing strategies, among others are strong determinants of individuals' perception to health. People's beliefs and practices are part of the culture of the society in which they live. Cultural characteristics should be seen as a dynamic factor of health and disease. To be able to provide better health care, it is necessary to at least understand how the people receiving care perceives and responds to disease and health, and what cultural factors lie behind their behaviors (Deger, 2017).
In relation to the study, the researcher determined if there were close associations with the social and cultural variables such age, gender, number of children, educational attainment, income, religion, ethnicity of the respondents on their perception of health and extent of practice of available services pertaining to reproductive health such as family planning, maternal and child health and nutrition, adolescent and youth RH education and counseling, prevention and management of sexually transmitted infections, and male involvement in Reproductive Health.
The theory of Martin Fishbein's Reasoned Action or Planned Behavior suggest that a person's health behavior is determined by their intention to perform a behavior. It is predicted by one's attitude toward the behavior, and the subjective norms regarding the behavior. The key component to this model is behavioral intent which are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome (Salgues, 2016). In this study, people utilize reproductive health services because of one main specific intention; to ensure a healthy body away from diseases or infirmity. The respondents believed that using RH services helped them on issues of birth control, improving maternal and child health, prevention of STDs, and enhancement of their knowledge concerning adolescent and youth RH issues.
Another theory that supported this study was the Social Ecology Theory by Urie Bronfenbrenner. It describes a wide array of understanding the range of factors that influences health and well-being. It can assist in providing a complete perspective of the factors that affect specific health behaviors, including the social determinants of health (Garrido, et. al., 2015). One of the foci of this study is determining the extent of practice on RH services. The model strengthened this study as it focuses on the multiple levels of

influence, complexities, and interdependence between social and cultural determinants of RH services choices (Gombachika, 2012).

Another theory that is applicable in this study is the Everett Rogers' Diffusion of Innovation Model. It focused on the dissemination of any physical element, idea, value, social practice, or attitude through and between populations (Combi, 2016). In this study, it investigated how new products and services are introduced to the community people for their consumption, the manner of program execution and the barriers to implementation faced by the health care providers in delivering the services to the people.

The results of this study benefited the health care providers, government officials and other stakeholders. They were properly informed about the level of awareness of the respondents and their extent of practice on the available reproductive health services provided by the government. They knew on what areas needed to enhance and improve so that the community people would totally embrace and fully used the RH services. Understanding this helped service providers, organizations, and policymakers to better coordinate their efforts in meeting the emerging issues and problems in the community, as well as promote a healthy population in the nation at large.

The Department of Health personnel in coordination with the Department of Education can increase awareness of the community people, most especially the youth, on matters and concepts related to personal development, family planning, responsible parenthood, and reproductive health issues, with the end goal of enhancing the quality of life among the people. Furthermore, the findings in this study filled the knowledge gap in reproductive health education and service practiced of the people.




**Moderating Variable**

**Fig 1.** *The Research Paradigm*

The IV-MV-DV research paradigm was used in this study. The independent variable is the one that is unaffected by the other variables under study. It is assumed to be the source of any changes that may occur in the other variable. The independent variable in this study were the respondents' sociocultural profile. The dependent variable, on the other hand, is the effect of changes in the independent variable. In this study, the respondents' level of awareness and extent of practiced of reproductive health services may be influenced by their sociocultural backgrounds, which are thus considered a dependent variable. The variables that can enhance, reduce, negate, shift the direction, or otherwise influence the association and relationship between the independent and dependent variables are known as moderating variables. In this study, the respondents' sociocultural characteristics also served as moderating variables.

**Statement of the Problem**

This study determined the sociocultural implications of Reproductive Health Programs in the Province of La Union.

Specifically, it answered the following problems:

**1. What are the sociocultural profile of the respondents along:**

a. age;
b. gender;
c. number of children;
d. educational attainment;
e. income;
f. religion;
g. ethnicity;
h. municipality;
i. access to media;
j. health-seeking behaviors;
k. pregnancy and birth practices/ beliefs; and
l. superstitious beliefs?

**2. What is the level of awareness of the respondents on reproductive health services along:**

a. family planning information and services;
b. maternal, infant, and child health and nutrition;
c. adolescent and youth reproductive health education and counseling;
d. prevention and management of sexually transmittable infections; and
e. male responsibility and involvement in reproductive health?

**3. What is the extent of practice of the respondents on reproductive health services along:**

a. family planning information and services;
b. maternal, infant, and child health and nutrition;
c. adolescent and youth reproductive health education and counseling;
d. prevention and management of sexually transmittable infections; and
e. male responsibility and involvement in reproductive health?

**4. Is there a significant relationship between the sociocultural profile of the respondents and the following:**

a. level of awareness of the respondents on the RH services; and

b. extent of practice of the reproductive health services?
**5. Is there a significant difference in the level of awareness and extent of practice when group according to:**
a. age;
b. gender;
c. number of children;
d. educational attainment;
e. income;
f. religion;
g. ethnicity; and
h. municipality?
**6. What are the barriers in the reproductive health used?**

**Definition of Terms**

For a better understanding of this research report, the following terms were operationally defined:
*Barriers to reproductive health used* refers to the list of possible reasons that will stop people from utilizing the services intended for them by the health facilities
*Birth Control* is one of the programs of the government to counter the rapid growth of population.
*Child mortality* refers to the death of children related to underlying diseases due to the failure to receive vaccines and other causes such as poor nutrition.
*Communicable diseases* are illnesses that can be easily transferred from one person to the other due to rapid growth of population.
*Contraceptives* are drugs, process or devices available at the health care facilities given to men and women to avoid pregnancy.
*Contraceptive prevalence rate* is one of the determinants on the number of people using the products and services provided by the government to control population growth.
*Extent of practice* refers to degree of utilization of the people on the reproductive health services available in the health care facilities.
*Family planning methods* are series of activities or services in a health care facility given to males and females to limit childbearing.
*Fertility* refers to the ability of men and women to produce offspring.
*Health care facility* is the place where reproductive men and women receives products and services from the government for the purpose of family planning.
*Health promotion programs* are activities of the government that aims to reduce incidence of disease development among the population.
*Health- seeking behavior* are the things that people are doing when they need medical attention or are experiencing problems on their health.
*Infertility* refers to the inability of men and women to produce offspring.
*Level of awareness* refers to the extent of consciousness of thepeople on the reproductive health services available in the health care facilities.
*Male contraception* refers to the used of available reprodcutive health services for the male population such as vasectomy and condoms.
*Maternal mortality* refers to the death of a mother during childbearing or child rearing due to illness or

complications of pregnancy and delivery.
*Perceived susceptibility* refers to the known disadvantages of using reproductive health products and services.
*Preventive health care practices* are sets of activities done by reproductive men and women to avoid the development of diseases associated with parenting.
*Reproductive Health Law* is a law that aims to control the rapid population growth and associated problems with overpopulation, maternal mortality, child death, rising sexually transmitted infection cases, and teenage pregnancy.
*Sociocultural profiles* are the possible link of diverse culture, ethnicity, beliefs, practices, among others that would affect the level of awareness and extent of practice of the respondents on the reproductive health services provided by the government.
*Superstitious beliefs* are set of norms the couple are following as part of their culture in order to ensure a healthy body, safe pregnancy and delivery.
*Pregnancy and birth beliefs or practices* refers to the set of norms the couples are following during pregnancy, child-bearing, and rearing as part of their culture.

## Chapter 2
## METHODOLOGY
### Research Design

The researcher used the descriptive- correlational research design. The purpose of descriptive research design is to describe individuals, events, phenomenon, or conditions by studying them as they are in nature. It looks at the characteristics of the population, identify problems that exist or look at variations in the characteristics or practices. The purpose is to evaluate or measure the results against some known or hypothesized standards (Siedlecki, 2020). On the other hand, a correlational research design measures a relationship between two variables without the researcher controlling either of them. It allows testing of expected relationships between and among variables and the making of predictions (McCombes, 2020).
The researcher determined if there was a significant relationship in the sociocultural profile, level of awareness, and the extent of practice of the respondents on reproductive health services. Aside from that, the researcher investigated if there was a significant difference in the level of awareness and extent of practice of the respondents on the RH services when grouped according to age, gender, number of children, educational attainment, income, religion, ethnicity.

### Sources of Data

The study was conducted in the upland Municipalities in the Province of La Union namely: Santol, San Gabriel, San Fernando, Burgos, Bagulin, Tubao, and Pugo.

**Table 1.** ***Distribution of Respondents***

| Municipality | Population | Sample |
|---|---|---|
| Santol | 4,268 | 38 |
| | | |
| San Gabriel | 7,550 | 67 |
| | | |
| San Fernando | 5,807 | 51 |

| | | |
|---|---|---|
| Burgos | 2,092 | 19 |
| | | |
| Bagulin | 9,313 | 81 |
| | | |
| Tubao | 2,694 | 23 |
| | | |
| Pugo | 11,723 | 102 |
| | | |
| TOTAL | 43,447 | 381 |

**Fig 2. Map of La Union**

The location of these towns and the city were considered in the selection of the respondents. These areas have varied rich culture and traditions, with distinct traditional habitats or ancestral territories. The researcher used proportionate stratified random sampling in the selection of the respondents. Community people, men and women, ages 15 to 65 years old, single, or married, working or not, living in the geographically isolated barangays, if bonafide residents in each town/city and the province served as respondents in this study.

Because of the disapproval of the request to gather data due to precautionary measures on COVID-19 pandemic imposed by the local chief executive along with the local disaster risk reduction and management office of the Municipality of Sudipen, the researcher was not able to gather data in the above-mentioned municipality. A total of 381 respondents obtained using lynch formula took part in this study.

To validate the results of the study gathered using survey questionnaires, the researcher conducted an interview. Purposive sampling was done in the selection of key-informants. Interviews were conducted until the point of saturation were reached. A total of twenty five key-informants participated in the

interview. Also, the researcher conducted a phone interview to the seven community leaders and workers from each of the municipalities.

**Instrumentation and Data Collection**

The questionnaire was composed of two parts—part one dealt with the sociocultural profile of the respondents along age, gender, number of children, educational attainment, income, access to media, religion, ethnicity, health-seeking

**Table 2. Mean Statistical Values to Determine the Validity of the Questionnaire**

| Statistical Range | Descriptive Interpretation |
|---|---|
| 4.20 – 5.00 | Very Highly Valid |
| 3.40 – 4.19 | Highly Valid |
| 2.60 – 3.39 | Moderately Valid |
| 1.80 – 2.59 | Fairly Valid |
| 1.00 – 1.79 | Not Valid |

behavior, pregnancy, and birth beliefs/ practices, and superstitious beliefs and was crafted by the researcher. The second part were focused on areas of assessment along reproductive health services such as family planning information and services, maternal, infant and child health and nutrition, adolescent and youth reproductive health education and counseling, prevention and management of sexually transmittable infections, and male responsibility and involvement in reproductive health and were patterned after the the Field Health Service Information System by the Philippine Department of Health. The researcher determined the level of awareness and extent of practice on reproductive health services among the respondents on these areas of assessment.

The researcher subjected the questionnaire for validity testing by a pool of experts in the field of health care, research, and education which yielded a result of 4.72 interpreted as **very highly valid.** Suggestions and recommendations were incorporated before the questionnaire was subjected for pilot testing. The pilot testing was conducted in the upland Municipality of Sugpon, Ilocos Sur. Using Cronbach alpha, it yielded 0.9188 result.

For data validation, the researcher also made use of open-ended questions for the face-to-face interview of the residents and phone interview to some community leaders. Interview questions was checked by the same experts in the field of health care, research and education who validated the survey questionnaire to ensure its alignment with the research objectives. An Iloko vesion of the data gathering tool was made so that the key-informants can fully understand the questions and thus, provide an information-rich data necessary in the data transcription and analysis.

The researcher made the necessary preparations for the administration of the questionnaire after the reliability were established. The researcher secured noted endorsement from the researcher's adviser and the Dean of the Graduate Studies of Don Mariano Marcos Memorial State University- Mid La Union

Campus. After which, the researcher arranged with the community leaders to seek permission to gather in the locale of the study. Actual data gathering was last January 8 to May 5, 2021. Before the conduct of the data gathering, the respondents were properly oriented about its significance to the community. The researcher were able to retrieve all the survey questionnaires used during the data gathering.

Respondents were also interviewed face-to-face from September 4 to 25, 2021. They were asked to choose a place that they felt more comfortable and freer of interruptions. This allowed the researcher to use body language like head nodding and facial expressions that encouraged the respondents to elaborate their narration. It enabled the researcher, as well as to observe some physical or emotional feelings, such as hand gestures, accentuations, and facial expressions. The researcher gave written consent forms to the participants for review. They were asked whether they accept or reject being a participant of the said study. All the interviews were audio taped in order not to miss any important details during the process. After collecting data and information, their responses were transcribed and important gestures of the participants during the interview were noted. Collected data were interpreted to make a conclusion.

The interview questions were drawn based on the Interview Protocol Refinement by Castillo- Montoya (2016) which has four phases. The alignment of interview questions and research questions are the emphasis of the first phase. This alignment can help interview questions be more useful in the research process while ensuring their necessity for the study. Phase 2 involves the researcher creating an inquiry-based conversation using an interview protocol that includes: a) interview questions that are different from the research questions; b) an organization that follows social rules of ordinary conversation; c) a variety of questions; and d) a script with likely follow-up and prompt questions. The third phase is gathering feedback on the interview protocol that has been developed. The goal of getting comments on the interview protocol is to improve its trustworthiness as a research tool. To elicit feedback, the researcher gave the participants a copy of the interview questions. It can provide the researcher information about how well participants could comprehend with the interview questions and whether their understanding matches what the researcher intends or anticipates. For the fourth phase, the researcher is now ready to pilot test the improved interview protocol with participants who closely resemble those that will be interviewed for the actual study. The researcher simulated the interview in as realistic setting as possible. Any notes made to improve the interview protocol were based on the interviewer's previous experience of conducting the interview (Castillo-Montoya, 2016).

A phone interview were also conducted from October 9 to 13, 2021 with the community leaders. The researcher initially contacted the key-informants to seek approval and set the date and time of the interview. Objectives of the study were explained so that they could understand the importance of their participation in the procedure. The researcher contacted the participants through cellular phones and questions were asked to the interviewee and the researcher let them answer it freely. Important aspects of the conversation were noted, data were organized to come up with a condensed idea that represented their perception about the questions asked.

As the study required the participation of human respondents, certain ethical issues were addressed. The researcher considered these ethical issues which were necessary for ensuring the privacy and safety of the participants. To secure the consent of the participants, the researcher discussed all important details of the study, including its aim and purpose. By explaining these important details, the respondents understood the importance of their role in the completion of the research. The confidentiality of the participants were also assured by not disclosing their names in the research. Only relevant details that helped the researcher

in answering the research questions were included. The researcher gave the participants enough time to complete the questionnaires and did not put pressure on them to read the questions properly.

**Analysis of Data**

The data gathered were tallied, tabulated, and analyzed accordingly. Problem number 1 which assessed the sociocultural profile of the respondents along age, gender, number of children, educational attainment, socioeconomic status (income), religion, ethnicity, health-seeking behaviors, pregnancy and birth practices/ beliefs, and superstitious beliefs utilized frequency and percentage.

Five-point Likert scale was used to determine the level of awareness and extent of practice of the respondents on the existing reproductive health services. The weighted mean was the basis for determining the descriptive interpretations. Frequency and percentage were utilized in determining the barriers to RH services used.

**Table 3. Data Categorization to Determine the Level of Awareness and Extent of Practice on Reproductive Health Services**

| Scale of Values | Statistical Range | Descriptive Interpretation (Awareness) | Descriptive Interpretation (Practice) |
|---|---|---|---|
| 5 | 4.20 – 5.00 | Very Highly Aware | Very Highly Practiced |
| | | | |
| 4 | 3.40 – 4.19 | Highly Aware | Highly Practiced |
| | | | |
| 3 | 2.60 – 3.39 | Moderately Aware | Moderately Practiced |
| | | | |
| 2 | 1.80 – 2.59 | Fairly Aware | Fairly Practiced |
| | | | |
| 1 | 1.00 – 1.79 | Not Aware | Not Practiced |
| | | | |

The Pearson Moment of Correlation r and chi square were used to determine whether there was a significant relationship between the sociocultural profile and the level of awareness and extent of practice of the respondents on reproductive health services.

T- test, ANOVA, and post- hoc analysis were used to determine if there is a significant difference in the level of awareness and extent of practice of the respondents in the RH services when group according to sociosultural profiles.

## Chapter 3

## RESULTS AND DISCUSSIONS

### Sociocultural Profiles of the Respondents

In Table 4 on page 47, it shows the distribution of age of the respondents from 19 to 40 years old which made up the 66.14 percent of the population. This was followed by respondents ages 41 to 65 omprising of 32.55, and 12 to 18 respondents which represented 1.31 percent of the sample population. These age groups represent the reproductive age of the population and are expected to be aware and are utilizing the reproductive health services provided by the government to ensure a healthy population at large. The RH

services awareness and practiced as to age is determined by the relative maturity, sexual readiness or sexual experience and exposure among the respondents to information in schools and other platforms (Gebreyesus, 2019).

The minimal perception of risk for sexually transmitted diseases among older people is a contributory factor in the use of family planning services such as condoms as they do not tend to use contraception during sexual activity, since they do not need this for birth control. Also, when older people choose to engage with the health system to discuss and seek help regarding their sexual and reproductive needs, it becomes inherently clear that the health systems are not designed to meet their needs or address their issues. In many settings, health workers have been stereotypical, prejudiced, and discriminatory against older people based on their age (Thomas, et. al., 2020).

**Table 4. Sociocultural Profiles of the Respondents**

| Sociocultural Profiles | Frequency | Percentage |
|---|---|---|
| Age | | |
| 12- 18 | 5 | 1.31 |
| 19- 40 | 252 | 66.14 |
| 41-65 | 124 | 32.55 |
| Total | 381 | 100 |
| Gender | | |
| Male | 113 | 29.66 |
| Female | 268 | 70.34 |
| Total | 381 | 100 |
| Number of children | | |
| None | 87 | 22.83 |
| 1 | 76 | 19.95 |
| 2- 4 | 188 | 49.34 |
| More than 4 | 30 | 7.87 |
| Total | 381 | 100 |
| Educational attainment | | |
| Elementary | 41 | 10.76 |
| High school | 231 | 60.63 |
| College | 105 | 27.56 |
| Graduate studies | 4 | 1.05 |
| Total | 381 | 100 |
| Income | | |
| Less than P10, 481 | 312 | 81.89 |
| P10, 481 - P20, 962 | 50 | 13.12 |
| P20, 963 - P41, 924 | 14 | 3.67 |
| P41, 925 - P73, 367 | 5 | 1.31 |
| Total | 381 | 100 |

| | | |
|---|---|---|
| Religion | | |
| Roman Catholicism | 292 | 76.64 |
| Protestantism | 67 | 17.59 |
| Islam | 0 | 0.00 |
| Religious Sect | 22 | 5.77 |
| Total | 381 | 100 |
| Ethnicity | | |
| Igorot | 131 | 34.38 |
| Ilokano | 250 | 65.62 |
| Total | 381 | 100 |
| Municipality | | |
| Santol | 38 | 9.97 |
| San Gabriel | 67 | 17.59 |
| San Fernando | 51 | 13.39 |
| Burgos | 19 | 4.99 |
| Bagulin | 81 | 21.26 |
| Tubao | 23 | 6.04 |
| Pugo | 102 | 26.77 |
| Total | 381 | 100 |

Reardon (2020) mentioned that for the young population, they tend to have a limited clinic visits due to mental health stigma and embarrassment, a lack of mental health knowledge and negative perceptions of help-seeking. On the other hand, an increase in the number of young people seeking services does not necessarily mean an increase in the percent of young people with RH needs or issues. The increase may be attributable to other factors, such as an information campaign advertising the services or a health promotion program that enables more young people to recognize the need for preventative or curative services, like recognizing the symptoms of an STI or to increase the demand for contraceptives (MEASURE Evaluation, n.d). Also, Anike, et. al., (2021) revealed that the utilization of RH programs among young people in Nigeria is low. Results showed that RH were normally provided in the general health facilities which are not so comfortable for young people.

It can be seen in Table 4 on page 47 that 70.34 percent of the respondents are females compared to the 29.66 percent which are males. The higher number of female respondents can be associated to the openness of women to talk about reproductive health as compared to men. It is a long-time perception that family planning services are for females due to their ability to conceive and thus, services are geared towards the care of mother and pregnant women only. Gender attitudes and beliefs result to low utilization rate and promotes unwanted pregnancy. The lack of education associated with male involvement in RH is a matter that needs immediate and appropriate action. Gender inequality can impact the clients' RH choices and decisions (MEASURE Evaluation, 2015). As such, understanding gender and gender norms, and how they can influence access to services, including family planning, is a crucial step in any intervention to involve men in RH as clients, supportive partners, or agents of change.

Binder and Kennedy (2020) highlighted that lack of knowledge in gender norms will end up doing more harm. Using a gender analysis will better ensure that efforts 'do no harm', as services that are gender blind can perpetuate harmful gender norms and stereotypes, which sustains gender inequality and has a negative impact on health outcomes. If gender inequalities persist when men are involved in family planning decision-making, for example, men may simply wind-up exerting control over their partner's reproductive

choice and make the family planning decision for their partner, without acknowledging or respecting their partner's needs (Nanda, 2011).
It can be gleaned from Table 4 on page 47 the distribution of the number of children of the respondents. It can be gleaned that majority of them have 2 to 4 children with 49.34 percent. Eighty-seven or 22.83 percent of them reported that they have no children, while seventy-six or 19.95 percent has only a child. Meanwhile, 7.87 percent or 30 respondents mentioned that they have more than 4 children. The limited number of children can be attributed to the difficulty of the respondents in raising their children as well as sustaining their needs. Living in the mountainous areas are difficult due to lesser opportunities to earn for living. Parents think that they can provide the needs of their children if they are just limited. Aside from economic impact, the stress levels of growing children are also considered by some (Dhel, 2020). These experiences are summed up in the decision of the couple to limit the number of children. Aside from self-control, the limited number of children among the respondents can be associated with contraceptives used. Their access to birth control measures helped them achieved their desired family size, reduced high-risk pregnancies, and improved child health and growth (Innovations for Poverty Action, 2020).
The distribution of the respondents along highest educational attainment is shown on Table 4 on page 47. Majority of them, with 60.63 percent, had reached high school, 27.56 percent in college level, 10.76 percent reached elementary, and 1.05 percent of them had their graduate studies. Schooling in mountainous areas are critical. Despite the population density to be low, there is still a corresponding deficiency in schools and classrooms. Public school is free, but families still cannot afford to send their children for complicated reasons. In agriculture-based communities where farming is the primary livelihood, having children around to help with the work means more income for the family. They are expected to work in the fields during harvest time (Wymann von Dach, et. al., 2014). Transportation is another big problem. They need to walk 5 kilometers or more to and from the school every day (Nadela, 2016). They must cross rivers and climb hills with their school bags. Schools are sometimes too far for the most remote communities to practically access. So, the families cannot afford to pay, and the children are pulled from school (Weinstein, 2010).
It was reflected on Table 4 on page 47 the respondent's monthly income in which 81.89 percent of them earn P10, 481 and below. A total of fifty respondents (13.12%) reported a monthly income of between P10, 481 to P20, 962, followed by fourteen respondents (3.67 percent) receiving P20, 963 to P41, 924. Meanwhile, only five (1.31 percent) of them is receiving a monthly income of P41, 925 to P73, 367.
The limited job opportunities due to the geographic characteristics of the area results to lesser chances to work and earn higher for a living. Majority of the respondents rely on agriculture- based jobs in which they claimed that is not enough to sustain their daily expenditures and avail of essential services, among others. According to Gioli (2019), poverty in mountainous communities is associated with social markers and inequality at the intersection of class, caste, ethnicity, gender, education, occupation, and employment status. The determinants of poverty and its persistence are remoteness and low access to markets and basic facilities, demographic factors, social and cultural factors, marginalization specifically political and socioeconomic. Mountain communities are among the poorest. Many mountain people live in rural areas are threatened by food insecurity and are deprived of other opportunities such as work and other sources of living aside from their health that is suffering (Chin & Dye, 2016). Consequently, the need to not only protect highland environments, but also ensure the economic and social well-being of mountain communities is widely recognized (McKenna, 2020).

It can be gleaned in Table 4 on page 47 that as far as religion is concerned, 76.64 percent of the respondents are Roman Catholics, followed by Protestants with 17.59 percent, and other religious sects with 5.77 percent. Nothing among the respondents profess an Islam faith. The large number of respondents are Roman Catholics is that majority of the Filipinos with more than 80 percent of its population professing the faith (Cornelio, 2018). From politics to education to health, Catholicism pervades much of Philippine society. Given the wide range of religious practices across the national population, it is no wonder that healthcare providers and systems are often challenged by delivering care that meets the religious needs of patients and their families.

The social teaching of the Church, particularly the preferential option for the poor, could help shift the enduring issue that global resources often flow where they are least needed (Rozier, 2020). As far as decision making in the healthcare utilization is concerned, people follow decisions that are influenced by the moral code of their chosen religion. They make decisions based on their religious beliefs, and weather they think they are following their religions creed and code.

As far as ethnicity, Table 4 on page 47 reveals that 65.62 percent of the respondents are Ilokano, and the remaining 34.38 percent are affiliated with Igorot ethnic group. Igorot is the mainstream, collective name of several of the tribes in the Cordilleras which includes Tinggian, Isneg, Kankanaey, Iyaplay, Ibaloi, Bago, and Tuwali (University of Hawaii and Manoa, 2021). The Bago Tribal group is a product of intermarriage between the Ilocanos of the lowlands and different indigenous cultural communities of the Cordillera. They settled between the mountain ranges of Ilocos and the boarders of the Ilocos Provinces, La Union, and Pangasinan. They are of medium built, although some resemble the Kankanaeys with fair complexion and a sturdy build (Akkin, 2014). On the other hand, Ilocanos are the third largest ethnolinguistic group in the Philippines, and they originally lived in the north of Luzon (Jordan, 2015).

Valdeavilla (2018) mentioned that these ethnic groups, along with other groups in the country remain some of the poorest, least privileged, and impeded members of society. Communities are found in the mountains and lowlands with varied levels of socioeconomic development. They are engaged in a mix of production systems including farming in mountain slopes, settled or sedentary agriculture of rice, corn and vegetables, livestock raising, and producing and trading local handicrafts (Carino, 2012).

As far as sociocultural profile along municipality, Table 4 on page 47 reveals that out of 381 respondents, 26.77 percent of which were from the Municipality of Pugo. This was followed by 21.26 percent from Bagulin, and 17.59 percent from San Gabriel. Meanwhile, the Municipality of Tubao and Burgos had the lowest with 6.04 percent and 4.99 percent respectively. The seven municipalities in this research study had a total of 43, 447 population size based on the criteria set on the selection of the respondents.

The location of these towns and city were considered in the selection of the respondents. These areas have varied rich culture and traditions, with distinct traditional habitats or ancestral territories. The researcher used proportionate stratified random sampling in the selection of the respondents. Community people, men and women, ages 15 to 65 years old, single, or married, working or not, living in the geographically isolated barangays, if bonafide residents in each town/city and the province served as respondents in this study.

La Union, according to the National Economic Research and Business Assistance Center (n.d.), is a province in the Philippines located in the Ilocos Region, in the northwestern part of the island of Luzon. It is bounded on the north and northeast by Ilocos Sur, on the east by Benguet, on the south by Pangasinan, and on the west by the China Sea. The City of San Fernando serves as its capital. The province covers

1,499.28 square kilometers (578.88 square miles) of land. It has a hilly terrain that gradually rises eastward from the shore. The western border is a raised coral and alluvial plain overlying older sediments.

The population was 822,352 according to the 2020 census. This accounted for 15.51 percent of the total Ilocos Region population, 1.32 percent of the overall population of the Luzon island group, and 0.75 percent of the total population of the Philippines. Based on these figures, the population density is calculated to be 548 persons per square kilometer or 1,421 persons per square mile. According to the 2015 population census, the age group with the highest population in La Union is 5 to 9, with 75,059 persons. The age group with the lowest population is 75 to 79, with 10, 108 persons. La Union's population increased from 137, 847 in 1903 to 822, 352 in 2020, an increase of 684, 505 persons over the course of 117 years. The most recent census figures for 2020 show a 0.94 percent increase, or an increase of 35,699 persons, over the previous population of 786,653 in 2015. Ninety- three percent of the population is Ilocano, who primarily speak Iloko; some Pangasinenses live in the province's south, and Igorots live in the Cordillera foothills. La Union has a relatively arid and long dry season with little precipitation. It experiences two distinct seasons: dry from November to April and wet from May to October.

Farming and fishing are the primary sources of income. The province's economy is diverse, with service, manufacturing, and agricultural industries spread throughout. Rice, corn, tobacco, garlic, sugarcane, and cassava are the main products. Grapes are also widely grown. Blanket-weaving, basketry, shellcraft, pottery, and furniture-making are examples of cottage industries. La Union is also famous for its "basi," a native wine made from fermented sugarcane juice (PhilAtlas, n.d.).

It was shown in Table 5 on page 55 the distribution of profiles of the respondents along access to social media. A 41.94 percent and 26.37 percent of the respondents rely on television and radio, respectively, regarding information pertaining reproductive health services. The National Demographic and Health Survey conducted last 2017 revealed that seven in ten women are exposed to any messages about family planning on the radio, television, newspaper/magazines, mobile phones, or through the internet. Television is the most frequent medium for family planning messages with 62 percent of the respondents surveyed. Regionally, lack of exposure to family planning message is lowest in Caraga region with 17 percent and highest in ARMM with 62 percent.

The continued increase in the reach of television and associated growth in viewing has the potential to act as a driver of improved reproductive behaviors and a has potential to influence other behaviors relevant to emerging health threats. Television

**Table 5. Sociocultural Profiles of the Respondents along Access to Media**

| Media | Frequency | Percentage |
|---|---|---|
| Radio | 986 | 26.37 |
| | | |
| Television | 1568 | 41.94 |
| | | |
| Facebook | 752 | 20.11 |
| | | |
| Twitter | 14 | 0.37 |
| | | |

| Messenger | 419 | 11.21 |
|---|---|---|
| | | |
| Total | 3739 | 100.00 |
| | | |

watching is expected to influence health behavior through exposure to sponsored health programs and health reporting among others (Rahman, 2017).

Meanwhile, Table 6 on page 57 shows the sociocultural profile of the respondents along health-seeking behavior specifically, the first thing they do when health problems arise. It can be gleaned that 37.93 percent of the respondents seek the advice of the physician when there are health issues. Self-medication obtained 27.81 percent followed by 24.90 percent of the respondents who seek the help of public health nurses or midwives.

Clinic visit depends on the severity of the signs and symptoms of the disease felt by the respondents. They tend to go and see a doctor if it's worst and do self-medication if tolerable. These behaviors can be attributed to some personal concerns such as low motivation, laziness, and lack of self-discipline. Lack of resources such as money, time, support groups, and social factors like unemployment and long waiting hours contributes as well not to seek the advice of medical professionals during sickness (Maneze, et al, 2015).

Meanwhile, the most important attribute in terms of health-seeking behavior is the physician's experience. Clients tend to seek health care from expert practitioners who provide full information regarding illness (De Guzman, 2014). The health-seeking behaviors were determined by need factors including disease status and having poor health perception and by enabling factors such as education, income, insurance status and ability to pay by oneself (Abuduxike, 2020).

**Table 6.** ***Sociocultural Profiles of the Respondents along Health-Seeking Behavior (First thing to do when health problems arise)***

| First thing to do when health problems arise | Frequency | Percentage |
|---|---|---|
| 1. Consult a physician | 1671 | 37.93 |
| | | |
| 2. Consult a pharmacist at pharmacy outlet | 192 | 4.36 |
| | | |
| 3. Consult an "albularyo" | 220 | 4.99 |
| | | |
| 4. Consult nurses or midwives | 1097 | 24.90 |
| | | |
| 5. Self-medication | 1225 | 27.81 |
| | | |
| Total | 4405 | 100 |

In terms of medication-taking behavior, it can be seen in Table 7 on page 58 that 43.14 percent of the respondents have it based on physicians advise. Some 29.56 percent have medications based on their experience to similar illnesses, and at least 27.30 percent of the respondents based it from information

obtained from relatives, friends, and the media. The consumption of medicines depend mainly on the extent of
severity of discomfort that the patient experience. For major illness, people tend to seek professional's advice. There are several medicines which they can not avail without doctor's order or prescription. This will push them to have clinic visits and avail the service of a physician. For mild symptoms or discomfort, some people rely on their personal experience with similar illnesses or seek advice from other people such as their close relatives who have experienced same illness it in the past, close friends, and even an information that they can simply get online. For people who have access to computers and internet at home, they are more knowledgeable in searching for information online which can basically affect their health-seeking behavior.

**Table 7. Sociocultural Profiles of the Respondents along Health-Seeking Behavior(Medicine-taking Behavior)**

| Medicine-taking behavior | Frequency | Percentage |
|---|---|---|
| 1. Based on doctor's advice | 1836 | 43.14 |
| | | |
| 2. Based on experience with similar illnesses | 1258 | 29.56 |
| | | |
| 3. Based on advice from relatives, friends, & media | 1162 | 27.30 |
| | | |
| Total | 4256 | 100 |

The choice not to consult a physician because of time, money, and other forms of inconveniences they may experience during hospital visits promotes irresponsible self-medication which is harmful in the body of the patient.

It can be gleaned in Table 8 on page 59 that 61.58 percent of the respondents had self-medication for their illness more than twice. This was followed by 23.82 percent who reported that they had it twice and 14.25 percent experienced it once. Meanwhile, 0.36 percent of them reported no experience for such action. Iloka (2018) mentioned that people take medications without a doctor's prescription for a variety of reasons. While some people want to cut down on the time and cost of clinical consultations, others just trivialized illness and self-medicate. Other considerations could include personal concerns and the fear of losing a job because of a diagnosed condition, mental illness, pain alleviation, or even ignorance.

Potential risk for irresponsible self-medication practices includes incorrect self-diagnosis, delays in seeking medical advice when needed, infrequent but severe adverse reactions, dangerous drug interactions, incorrect manner of administration,

**Table 8. Sociocultural Profiles of the Respondents along Health-Seeking Behavio (Prevalence of Self-medication)**

| Prevalence of self-medication | Frequency | Percentage |
|---|---|---|
| Once | 320 | 14.25 |
| | | |
| Twice | 535 | 23.82 |
| | | |

| More than twice | 1383 | 61.58 |
|---|---|---|
| | | |
| None | 8 | 0.36 |
| | | |
| Total | 2246 | 100 |

incorrect dosage, incorrect choice of therapy, masking of a severe disease and risk of dependence and abuse (Jeneta and Priya, 2018). With this, educating the people about the dangers of self-medication is crucial to always ensure safety and health. The role of health care providers as agent of change in modifying this dangerous behavior is critical.

It was shown in Table 9 on page 60 the sociocultural profiles of the respondents along pregnancy and birth practices/ beliefs. It can be seen in the table that 19.52 percent of the respondents believe and did walking during labor to facilitate descent of the fetus' head. This belief was followed by 14.57 percent where there is a need for the woman to rest while the relatives will do all the house works and cooking after giving birth. Next is the belief of binding the abdomen tightly as it helps to prevent bleeding and helps the uterus to retract, with 14.56 percent of the respondents have done and believed this practice.

According to Bellefonds and Payson (2020), the simple act of walking during pregnancy may help draw the baby down into the pelvis because of gravity and the swaying of hips. The pressure of the baby on the pelvis may then prime the cervix for

**Table 9. Sociocultural Profiles of the Respondents along Pregnancy and Birth Practices/ Beliefs**

| Indicators | Frequency | Percentage |
|---|---|---|
| 1. Walk during labor to facilitate descent of the fetus' head | 2009 | 19.52 |
| 2. Cravings for food during pregnancy should be satisfied. | 1003 | 9.75 |
| 3. Drinking coconut water can facilitate a fast labor. | 489 | 4.75 |
| 4. Putting squash leaves on the abdomen of a laboring woman can facilitate labor. | 197 | 1.91 |
| 5. Women should not bathe for about ten days after giving birth. | 1083 | 10.52 |
| 6. Bathing after giving birth is seen as a cause of ill health and rheumatism in old age. | 601 | 5.84 |
| 7. Woman usually rests while her relatives do all the housework and cooking after giving birth. | 1500 | 14.57 |
| 8. Women may be massaged with coconut oil, with the aim of restoring their lost health, expelling blood clots from the uterus, returning the uterus into a normal position, and promoting lactation. | 1445 | 14.04 |
| 9. Bind abdomen tightly, believing that this practice helps to prevent bleeding and helps the uterus to retract. | 1499 | 14.56 |
| 10. Women wear heavy clothes or wrap themselves in blankets to prevent exposure to ‘cold’ and ‘wind’. | 466 | 4.53 |
| Total | 10, 292 | 100 |

labor or may help labor progress if the mother already felt some contractions. Women who are upright and moving around during labor typically have shorter labors, report less pain and receive less intervention (Weiss & Levine, 2020). With the very stressful and tiring experience of birth and delivery, recovery takes

several months. The mother needs a lot of rest. But as soon as they're comfortable after a difficult delivery, they need to get up and walk around. This is important in decreasing the risk of blood clots. Family can help by taking on the cooking and cleaning responsibilities in the home for several weeks (Jones, 2018). As far as wrapping of the abdomen is concerned, it promotes uterine healing and prevent bleeding. According to Rasminsky (2018), it takes approximately six weeks for this organ to shrink back to its original size. Abdominal binding can speed this process along by compressing the organ into place and increasing blood flow. Putting pessure to the affected area reduces soreness, inflammation, and increase range of motion. Wallis and Garcia (2020) mentioned that the use of abdominal binders will let the woman experience less pain, bleeding, and discomfort. It provides support to the pelvic floor and offers gentle compression that holds muscle and ligaments safely in place as the body heals.

Some 14.04 percent of the respondents believed and practiced the use of coconut oil to massage the mother after delivery with the aim of restoring their lost health, expelling blood clots from the uterus, returning the uterus into a normal position, and promoting lactation. The claim was supported by Aparna and Sonpal (2017), who enumerated several benefits of doing massage post-delivery. It includes the help in the recovery of the uterus, reduction of swelling, improves breastfeeding, reduction of blocks and lumps formation in the breast, reduction of stress, improves stability, posture, and co-ordination, speeds up recuperation, helps in dealing with postpartum blues, and helps in the return of the pre-pregnancy body.

The belief for the women not to bathe for about ten days after giving birth was supported by 10.52 percent of the respondents. Contrary to this, Palacpac (2020), emphasized that women want to be fresh and clean when they cradle the baby and start taking care of them. Washing up from all the postpartum bleeding is an important thing that must be done. Women who have vaginal births are safe to take a bath right away after they deliver their babies. Warm baths can ease the feeling of soreness after giving birth (Mazel, 2020). However, if the mother has an episiotomy (a surgical incision in your vagina) or if the mother has a tear during the birthing process that needs to heal, the doctor may advise to wait 24 hours before going under the shower and to take necessary precautions to avoid risking any complications (Jacobson, 2020). Sitz bath are effective in treating hemorrhoids. These baths consist of sitting in a bath of salty, warm water and may alleviate the discomfort and help ease the pain for those who need to wait for their vaginal stitches to heal (Nall, 2018). Quick showers are the safest way to take baths. Bubble baths and hot tubs are prohibited because soaking with these might cause infection that may infect your still healing wounds (Wilson, 2020). If the mother gave birth through a cesarian section, she will most likely be advised to wait until the wounds heal before taking a full bath (Wallis, 2020).

Satisfaction of food cravings during pregnancy obtained 9.75 percent. The source of this phenomenon is unknown, but health experts relate it to hormonal changes, heightened sense of smell and taste, and nutritional deficiencies during pregnancy (Dragon, 2016; Warwick, 2020). Meanwhile, there are number of foods that should be avoided during pregnancy. Things like soft cheeses, raw eggs and undercooked meat can contain harmful bacteria, including salmonella and E. coli. and lead to harmful illnesses such as listeria or toxoplasmosis (Dieticians Association of Australia, 2019).

It was reflected in Table 10 on page 63 the sociocultural profile of the respondents along superstitious beliefs. A 20.52 percent of the respondents believe that women must not stay under the rain, and not to take in cold drinks after giving birth to avoid chilling. People usually suggest drinking warm water and beverages after delivery

**Table 10. Sociocultural Profiles of the Respondents along Superstitious Beliefs**

| Indicators | Frequency | Percentage |
|---|---|---|
| 1. Pregnant will deliver a baby boy if her fetus has fast heartbeat. | 261 | 4.12 |
| 2. Do not hide pregnancy to avoid abnormalities. | 334 | 5.28 |
| 3. Avoid eating black foods to avoid the birth of an infant with a dark skin tone. | 529 | 8.36 |
| 4. Newborns must have a rosary beside them when they are left by the mother alone. | 933 | 14.74 |
| 5. Mother's mood can be transmitted through breast milk and therefore do not feed if they feel sorrow or anger. | 219 | 3.46 |
| 6. Do not attend to funerals or look to dead to avoid fetus' death. | 600 | 9.48 |
| 7. Let the husband burry the placenta to end labor pains and bleeding. | 1299 | 20.52 |
| 8. Must not stay under the rain, and not to take in cold drinks after giving birth so that she will not get easily chill. | 1314 | 20.76 |
| 9. A woman in labor should prohibit guest/s to stand near or at the door and at the stairs to prevent complications in labor. | 102 | 1.61 |
| 10. Being tidy and beautiful, believing that these practices will influence the beauty of their child. | 740 | 11.69 |
| Total | 6331 | 100 |

in the line of belief that it helps a new mother heal quickly and to avoid chills. Anjum and Nair (2020) mentioned that there is no sufficient evidence to support this claim. While warm water is good to drink and women can often indulge in it during cold temperatures, there are some who are unable to do so, especially when they live in areas with warm temperatures. This ends up being a problem because their water intake starts reducing. Drinking cold water after giving birth is believed to cause colds and prevent the shrinking of the womb, but there is no study to confirm the same. Water irrespective of its temperature is essential for breastfeeding mother as the body needs lots of fluids for proper production of breast milk (Roth, 2021). Having adequate breast milk is essential for the proper growth and development of the baby. Meanwhile, 20.52 percent of the respondents believe in letting the husband burry the placenta to end labor pains and bleeding. This is one of the long-standing superstitious beliefs among Filipinos, but found of no significance and scientific evidence to prove the claim. In the current clinical practice, Smith (2018) mentioned that post-partum pains are managed with pharmacologic therapy and some relaxation and breathing techniques, perineal exercises, and breastfeeding. In terms of the management of post-partum bleeding, Fontaine (2017) highlighted the importance of initiation of fluid resuscitation with intravenous fluids, promotion of uterine contraction through massage and medication administration, and manual removal of placental fragments that can possibly cause bleeding. Other superstitious beliefs mentioned in the table does not have any scientific evidence to prove the claims.

**Level of Awareness on Reproductive Health Services**

It was shown in Table 11 on page 65 the level of awareness of the respondents to the reproductive health services per municipality. It can be seen that residents from the Municipalities of Pugo, Santol, and San

Fernando were **very highly aware** of the RH services with computed means of 4. 22, and 4.21, respectively. Meanwhile, Bagulin had the lowest with 3.58 but still interpreted as **highly aware.** The results of the study denotes a commendable performance of the local government units in informing the people about the salient aspects of reproductive health services which affects their decision in the utilization of the services.

In support to the results of the study, records from the Provincial Government of La Union showed that they met the national target as far as family planning services are concern. The Provincial Health Office of La Union (2020) showed a total of 72, 751 residents are currently using contraceptives services as of December 2020. Of the twenty local government units, the City of San Fernando recorded the highest number of users

with 12, 806 residents currently using the services. This was followed by Agoo with 6841, Bauang with 6152, Rosario with 5810, and Naguilian with 4825. The municipalities of Santol, Bagulin, and Burgos ranked 18th to 20th with 1176 users, 1080 users, and 706 users, respectively. Meanwhile, the City of San Fernando ranked first recording 52.86 percent of the eligible population currently taking oral contraceptive pills. This was followed by Naguilian with 46.82 percent, Agoo with 32.60 percent, Rosario with 37.28 percent, and Bauang with 3472 percent. The municipalities of Bagulin, Sudipen, and Burgos ranked the lowest with 30.00 percent, 29.45 percent, and 28.47 percent respectively placing 18th to 20th spots in the ranking.

**Table 11. Level of Awareness of Reproductive Health Services per Municipality**

| Municipality | Mean | DI |
|---|---|---|
| Santol | 4.21 | VHA |
| San Gabriel | 3.65 | HA |
| San Fernando | 4.21 | VHA |
| Burgos | 3.79 | HA |
| Bagulin | 3.58 | HA |
| Tubao | 4.07 | HA |
| Pugo | 4.22 | VHA |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

Table 12 on page 67 shows the level of awareness on RH services along family planning information and services. The respondents are **highly aware** of this aspect as evidence by 3.88 computed grand mean. This awareness is because of the reinforced mandate of the Department of Health along family planning to curb the rapidly growing population of the country. Several information about family planning services is available in broadcast and print media which aided in the high awareness of the respondents. It was mentioned by Melaku (2014), that awareness of sexual and reproductive health issues, especially contraception methods, is a critical step towards obtaining and using a suitable contraceptive method in a timely and effective manner. Unwanted pregnancy, unsafe abortion, teenage delivery, childbearing, school dropout, and other complications, including death, are all risks those teenagers face due to a lack of knowledge about contraceptive methods and use. Knowledge regarding family planning programs is hampered by a slew of serious issues. The lack of primary health care services restricts access to education and clinical counseling. It is important to think of family planning clinics as a source of high-quality family

planning services (Alenezi, 2021). Education continued to be a key factor in raising awareness and usage, indicating the need for a more comprehensive multi-sector approach in addressing family planning needs (Cammock, 2018).

The **very high awareness** on oral contraceptive pills registered a weighted mean of 4.21. It can be associated with the fact that it is the most widely used methods of contraception due to is convenience and accessibility without the need for doctor's prescription. Several studies indicate that making it over the counter would lead to

**Table 12. Level of Awareness along Family Planning Information and Services**

| INDICATORS | Level of Awareness | |
|---|---|---|
| | WM | DI |
| 1. Healthcare workers provide information on birth spacing or gap to ensure healthy population. | 4.30 | VHA |
| 2. The facility advocates the use of the following birth control products and services for low or no cost. a. oral contraceptive pills | 4.21 | VHA |
| b. Depo Shot | 4.03 | HA |
| c. Patch (Ortho Evra) | 3.43 | HA |
| d. Vaginal Ring (NuvaRing) | 3.37 | MA |
| e. Intrauterine device (Mirena/ Paraguard) | 3.43 | HA |
| f. Implant (Implanon/Nexplanon) | 3.80 | HA |
| g. Male and female condoms | 4.05 | HA |
| h. Vasectomy "snip-snip" | 3.87 | HA |
| i. Tubal Ligation "tubes tied" | 4.01 | HA |
| j. Hysterectomy (removal of womb) | 3.43 | HA |
| 3. Healthcare workers give information on natural family planning methods such as: a. Sympto-Thermal Method/ Body Temperature | 4.00 | HA |
| b. Standard days method | 3.88 | HA |
| c. Lactational amenorrhea method | 3.81 | HA |
| d. Abstinence (no sex) | 3.90 | HA |
| e. Calendar method | 3.93 | HA |
| 4. Health care workers monitor the strict compliance of family planning method use (i.e., injectables, pills). | 4.25 | VHA |
| 5. Health care workers regularly conduct client education focusing on the benefits and risk of FP products and services. | 4.13 | HA |
| Grand Mean | 3.88 | HA |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

greater use of effective birth control and lower rates of unintended pregnancy (Ibis Reproductive Health, 2015). Educational programs can help people gain a better understanding of the various contraceptive

options available, allowing them to make more informed choices and use contraceptives more effectively (Mahamed, 2012). The proper and consistent use of contraceptives demonstrates the value of contraceptive education. Contraceptive efficacy is one of the most important factors to consider. Better awareness of contraceptive efficacy is linked to higher adoption rates. Inadequate contraception awareness, on the other hand, is linked to erroneous views of the dangers and side effects of contraceptive usage, as well as, inaccurate or inconsistent use and procedure discontinuation (Pazol, 2016).

The moderate awareness on vaginal rings recorded a weighted mean of 3.37. Vaginal ring needs physician's prescription and less convenient for use among the women population. With this, less people are aware of it leading to low levels of utilization in this contraceptive method. Vargas (2019) mentioned that familiarity with the ring is low, and women commonly had initial concerns about the method often related to insertion and removal, cleanliness, and discomfort with touching their vagina. This unfamiliarity may have contributed to some of the problems, such as its unusual usage and the fact that there was less knowledge available for the ring than for more well-known methods like the pill. In terms of hysterectomy, the level of awareness registered to be 3.43 described as **highly aware.** For some eligible clients, the lack of knowledge on the possible age to conduct the procedure, the type of facility where the operation will be performed, and the reasons for hysterectomy were major limitations (Shekhar, 2019).

During the interview, respondents were asked how were they informed of the services available in the healh care facility. One of them uttered, *"Umay da agibaga nga adda ijay health center .. ngem dagijay piman han nga mapan .. umay da met ag house to house … apan kami ta umay da met ibaga .. iremind da met nga un-una .. ti schedule .. adda kastoy nga mapasamak .. umay kayo … kastoy nga aldaw". (*They will come and inform us that there will be available services in the health center, but for those who can not come, they will conduct house- to- house visits inform them to come on a particular day). Also, some of the participants mentioned that there were information drives that were organized by the health center in which they participated. They claimed, *"Um-umay da ah agpapaseminar ditoy .. agpaayab da ijay barangay hall".* (They will come and facilitate seminars and they will ask people to go to the barangay hall). Another mentioned, *"Adda met ah ti im-immay idin nga nagle-lecture ijay barangay hall .. han met nga kanayon .. kasla mamin tallo lang makatawen".* (There were those who came and gave lectures at the barangay hall, it is not always but it is just like three time in a year". Seminars were conducted to let the people know about their programs most especially on the facet of family planning services. This gives an idea to the people as to what type of family planning methods they will avail. One of them voiced out, "*Adda metten dagijay im-immay idi from munisipyo .. nagdidiscuss .. maawatan mi met .. ngem adda latta kenka nga agpili nu anya kayat mo kadagijay nga usaren".* (There were those who came from the town hall, they discussed, we understood, but still it is up to you which contraceptive do you want or prefer to use).

The claim was supported by the community leaders when asked during the phone interview. One of them were quoted saying, *"Ipaseminar damet dagita .. karkaro dagijay 4Ps .. tinawen data nga adda latta umay ag explain .. ipalaw lawag da .. agpaayab da .. ditoy ngay barangay hall".* (They will conduct seminars, especially those "Pantawid Pamilyang Pilipino Program" members, that is a yearly activity where they will explain and will englighten the people, they will call them in the barangay hall). Community leaders even claimed that participation of 4Ps beneficiaries in these programs are mandatory or else they will not receive their monthly financial assistance from the government. This is their way of encouraging the people to actively participate in the government's initiative to reproductive heatlth services intended for them. A health worker during the phone interview agreed also with this claim of other interviewees.

According to her, *"Usually agcoconduct da met ti information drive regarding FP .. isabsabay da ti sabali nga programs .. nu adda met lang information drives da .. narigat gamin ag gather ti tao .. maymaysaen min amin .. nu dadduma maisali mi met nu adda marriage counseling"*. "Usually, they will conduct information drives regarding FP, they will do it simutaneously with other programs, if there are also information drives, it is very difficult to gather people. We will do it at once, sometimes it can be incorporated in the marriage counseling).

The interviewee even mentioned that multiple services are given in one encounter with the residents due to budgetary concerns and to ease the difficulty of mass gathering because of distance to the facility and hectic schedule of the residents since most of them are busy working in farmlands just to earn a living. She said, *"Usually agcoconduct da met ti information drive regarding FP .. isabsabay da ti sabali nga programs .. nu adda met lang information drives da .. narigat gamin ag gather ti tao .. maymaysaen min amin .. nu dadduma maisali mi met nu adda marriage counseling .. example .. tatta kuma ta ti focus ket COVID-19 vaccinations .. nu agpameeting ka mi ti barangays ah ket agsasabay aminen dagijayen .. tapno mas minimize ti panagayab ti tattao .. adda met gamin pay budget considerations na .. mainayunen sabali nga programs.* (Usually if they will conduct information drives, they will do it simultaneously with other programs if they will also have the same. It is very diffcult to other people, we will have it as one and sometimes it can be added to marriage counseling. For example, now that we have COVID-19 vaccinations, when we will have meetings with the barangays, everything will be done simultaneously to minimize the contacts to people and also budget considerations are taken into account and it will be added to other programs).

While on Table 13 on page 72 shows the level of awareness on reproductive health services along maternal, infant, and child health and nutrition. The grand mean is 4.17 described as **highly aware.** The results can be attributed to the fact that majority of the services available nowadays in the health care facilities are geared towards the care of maternal and child and is a flagship program of the Department of Health in the community setting. Thus, people are knowledgeable about these services that they can obtain in the nearest facility. Meanwhile, community health workers such as public health nurses and rural health midwives with the help of barangay health workers are delivering some services per household just to make sure that target population such as mother and children are receiving the services expected of them. This results to familiarity of the services provided to the people by the government. The "No Home Delivery Policy" obtained a weighted mean of 4.39 described as **very highly aware.** The results implied that people are knowledgeable about the mandate of the government to avoid the usual practice of giving birth at home to ensure safe delivery. With this, immediate concerns of both the mother and child will be catered preventing any possible complications that may arise post-delivery. According to

**Table 13. Level of Awareness along Maternal, Infant and Child Health and Nutrition**

| INDICATORS | Level of Awareness | |
|---|---|---|
| | WM | DI |
| 1. The facility conducts pregnancy testing service to the clients. | 4.20 | VHA |
| 2. The facility offers gynecologic examinations to mothers. | 3.44 | HA |
| 3. The facility conducts pap smear and pelvic exam. | 3.68 | HA |
| 4. The facility conducts prenatal, and postnatal care. | 4.19 | HA |

| | | |
|---|---|---|
| 5. Healthcare workers regularly conducts home visit for pregnant and their children. | 4.05 | HA |
| 6. The facility advocates "No Home Delivery" policy of the government. | 4.39 | VHA |
| 7. The facility provides anemia testing regularly for pregnant women. | 4.10 | HA |
| 8. The facility provides routine prenatal test such as complete blood. count, hepatitis screening, and urinalysis. | 4.11 | HA |
| 9. The facility gives full dose of iron supplement to pregnant women. | 4.14 | HA |
| 10. Health care workers advocate exclusive breastfeeding. | 3.88 | HA |
| 11. The facility has a conducive breastfeeding room. | 3.77 | HA |
| 12. Health care workers provide nutrition counseling. | 4.23 | VHA |
| 13. The facility provides vitamin A supplementation to infants. | 4.38 | VHA |
| 14. Health care workers provide basic oral health care to children. | 3.80 | HA |
| 15. The facility conducts deworming of the children. | 4.43 | VHA |
| 16. The facility provides regular child immunization services like a. Hepatitis A vaccine | 4.39 | VHA |
| b. Hepatitis B vaccine | 4.40 | VHA |
| c. Diphtheria, tetanus, and pertussis vaccine (Anti tetanus, whooping cough, and diptheria) | 4.44 | VHA |
| d. Haemophilus influenzae type b vaccine (Anti pneumonia, meningitis, bone infection) | 4.37 | VHA |
| e. Oral Polio vaccine 1, 2, 3 (Anti polio) | 4.45 | VHA |
| f. Pneumococcal conjugate vaccine 1, 2, 3 (Anti pneumonia and meningitis) | 4.42 | VHA |
| g. Rotavirus vaccine 1, 2 (Anti severe diarrhea disease) | 4.32 | VHA |
| h. Influenza vaccine (Anti Flu) | 4.40 | VHA |
| i. Mumps, measles, and rubella vaccine | 4.43 | VHA |
| j. Varicella (Chikenpox) vaccine | 4.32 | VHA |
| k. Meningococcal conjugate vaccine (Antimeningococcal disease) | 3.57 | HA |
| l. Human papilloma virus vaccine (Anti cervical cancer) | 4.13 | HA |
| m. Japanese encephalitis vaccine (Anti brain inflammation) | 3.87 | HA |
| n. Bacille Calmette-Guérin (BCG) vaccine (Anti tuberculosis) | 4.18 | HA |
| o. Pentavalent Vaccine 1, 2, 3 (Anti diphtheria, pertussis, tetanus, and hepatitis B and Haemophilus influenzae type b) | 4.28 | VHA |
| p. Anti-measles vaccine | 4.44 | VHA |
| Grand Mean | 4.17 | HA |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

Perez (2019), the Department of Health issued an administrative order banning the delivery of babies at home to promote maternal health and to curb neonatal death. With this, the freedom given to the different Local Government Units to craft ordinances are consistent to fully implement the order. The health office of each municipality and cities were task to monitor citizen's compliance to ensure maternal and child

health. And thus, majority of the people are aware of it and is complying with it.

But despite strengthening maternal health services and facilities to reduce maternal deaths in the Philippines, majority of mothers in Eastern and Western Maguindanao still gave birth at home with the help of traditional birth attendants, locally known as "*hilot*". One major factor is the internal displacement of some respondents, wherein mothers are forced to leave their places due to armed conflicts or floods, leading to less access on health facilities and services (Philippine Council for Health Research and Development, n.d).

On the area of maternal, infant, and child care, participants duirng the interview, all agreed that the manner of information dissemination and provision of services to the target population were the mobilization of the barangay health workers and officials. One of the interviewees mentioned, *"May mga time din naman na nagbabahay bahay sila .. may time din na kami yung pumupunta sa center .. after 6 months .. 9 months ganon".* "There were times that they conduct house -to- house visits and there were also times were we personally visit the center, after 6 months or 9 months like that). This was supported by another participant when she said, *"Ischedule da ah ijay center .. iyumay mi dagijay ubbing .. nu dadduma ibalay balay da .. para dagijay han nga makaumay".* (The center will set a schedule, we will bring the kids but sometimes, they will have it house- to- house visits for those who can not come). Indeed, this action and initiative of the health care providers in close coordination with the officials of the barangay are beneficial and contributed a lot in the high awareness and practice of the services along this area.

As far as deworming is concerned, the very high level of awareness of the respondents recorded to have a weighted mean of 4.43. The results can be associated with the strong partnership between the departments of education and health were the two agencies take a lead in informing the public about the importance of children undergoing deworming and thus, contributes to the acceptance and eventual utilization of the service. This is due to the belief of the government that, "healthy learners are better learners". Providing awareness about deworming to the school community aids in the people's understanding of the importance of the practice. Parents and guardians will ideally be encouraged to get their children dewormed because of increased awareness. It was reported that the deworming campaign's success in the year 2016 was tremendous and remarkable (Briones, 2018).

Generally, the respondents are highly aware of the several vaccines given to the clientele. These results are due to the reinforced activity of the Department of Health on Expanded Program for Immunizations. Vaccines are given to children on a scheduled basis in the health care facilities. In cases of geographically isolated places, public health workers are giving it at the comfort of the clients' home. Part of the activity is health education of the parents and the children on the advantages and disadvantages of these vaccines, and the correct schedules that they must follow for such. Given these, clients will have the chance to clarify things with the health care providers to correct misinformation. The Center for Disease Control and Prevention, which sponsors National Immunization Awareness Month, released vaccination schedules and frequently asked questions about vaccine safety to increase vaccine awareness (Swamy, 2018).

Contrary to the results generated using survey questionnaires, some of the participants during the interview brought out issues on the administration of immunization services . They claimed that their children completed the services but lack specific information deem necessary to be shared to them regarding the nature of vaccines given to their children. One of the interviewee stated, *"Basta na itudok da lattan .. "anya ngay data?" .. ibaga da lattan ah ket .. "BCG" .. syempre han mo met salsalud sudenen nu anya data BCG .. proteksyon ti anak .. kun kunada lattan .. nu mealses ket .. para kamuras .. kun kunada latta*

*metten ahh". (*They will just give the vaccine and tell us that it is BCG, for the protection of their kids if we try to ask them. If the vaccine is for measles, they will say its for measles).

This was supported by the other two participants. One of them stressed, "*Han da metten sinaggaysa .. basta BCG , DPT, hepa .. kunkuna da lattan ah .. han met nga individual nga datoy .. para kastoy .. para ijay .. han nga kasjay … basta proteksyon .. para ubbing nu adda an annayen na".* (They did not explain one by one each vaccine to be given like BCG, DPT, hepatitis vaccines, they will just say it is for protection, for their children if they have complaints). Also, one of them mentioned, *"Jay dadduma lang ah .. ta kunada met ket .. ma-immune kano .. kadawihan gamin ditoy .. ta nu bakuna ditoy ket .. ta nu uray sikami idi ubbing kami .. proteksyon kunana da met lattan .. patudukan mi lattan".* (For some, they will just say it is for immunity, but it is a common thing here, because even when we are children, they will just say it is for protection so we will just let them give it).

Because of these things happening, it resulted to limited knowledge of the parents on the matters concerning the immunization of their children. One mother pointed out, *"Yung mga bakuna .. basta tinusok nalang .. 9 months na yang anak mo .. ito yung ibibigay .. di naman masyado ine-explain .. kompleto pero diko matandaan kung ano yung mga yun".* (Those vaccines will just be given especially if your child is 9 months old. They will just give it and they do not explain further and I can not remember what those vaccines for).

One of them even emphasized that it is more important to complete the immunization services, disregarding the information that are given to them. She claimed, "*Kumpleto ti bakuna da .. ta adda met record .. adda met jay pang measles .. tapos .. han kon ammo amin .. (laugh) … idiscuss da met bassit piman .. ken han mo metla maw-awatan .. ken mysa .. dimmet kayat surwen .. ibagbaga da man .. ngem han nga agsink-in .. ti importante malpas ko .. makompleto".* (The immunizations are complete for we have the record. We have for measles, then I do not know the others, but they will discuss it somehow and still we cannot understand for we do not want to know about it, bu the most important thing is our children can complete the vaccines). A mother also realized her mistake on this issue, she shared, *"Han ko ammo dagita .. han ko sure .. nu dakami met lang .. part mi diyay .. mistake mi met lang .. kase .. kasla awan pakiaalam nu anya dagijay iinject .. ti ammo mi lang mayat .. makompleto .. protection".* (I do not know those vaccines and I am not sure for what it is, but it is our part and also our fault because we do not care what those injections are for. The only thing we know is that, it is to complete the vaccination record for the protection of the children).

Even their partners, all of them agreed that the father of their children have little to no knowledge and participation in the immunization of their children. One of them verbalized, *"Awan ah ti ammo ni lakay ko kadagita ahh .. karkaro pay .. awan ta han met nga suda ti agkadwa-kadwa". (*Our husband does not know anything about it because they are not the ones accompanying our children). These issues that were brought out by the participants clearly shows the need to reinforce information dissemination along areas of child immunization to enhance the communities' awareness on this aspect of reproductive health care. The level of practice seem to be high but has a discrepancy as to the level of awareness that the community people have. A lot of them subjected their children to the service but has a narrow and limited understanding about the nature, benefts, and risk of receiving these essential vaccines.

In congruence with the data gathered during the interview, Jailani and Verulava (2019) concluded that the mother's lack of information about immunization yields to incomplete immunization along with limited awareness about the second and the third dose of vaccination, and it is also related to fear of child getting sick after the vaccination. Some parents believe that vaccination is not safe and can cause serious side

effects. Majority of them have a positive attitude towards child immunization, but their levels of awareness are very low and they do not have comprehensive information about a routine vaccination schedule. The necessity to raise public awareness on the importance of immunization by implementing educational programs and by traditional and social media is imperative. Even in the presence of maternal illiteracy, educating mothers about the vaccines and vaccine preventable diseases may be highly effective in increasing the immunization coverage (Fadda, 2017).
The level of awareness along adolescent and youth RH education and counseling Table 14 on page 79. It can be gleaned from the table that the computed grand mean is 3.68 described as **highly aware.** The lack of awareness for some people along this area is associated with the fact that sexual and reproductive health is still considered a taboo in the society. The morals, values and beliefs people have been a result of their upbringing, interwoven with a rich tapestry of family and societal expectations (Ivankovich, 2018).
The level of awareness can also be affected by strong cultural beliefs. According to Reece (2020), people have learned that sex and reproductive health are not natural topics, and it should not be discussed with others and that it needs to keep a cone of privacy around them. This results to the difficulty on the part of the health care providers to educate the people because they are unreceptive to information shared to them. Also, the lack of responsiveness of educational programs and activities on the needs of young people in these areas as well as inadequate training of teachers in the field, are among the reasons for lack of awareness among adolescents on RH and family planning issues (Masood, 2017).

**Table 14. Level of Awareness along Adolescent and Youth RH Education and Counseling**

| INDICATORS | Level of Awareness | |
|---|---|---|
| | WM | DI |
| 1. The facility provides informational and/or audiovisual materials on RH services and concerns of youth clients. | 3.41 | HA |
| 2. The facility has counseling and examination rooms to ensure privacy for youth clients. | 3.73 | HA |
| 3. Education materials are available, printed and displayed for the youth clients. | 3.72 | HA |
| 4. The facility has available counseling and/or mental health services. | 3.83 | HA |
| 5. Information campaign materials are distributed to the barrios' health centers for adolescent and youth information. | 3.56 | HA |
| 6. Health personnel provides referral information for obtaining services. | 3.87 | HA |
| 7. Health care workers conduct parent education sessions among parents of adolescents. | 3.87 | HA |
| 8. The facility provides psychosocial risk assessment and management. | 3.45 | HA |
| Grand Mean | 3.68 | HA |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

The conduct of parent education sessions among parents of adolescents obtained a weighted mean of 3.87 described as highly aware. For some parents, they may be unable to communicate about these issues due to shame, inaccurate awareness, low self-efficacy, religious and cultural values opposing comprehensive reproductive and sexual health education, and parental underestimation of their child's sexual conduct. Adolescents also have mixed feelings about participating in related activities with their parents, citing awkwardness, generational gaps, and relationship issues as major barriers. Many young people are reluctant to initiate discussions that could cause their parents to believe they are having sex, and some parents are concerned that discussing these subjects would promote sexual behavior (Aventin & Gough, 2020).

Both children and adolescents need accurate RH education to learn how to practice safe sexual activity in the long run. Unhealthy, exploitative, or dangerous sexual behavior can contribute to a variety of health and social issues, including unintended pregnancy and sexually transmitted infections (Breuner, 2016). Meanwhile, adolescents find the new healthcare system less attractive. There is a lack of privacy in most of the programs, and there are few qualified health professionals who can provide reliable adolescent-friendly services. Age-appropriate materials are needed. A corner or room in a health facility dedicated to adolescent health should be designated (Atuyambe, 2015).

It was emphasized by Wingate (2020) that reproductive health programs tailored to the needs of young people perform significantly better. Counseling specifically targeted at young people to promote behavior change is more successful. Also, since many adults have such a strong influence, authority, and control over the lives of young people, involving various stakeholders such as parents, health professionals, and community leaders is critical in preventing problems for young people.

During the interview, some of the respondents claimed lack of information along this area and mentioned that the services of the rural health center focused only on maternal and child care. During the interview, one of the participants said, "*Yung sa mga kabataan .. ganon .. di ko pa naexperience na may seminar ng mga ganyan dito .. ewan ko lang dun sa iba .. yung malapit sa center .. yung doktor kung nag gaganon sila don".* (For the youth, I have not experienced any seminar like those in our place. I just do not know with the others for those who are close to the center and if the doctor is giving those services). This was supported by other two participants, one voiced out, *"Awan met .. anya ngay kuma .. kaadwan met ket para nanang .. kabayag ko ditoyen .. awan ti kakasta".* (There are no seminars given because majority of the services are for mothers only for the longest time that I was here). And the other said, *"Naka focus da lang gamin ti sikog .. kay yanak .. ubbing .. awan met madamdamag mi para dagita barito ken balasang .. awan pay naencounter ko nga kakasta". (*They are just focused on the pregnant women, newborn, children. I have not heard any seminars extended for the young men and women .. I have not encountered any that concerns them).

Some others claimed that information dissemination happened in the schools and not in the barangays. Two participants reiterated, "*Awan met .. wala .. awan met .. sa iskul lang .. sa barangay .. awan met malagip ko sir".* (No information dissemination took place in the barangay as far as I can remember, maybe in the schools). It was supported by another, she said, *"Awan met ditoy barangay ti kakasta .. adda lang met immay naminsan idi .. ngem ijay ah iskwelaan .. ijay da aglecture .. han nga barangay .. ta ditoy ket maypanggep lang ah ti drugs-drugs kasjay".* (We do not have like those here in our barangay, but in the school where once they had a lecture there but not in the barangay. What they had here before were topics related to drugs). This implies that the government has a little to no age-specific programs that are centered to RH for youth and adolescent population. The need to reinforce information dissemination is

imperative most especially to out of school youths to ensure that everybody has equal access to information and services.

Relative to this, Stover (2016) highlighted that ensuring young people have the appropriate information to plan to protect themselves before their first sexual experience is vitally important. Young people around the world are seeking access to reliable information on reproductive health and answers for their questions and concerns about sexuality. They need information not only about physiology and a better understanding of the norms that society has set for sexual behavior, but they also need to acquire the skills necessary to develop healthy relationships and engage in responsible decision-making about sex, especially during adolescence when their emotional development accelerates.

Table 15 on page 83 shows the level of awareness along prevention and management of sexually transmitted diseases. The computed grand mean is 3.55 described as **highly aware.** For some areas in the country, most especially the remote places, the results can be traced and attributed with limited number of social hygiene clinics, treatment hubs and even health care professionals providing specialized care and health education across the country (Tenorio, 2012). It was noted that there are uneven distributions of healthcare workers most especially in remote areas. Physicians, nurses, and midwives are most likely to serve in places where earnings are potentially high. Aside from physical considerations like the challenge of traveling to far-flung areas just to provide health care to the people, they are less likely to serve in areas with high levels of ethnic concentration (Macaraeg, 2020). The problems in manpower who will cater the needs of the people result to an inadequacy of services provided to the people. Basic services such as provision of risk reduction, counselling, STD/ HIV risk assessment, disease screening, diagnostic exam such as gram staining and culture and

**Table 15. Level of Awareness along Prevention and Management of Sexually Transmitted Diseases**

| INDICATORS | Level of Awareness | |
|---|---|---|
| | WM | DI |
| 1. The facility provides STD/ HIV risk assessment. | 3.12 | MA |
| 2. The facility provides diagnostic exam such as gram staining and culture and sensitivity. | 3.62 | HA |
| 3. The facility provides risk reduction counselling. | 3.78 | HA |
| 4. The facility offers FREE sexually transmitted disease/ HIV/ AIDS screening. | 3.35 | MA |
| 5. The facility provides easy access to condoms. | 3.90 | HA |
| 6. The facility conducts STD- HIV/ AIDS awareness campaigns and information drives. | 3.52 | HA |
| 7. The facility has a well-established social hygiene clinic with fully trained personnel. | 3.57 | HA |
| Grand Mean | 3.55 | HA |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

sensitivity, easy access to condoms, among others will also be hampered. With this shortage in health professionals serving the geographically isolated localities, the Department of Health is pursuing on decentralization of HIV/AIDS management in the local government units to allow rural health physicians to manage HIV/ AIDS related cases in their general practice. People who live in remote areas where there are no hubs face challenges because treatment facilities are only found in major cities. Along the area of education, the Commission on Higher Education is also pursuing that medical and nursing curriculum should emphasize HIV/AIDS education, and mandatory rotations or exposures to social hygiene clinics are required to strengthen manpower in these areas to raise public awareness and encourage disease prevention and mitigation (Gangcuangco, 2019).

Meanwhile, the **high awareness** of the respondents on the conduct of STD- HIV/ AIDS campaigns and information drives by the health care facility in their area recorded a weighted of 3.52. For some residents, the personal will of the people to participate in these activities hinder the health care providers to conduct a meaningful health education session. Human Rights Watch (2018) claimed that there is a serious lack of public education about HIV transmission and safer sex practices. This represents the government's long-standing inability to properly resolve the HIV crisis. Millions of Filipinos are unaware of the importance of condoms in HIV prevention. Only one out of every five men who have sex with men has a basic understanding of HIV. Stigma and discrimination in the workplace are facilitated by a lack of public education about HIV and the interests of people living with HIV.

In Table 16 on page 85, it shows the level of awareness on male responsibility and involvement in reproductive health. It has a computed grand mean of 3.93 described as **highly aware.** The lack of knowledge for some males about services, access to services, beliefs and misinformation surrounding reproductive health for men, gender roles and social norms around men’s fertility and roles and responsibilities for reproduction and family planning is primarily because of their lack of interest (Leibtag, 2017). Bersamin (2018) reiterated that with few men interacting less with health providers, it is not surprising that they report a relative lack of knowledge and misinformation about available health services. Men need additional education about how to access sexual and reproductive health services to support their own and their partner’s health.

Their inadequate desire to participate in ensuring maternal and child wellbeing

**Table 16. Level of Awareness along Male Responsibility and Involvement in Reproductive Health**

| INDICATORS | Level of Awareness | |
|---|---|---|
| | WM | DI |
| 1. Facility service are offered to both male and female clients. | 3.97 | HA |
| 2. Health care workers conduct parenting classes. | 3.91 | HA |
| 3. Health care workers provide infertility consultations. | 3.83 | HA |
| 4. Several training on male involvement in reproductive health are conducted on a regular basis. | 3.86 | HA |
| 5. Campaigns are initiated on promoting male roles on: a. avoidance of unwanted pregnancy | 3.91 | HA |
| b. violence prevention | 3.98 | HA |
| c. promotion of responsible fatherhood | 3.97 | HA |
| 6. The facility conducts minor operations such as male sterilization | 4.00 | HA |

| | | |
|---|---|---|
| or vasectomy to prevent pregnancy. | | |
| Grand Mean | 3.93 | HA |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

results to fewer clinic visits, restricting access to resources such as family planning, including vasectomy; fertility assessment and infertility; prevention and treatment of STDs and AIDS; sexuality and sexual dysfunction; information, education, and communication, including counselling, urologic conditions; cancer screening; drug abuse and mental health needs; referral to other medical and social services; prevention of gender-based violence; promotion of responsible attitudes toward sexuality and expressing concerns for pregnancy support; parenting, including early detection of diseases in children, such as malnutrition (National Institute of Child Health and Human Development, 2016).

Men in all ages are underserved by RH services. Most programs assume that women use contraception and that men should help their partners because, little focus is given on men as family planning consumers. In addition to initiatives to counter gender-based norms and actions that obstruct the use of family planning services, there is a need to expand programs to involve men as consumers too (Hardee, 2017).

Some of the interviewees brought out their concern on the need for their husbands to be educated along male contraception. They voiced out concerns on their difficulties and sacrifices. One of them were quoted saying, “Imbagak met nga ipadas mi .. ngem madi na kayat”. (I told my husband that we have to try, but he declined). Another even pointed out issues on ego integrity, she mentioned, *“Sa mga lalaki kase .. ayaw nilang bumaba yung pagkalalaki nila”. (*For the men, they do not want to degrade their masculinity). At some point, it can be a topic of discussion between the two such that, *“Minsan nga sinasabi ko sakanya .. ano kaya kung magpatali kana .. para ako naman yung magpahinga .. hindi nalang yung ako lage ang nagkokontrol”.* (I told to my partner once, what if you have yours tied so that I can rest too). Some of them even suggested ways to solve this problem, saying, *“Siguro kung mas maipapaliwanag pa .. pwede silang maencourage na .. lalo na dito sa lugar namin .. ang trabaho dito pagbubuhat”.* “Maybe if it will be further explained, we can encourage them because most male in our place do the works especially more of heavy lifting). Another participant seconded this claim. She uttered, “*Siguro .. ikwada mettenen .. agaramid da met seminar ti lallaki .. suda lang .. tapno ammo da met .. tapno gamin contraceptive .. more on babae ti agusar .. dapat mamwan da met”.* “Maybe they really should have to organize seminars for the males alone so that they will know the importance of contraceptives, not only for the females who are using it but also they really have to be informed). In congruence, one participant concluded, *“Nanipud pay kwa .. awan met sem-seminar ti lallaki ti kakasta .. nasaysayaat kuma met ah nu adda tapno ammo da met .. anya sir .. ta nu dadduma .. di da met makaaw- awat”. (*Ever since there were no seminars organized for the males. It is good so that they will be informed because sometimes they do not understand).

This suggests that a wide health education and information dissemination about the true nature, advantages, and risks of vasectomy should be conducted and given importance. The inadequate promotion of vasectomy as a men's family planning option may be to blame for the lack of understanding and awareness of vasectomy. Health providers frequently lack understanding about vasectomy or have negative attitudes and cultural biases regarding it, which influence what they say and do when interacting with clients. To expand access and awareness, practitioners must be trained in client-centered service provision for underutilized techniques like vasectomy.

In support of the result of the study, Karim, et. al (2021) concluded in a study they conducted that the current knowledge of contraception among men is limited. These degrees of knowledge, as well as the use of services, are influenced by social determinants. Correct knowledge, advertisement, availability, and reception of information from peers, family members, and health care practitioners were all linked to service practice. Their findings underscored the importance of educating men on this vital topic in order to minimize unwanted pregnancy while keeping cultural and social values in mind. Men's misconceptions and lack of proper knowledge regarding contraceptive methods, as shown by anxieties of current contraceptive methods' negative effects, appeared to be widespread. Renewing efforts to focus on men's knowledge, anxieties, and misconceptions could considerably improve family planning programs (Thummalachetty, 2017).

**Extent of Practice on Reproductive Health Services**

It was reflected on Table 17 on page 88 the extent of practice of the respondents to reproductive health services per municipality. It can be seen that residents from the Municipalities of Pugo, Santol, and Tubao highly practiced the utilization of RH services with computed means of 4. 15, 3.93, and 3.85, respectively. Meanwhile, Burgos had the lowest with 3.28 described as **moderately practiced.** The results of the study denotes an overall commendable performance of the local government units in implementing the mandates of the Department of Health to the people which shows high utilization rate of reproductive health services. In support of the study, records from the Provincial Government of La Union for
the last quarter of the year 2020 showed an exemplary performance of the different local government units meeting the national target set by the Department of Health of the country. A total of 72, 751 residents are currently using contraceptives as of December

**Table 17. Extent of Practice on Reproductive Health Services per Municipality**

| Municipality | Mean | DI |
|---|---|---|
| Santol | 3.93 | HP |
| San Gabriel | 3.49 | HP |
| San Fernando | 3.79 | HP |
| Burgos | 3.28 | MP |
| Bagulin | 3.29 | MP |
| Tubao | 3.85 | HP |
| Pugo | 4.15 | HP |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

2020. Of the twenty local government units, the City of San Fernando recorded the highest number of users with 12, 806 residents currently using the services. This was followed by Agoo with 6841, Bauang with 6,152, Rosario with 5,810, and Naguilian with 4,825. The municipalities of Santol, Bagulin, and Burgos ranked 18$^{th}$ to 20$^{th}$ with 1176 users, 1080 users, and 706 users, respectively. Meanwhile, the City of San Fernando ranked first with a recorded 52.86 percent of the eligible population currently taking oral contraceptive pills. This was followed by Naguilian with 46.82 percent, Agoo with 32.60 percent, Rosario with 37.28 percent, and Bauang with 3472 percent. The municipalities of Bagulin, Sudipen, and Burgos ranked the lowest with 30.00 percent, 29.45 percent, and 28.47 percent respectively placing 18$^{th}$ to 20$^{th}$

spots in the ranking.

Along the area of tubal ligation, San Fernando ranked first with 2358 residents who had the surgery, 1561 for Bauang, 1039 for Naguilian, 823 for Bacnotan, and 765 for Balaoan. In the lowest groups, Pugo recorded 298 recipients, 243 for Bagulin, and 186 for Burgos. For male sterilization or vasectomy, San Fernando recorded 23 beneficiaries, 8 from Rosario, 3 each from Pugo, Tubao, Bagulin, 2 from Caba, and 1 each from Naguilian, Aringay, and Santol. The rest does not have any recorded vasectomy acceptors as of the fourth quarter last year.

For injectables, Rosario listed the highest with 2278 users. This was followed by Agoo with 2175, San Fernando with 1744, Bauang with 1446, and Aringay with 1250. The lowest groups are Bagulin with 185, Santol with 133, and Sudipen with 128 users. Along implant utilization, San Fernando got the highest with 403 users. This was followed by 219 from Bauang, 200 from Aringay, 184 from San Gabriel, and 132 from Luna. The bottom groups are Santo Tomas with 14 users, Burgos with 6, and Bangar with only 2 users.

Along the used of condoms, Bangar ranked the highest with 333 registered users. Next is San Fernando with 261, and this was followed by Agoo with 205, Rosario with 188, and Luna with 129 beneficiaries. Naguilian, Bacnotan, and San Juan ranked the lowest with 19 users, 18 users, and 13 users respectively.

Along intrauterine device used, Luna got the highest with 497 users. This was followed by Balaoan with 360, San Fernando with 166, Bangar with 134, and Bauang with 76 beneficiaries. In the lowest groups, Burgos only had 14, Rosario had 5, and Caba does not have any service users.

Along the area of antenatal care, Bacnotan recorded 87.43 percent of its eligible population who had the service, Agoo had 64.05 percent, San Gabriel had 64.41 percent, Balaoan had 60.77 percent, and Tubao had 59.29 percent. Meanwhile, for the lowest groups, Nagulian had 30.53 percent, Luna had 28.33 percent, and Santo Tomas had 17.48 percent. Along pregnant women screened for gestational diabetes mellitus, Bacnotan had 48.60 percent, San Gabriel had 46.13 percent, San Fernando had 33.97 percent, Sudipen had 33.49 percent, and Luna had 19. 24 percent. Meanwhile, for the lowest groups, Rosario had 0.67 percent, Santo Tomas had 0.14 percent, and Bagulin does not had any patient who had the service.

Along the area of iodine capsule provision to pregnant women, Tubao ranked first with 37.74 percent against its eligible population. This was followed by Bangar with 32.97 percent, San Gabriel with 31.73 percent, Bagulin with 21.82 percent, and Balaoan with 21.53 percent. Meanwhile, for those pregnant women assesed for complete blood count and was diagnosed with anemia, Luna had 8.05 percent against its eligible population. This was followed by Balaoan with 5.59 percent, Bauang with 5.48 percent, Agoo with 5.37 percent, Sudipen with 4.70 percent, and Aringay with 4. 61 percent. For the lowest groups, the municipalities of Bacnotan, Bagulin, Bangar, Burgos, and Caba had no reports who availed the service.

On the aspect of deworming, Nagulian had 59.08 percent against its eligible population. This was followed by San Gabriel with 43.48 percent, Santol with 35.09 percent, Tubao with 33.64 percent, and Burgos with 31.77 percent. Meanwhile, for the lowest group, Agoo had 0.67 percent, and both Bacnotan and Bauang recorded zero beneficiary along this area. Along HIV screening for pregnant women, Bacnotan got the highest with 84.63 percent of its eligible population. This was followed by Tubao with 4.28 percent, San Fernando with 38.62 percent, Luna with 37.58 percent, and Naguilian with 35.94 percent. In the lowest group, Burgos, Santo Tomas, and Sudipen recorded zero on this aspect.

Along area of syphilis screening, Bacnotan ranked first with 85.01 percent against its eligible population. This was followed by Luna with 51.30 percent, San Gabriel with 49.07 percent, Sudipen with 47.89, and Bangar with 41.59 percent. For the bottom group, Balaoan had 7.77 percent, Pugo with 5.69 percent, and

Santo Tomas with 4.64 percent. Meanwhile on the aspect of hepatitis B screening, Bacnotan ranked first with 78.54 percent against its eligible population followed by San Gabriel with 49.07 percent, Tubao with 47.76 percent, Sudipen with 46.64 percent, and Agoo with 43.17 percent. The three municipalities who had the lowest results includes Santo Tomas with 5.60 percent, Balaoan with 2.72 percent, and Bagulin who had does not have any patiet who availed the service.

For the Pentavalent 1 vaccination, Bacnotan ranked the highest with 83.37 percent children vaccinated against its eligible population. This was followed by Tubao with 82.70 percent, Santol with 77.89 percent, Caba with 77.52 percent, and Bagulin with 77.37 percent. For the lowest groups, San Fernando had 63.56 percent, Burgos with 62.88 percent, and Pugo with 61.82 percent. Along pentavalent 2 vaccination, Tubao ranked the highest with 87.35 percent children vaccinated against its eligible population. This was followed by Santol with 80.88 percent, Rosario with 77.79 percent, Bagulin with 74.59 percent, and Caba with 74.37 percent. For the lowest groups, Burgos got 64.86 percent, Santo Tomas got 63.51 percent, and Sudipen got 62.92 percent. For the pentavalent 3 vaccination, Tubao ranked the highest with 87.53 percent children vaccinated against its eligible population. This was followed by San Juan with 80.69 percent, Rosario with 79.14 percent, Bacnotan with 78.29 percent, and Bagulin with 76.97 percent. For the lowest groups, Luna had 63.38 percent, San Gabriel had 60.52 percent, and Sudipen had 59.48 percent.

Along the aspect of Oral Polio 1 vaccination, Bacnotan ranked the highest with 83.37 percent children vaccinated against its eligible population. Tubao had 82.70 percent, Santol had 80.88 percent, Bagulin had 76.97 percent, and Caba had 75.10 percent. For the bottom group, Burgos had 62.88 percent, Naguilian had 62.73 percent, and Pugo had 62.10 percent. For the oral polio 2 vaccination, Tubao ranked first with 87.35 percent children vaccinated against its eligible population. This was followed by Santol with 81.31 percent, Rosario with 77.79 percent, Caba with 74.37 percent, and Bacnotan with 73.72 percent. For the bottom group, Santo Tomas had 63.51 percent, San Fernando had 62.20 percent, and Nagulian had 62.14 percent. For the oral polio 3 vaccination, Tubao ranked first with 87.53 percent children vaccinated against its eligible population. This was followed by Bagulin with 87.29 percent, San Juan with 80.69 percent, Santol with 79.60 percent, and Rosario with 79.14 percent. For the bottom group, San Fernando had 63.47 percent, Luna had 63.38 percent, and Sudipen had 62.29 percent.

Table 18 on page 94 shows the extent of practice on RH services along family planning information and services. Generally, the respondents **moderately practice** utilizing the services of reproductive health as evidence by 3.38 computed grand mean. The moderate practice can be linked with some issues of concern such as respondent's education, financial, personal choice, availability of the service, and distance from the health care facility, among others.

The result is supported by the study conducted by Nagai, et. al (2019), they mentioned that there were 72.6 percent women who had incidence of missed opportunities to receive family planning counseling at any health care unit visit. These findings suggest that the quantity and quality of family planning counseling provided at primary care clinic contacts to women who wish to delay or limit childbearing is inadequate and unlikely to significantly increase the use of effective contraceptive methods. Around 20 percent of women attending clinics in this study had previously used an effective contraceptive method, but had discontinued use, highlighting those contraceptive services must focus not only on attracting new users but also on improving continuation rates.

The incidence of COVID-19 contributes as well to the dwindling status of family planning services worldwide. With most people under quarantine, clients are less inclined to go out and get their family planning commodity or go to their community health facility for resupply or counselling. Even though

many of the health facilities are still offering family planning services daily, more and more facilities are reporting a low number of clients (Mendoza & Ombao, 2020).

**Table 18. Extent of Practice along Family Planning Information and Services**

| INDICATORS | Extent of Practice | |
|---|---|---|
| | WM | DI |
| 1. Healthcare workers provide information on birth spacing or gap to ensure healthy population. | 4.17 | HP |
| 2. The facility advocates the use of the following birth control products and services for low or no cost. | | |
| a. oral contraceptive pills | 3.98 | HP |
| b. Depo Shot | 3.67 | HP |
| c. Patch (Ortho Evra) | 2.56 | FP |
| d. Vaginal Ring (NuvaRing) | 2.47 | FP |
| e. Intrauterine device (Mirena/ Paraguard) | 3.05 | MP |
| f. Implant (Implanon/Nexplanon) | 3.39 | MP |
| g. Male and female condoms | 3.64 | HP |
| h. Vasectomy "snip-snip" | 2.61 | MP |
| ii. Tubal Ligation "tubes tied" | 2.71 | MP |
| j. Hysterectomy (removal of womb) | 2.40 | FP |
| 3. Healthcare workers give information on natural family planning methods such as: | | |
| a. Sympto-Thermal Method/ Body Temperature | 3.75 | HP |
| b. Standard days method | 3.60 | HP |
| c. Lactational amenorrhea method | 3.47 | HP |
| d. Abstinence (no sex) | 3.67 | HP |
| e. Calendar method | 3.69 | HP |
| 4. Health care workers monitor the strict compliance of family planning method use (i.e. injectables, pills). | 4.09 | HP |
| 5. Health care workers regularly conduct client education focusing on the benefits and risk of FP products and services. | 3.97 | HP |
| Grand Mean | 3.38 | MP |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

The **high extent of practice** on oral pills as a contraceptive method recorded 3.98 weighted mean. The result is attributed to the availability and easy access of this service in the health facility. In the United States, the pill remains one of the most popular methods and widely used birth control for women. Among the two-thirds of women aged 15 to 44 who used birth control between 2011 and 2013, approximately 16 percent used the pill (Haelle, 2014). In Europe, statistics showed that pill is the most common type of contraceptive used at 21.9 percent. However, an even larger share of individuals uses no contraceptives at all at 30.2 percent (Statista Research Department, 2016). In the Philippines, more than six years after the

reproductive health law was enacted, the country is still far from its goal of achieving a contraceptive prevalence rate of 65 percent by 2022. The current contraceptive use stands at 40 percent only (Yee, 2019). Of all the contraceptive services, result showed a weighted mean of 2.61 described as fairly practiced for vasectomy among the respondents. Several studies linked general lack of basic knowledge about the procedure among prospective men and women clients, pose a major initial demand-promotion barrier. Prospective clients' willingness to use vasectomy is very low, due in large part to limited knowledge and negative attitudes (Packer, et. al., 2016).

In 2017, Davao had a 51 percent drop in the number of men who underwent vasectomies. The City Health Office cited the decrease due to the perception that vasectomies would lessen the men's "macho image." The belief that vasectomies could lead to an inability to have an erection was also cited as the main reason as to why only eight men underwent the procedure in the entire Ilocos region in 2017. Other family planning services were unfamiliar to them such as the patch and vaginal ring and the rest of the natural family planning services that are available as an alternative. For some, to avail of services is a matter of choice.

Most of the participants during the interview mentioned that using contraceptive is really a reliable form of contraception, a benefit to plan a healthy family and control the population, prevent unwanted pregnancies and well as protection from sexually transmitted infections. As one of the respondents said, "*Innem annak kon .. nakatulong met ah .. tanu di ak nagus-usar ket .. ad adu kuma pay .. hanggang tatta pay siguro".* (I already have six children, the use of pills it helped. Maybe if I did not use it, I have more kids now). Another interviewee in the facet of child immunization also added, *"Mapanunut da met nga pagsayaatan na nga ina .. ken pagsayaatan met jay anak na .. isu nga ikarkarigatan da ti mapan agpa chek-up .. wenno mapan ijay barangay hall nu adda ayab bakuna kasjay .. proteksiyon kunada met gamin .. nasayaat ah".* (They can see that it is really for the benefit of the mother aside from the benefit it can give to the child).

This suggest that contraceptive methods available in the health care facilities are indeed beneficial to control the fast growing population of the country. Majority of the key-informants are appreciative of this program as it helped them to plan effectively the number of children they have. This ensures that couples can atleast provide the necessity of the family members due to their limited number. On the area of infant and child health services, given the fact that the scheme of provision of services were simplified and accessibility is much easier than before, parents are more comfortable because of the completion of vaccines their children received which gives protection to some vaccine- preventable diseases that are present nowadays.

In relation to the results of the study, the Medical City (2020) published an article enumerating the benefits the couple and their children can get from patronizing the family planning services of the Department of Health. They emphasized that family planning protects women from any health risks that may arise prior to, during, or after childbirth. High blood pressure, gestational diabetes, infections, miscarriage, and stillbirth are examples. Adolescent pregnancies can also be reduced by using contraception to protect teenagers from the physical, emotional, and financial burdens of an unplanned pregnancy. Infant mortality rates can be reduced, particularly when a pregnancy is unplanned, ill-timed, or too closely spaced because it affects the mother's health, which affects the health and safety of her unborn child.The appropriate and consistent use of male and female condoms protects teenagers and young people from unintended pregnancies as well as sexually transmitted infections like HIV, AIDS, gonorrhea, and chlamydia. Most significantly, when a couple or an individual is aware of their rights and options, they are able to make

wise life decisions. A couple or an individual can use family planning to choose what is best for their sexual and reproductive health. A couple can create financial security by strategically spacing pregnancies, allowing them to raise a family that they can properly care for. A healthy family is one that is well-cared for and a healthy family is the foundation of a healthy community.

The fear of the people to the possible adverse effects of contraceptive used determines the type of products and services they will be using. Even if taking birth pill is the most popular method of contraception, it comes with a list of adverse effects resembling the experiences of majority of the respondents, "*Nagusarak damo ti pills .. idi kwan madin .. makasawrsarwa akon .. sinukatak".* "I used pills and then I experienced nausea that is why I changed contraceptives). Other participant mentioned other physiologic changes, she emphasized, *"Inallukoy dak idi nga nga agusar .. ngem kunada ngamin ket nu pills .. anya ajayen .. adu side effects na .. maulaw ka .. kasjay".* (They encouraged me to use pills before, but some people said that pills have many side effects like you feel dizzy). Another mentioned the need to have a bed rest that hinders them to do house works, she said, *"Jay lang side effects na gamin .. nadagsen bagi .. nagmadi .. kayat ko nakakaidda ka lattan". "*The only thing are the side effects- lethargic, it is unpleasant and you just wanted to take bed rest).

Aside from those mentioned, the belief of chemical accumulation in the vagina and the fear of getting pregnant when they forgot to take pills on a daily basis were also concerns the participants. One of them mentioned, *"Jak kayat ti pills .. adda gamin jay taga ditoy ayan mi nga duwa tawen nga nagus usar ti pills .. ti kunada ket kasla naurnong ijay vagina na jay agas .. tapos adda met lang posibilidad nga makargaan ka diyay sir karkaro nu managlipat ka .. naka alarm ah (laugh)".* (I do not like pills because somebody used pills in our place for two years and she said that the pills will not be digested and stays in the vagina and there is a possibility that you will still get pregnant most especially if you forgot taking it but I am using an alarm). This was supported by other participants. One said, *".. ken mysa pay ket .. bka malipatam metlang .. useless .. isu kano metlang ngay pakaalaam nu kwa".* (.. and besides you might forget taking it and it will be useless and it will be the the reason that you might get pregnant). Another claimed, *"Kayat kon jay ligation tapno awanen panpanunutekon .. awanen tumtumarekon kasjay".* (I want ligation so that there will be no more concerns to think about and no more taking of pills).

With these justifications coming from the beneficiaries, they were encouraged to try other forms of contraception. Others considered the convenience in the choice of the method to be used. An interviewee was quoted saying, "*Nagligate akon di nalpas ko nayyanak data naudi .. nag wen akon ah lattan .. kesa jay agtumar tumar ak manen ti pills sen .. hanen nga istorbon".* (I used ligation after I delivered my last child, I just said yes to it instead of taking pills again). Another voiced out, *"May mayat jay inject ta diretso nga 3 months .. awanen jay rinabii nga panpanunutem nga agtumar ka .. kasjay .. isu dik kayat jay pills".* "Injectable is better because you can have it 3 months straight. You will not be bothered every night for the need to take it. That is why I do not like pills).

The health care worker supported the above-mentioned claims during the phone interview. She uttered, *"Ahh ijay gamin ket DMPA ken pills da lang .. han da kayat jay IUD ta han da nga comfortable .. haan da pay napadas ngem nag conclude dan nga han da kano komportable .. although kanayon da met nga mabagbagan".* (They are using DMPA and pills, they do not want IUD because they are not comfortable but some have not tried it and then they make conclusions that they are not comfortable. But they were always informed about it). In congruence, a barangay captain said*, "Ibirbiruk da jay haan nga bawal ti bagi da .. nu anya ti awaten ti bagi da .. isun usaren da".* (They will look for something that will fit to their body and what could their body accept and then that will be the one for them to use). This implies

that the inconvenience and discomfort people are experiencing when using RH services are a strong determinant in the nature of family planning methods they will be utilizing. The occurrence of side effects had a negative impact on continuation rates. Fears about the side effects are well documented barriers related to misinformation, while others reflect real experience.

In the study conducted by Alaii and Nanda (2012), the most commonly reported side effects were infertility and malignant growths, which were linked to pills and injectables. The two methods were also linked to an increased risk of birth abnormalities or unexpected pregnancy, especially if the pill regimen was not followed or if the injectable was outdated. Furthermore, injectables' effectiveness was thought to deteriorate over time, resulting in contraceptive failure. In relation to implants and IUDs, a number of individuals expressed concern over method switching or expulsion. Implants were thought to be at risk of being lost in the body via the bloodstream. The removal of the method shift would necessitate surgery, which was not only undesired due to the invasive process, but also thought costly. In addition, some physiological impacts spanned the entire range of modern contraceptive treatments, either participants' perceptions or real experiences. Changes in weight and menstruation patterns, localized pain related to implant and IUD delivery methods, changes in libido, elevated blood pressure, and shortness of breath, dizziness, or headaches were among the side effects.

For males, the feeling of weakness that hinders them to do heavy work is the primary factor that contributed to their non-utilization of vasectomy. A female partner mentioned, *"Madi dijay lakay ko ti vasectomy .. ta para kenyada .. agtatrabaho da ti nadagsen .. agkakapsot ti bagi da gamin .. ada mysa nga nagpa vasectomy dita .. agsasadot da nga ag trabaho .. ken mysa haan nga uso ditoy ayan mi data".* (My husband does not want to have vasectomy because for them, they do heavy works and that become weaker and vasectomy is not common in our place). With this, females does not have a choice but to receive contraceptives in their partner's behalf thinking of the heavy responsibility their partner has to carry in providing the needs of the family. This claim was supported by an interviewee who said, *"Kunada met gamin data kapon (vasectomy) .. nu lalaki ket agkapsot da kano .. isu nga dakami nga misis sen ah ti agkontrol .. sikamin ah ti agsakripisyo nga agusaren .. di da met lang kayat .. syempre .. han da maka ubra .. pangalaan mi ngay pag biag mi".* (They said that in vasectomy, males will become weak so wives wil be the one to sacrifice as to the use of contraceptives so that our husbands can work to provide us our source of living).

This misinformation were passed from one person to the other and created a huge problem in the implementation of male's sterilization program. Another participant supported this claim saying, *"Han nga sanay dagita lallaki nga agtutongtong ti kakasta .. han da kayat .. ta kumapsot da kano piman".* (The males are not used to conversing about those topics because for them vasectomy makes them weak.

This claim was supported by the health worker interviewed through phone call. According to her, "*Actually .. awan mairep report mi ti vasectomy .. naiinform damet nga han nga agpyso data nakakabawas nang pagkalalaki ken energy nakarkaro ta nadagsen trabaho ta adda da kanayun ijay farm .. awan met to kasjay nga effect na .. pero uray man pay .. han da latta mamati .. narigat mi nga maconvince .. zero talaga kami dita".* (Actually we do not have reports on vasectomy users. They were informed that the effects are not true such as it will degrade their masculinity and decreases energy levels most especially that they do diffcult work because they are always in the farm but still they do not believe. We have difficulty of convincing them, we are zero on that case).

Other misleading information about vasectomy also includes the fear of losing sexual prowess among the males. As the interview continued, one of the key-informants shared, *"Sa mga lalaki kase .. ayaw nilang*

*bumaba yung pagkalalaki nila"*. "For the males, they do not want to degrade their masculinity). The fear that this might be the reason of the couple's separation was the concern of another participant, most especially if their sexual needs are not provided and satisfied, she emphasized, " .. *adda gamin jay agkapsot da kano .. isu pay pagsinaan da ah .. ta awan kano ti kwa .. ganas dan .. agbirok dan ti sabali"*. (They have these episodes of weakness because this might be the reason of their separation- no more pleasure and they might look for other partners).Vasectomy, according to the participants, would encourage promiscuity. They believed that vasectomy would impair their sexual performance, forcing their partners to be promiscuous in order to meet their sexual needs. They also feared that vasectomy would increase unprotected sex, especially since the main disincentive to such behavior, "pregnancy," would be eliminated. They were concerned that this might have a bad impact on their marriage and sexual health.

Also, the long standing belief that contraception is intended only for women contributed to the low utilization rates among the males. This will end up that the females are the one's who will sacrifice and will endure all the difficulties of pregnancy and delivery. One of the key-informants discussed, *"Ni lakay ko .. madi na .. ta madit rikna na .. isu nga dakami lattan nga babae agsakripisyo .. nu gamin talaga nga madi ti lalaki ket han mo mapilit .. madi da latta ah"*. (My husband does not want it because he is not comfortable about it. That is why, we females are the one's sacrificing for you can not force the males on what they do not want). Thus, proper understanding and favorable attitudes are critical for ensuring informed vasectomy decision-making. This shows that a lack of understanding of vasectomy and false information are to blame for its low acceptance, and that men's perceptions of the treatment are often influenced by it. In support of this claim, during the phone interview, a health care provider said, *"Jay babae lattan ti agusar ta it is a responsibility ti babae .. FP commobidities according to them ket haan nga para kanyada nga lalaki .. itudo da lattan nga ni misis dan to agusar .. isu kasjay"*. (The females will just used contraceptives because it is their responsibility, FP commodities according to them are not for males, they will just let their female partners use it.)

This implies that there is relatively low utilization of male sterilization procedures due to common belief about the negative effects such as decrease pleasure and deteriorating body strength most especially to men in the mountainous areas were work and labor are expected to be more difficult. These beliefs severely affected their utilization rates which will end up females to sacrifice using contraceptive measures for a longer period of time than their counterpart. Stigma and the misconceptions in the community accounted for the low vasectomy uptake despite several advocacy strategies. The belief that the procedure was a form of castration and that it negatively affects men's sexual functions was widespread and this progressively fueled the stigma on vasectomy. Women were highly influential in a man's decision on vasectomy. This calls for the need to increase health education to demystify the misconceptions about vasectomy that should target both men and women.

The findings clearly depict a challenge on how to modify the wrong notion about this beneficial alternative of contraception focusing on the couple's male counterpart. The innacurate information cultivated in the mind of the respondents resulted to low contraceptive prevalence rate among males, most especially to those people with little to no access to sources of adequate and appropriate information. The prompt action of the health sector to this immediate concern is deem neccessary most especially to the poor, and vulnerable members of the society.

In support with the result of the study, Coconuts Manila (2018) mentioned that Filipino men, perhaps influenced by Hispanic culture, place a high value on being perceived as "macho" or "hot in bed." Many

people worry that having a vasectomy will make them the brunt of their friends' jokes. Also, many men regard vasectomy as a sort of castration, in addition to the visceral fear of having sharp things near their delicate bits. Many of them are concerned about the decreased sexual performance, pleasure, pain, or the fear of reproductive issues (The Modern Parenting, 2021).

Bell, (2016) debunked these claims of the key-informants based on scientific principles. Sexual desire, sex drive, or their ability to develop erections and ejaculate, as well as energy, will not be affected, according to the doctor. Everything remains the same, including orgasms. It's vital to wait until the patient is fully recovered before having sex after the treatment. The doctor explained that sexual desire, sex drive or their ability to have erections and ejaculate as well as energy will not change. Everything, including orgasms, remain unchanged. Although it is important to wait until patient feel recovered enough to have sex following the procedure. When a man is sexually aroused, he may suffer mild aching in his testicles, although this does not affect the majority of the delightful components of intercourse. Numerous health professionals backed up this assertion, stating that, aside from the desired alteration in fertility, male sexual and reproductive physiology is unaltered following vasectomy (Achola and Barone, 2015).

In support to the findings of the study, individual beliefs about health and conditions, according to the Health Belief Model, play a role in determining health-related behaviors. Key factors influencing approach to health include any obstacles that may be in the way, exposure to information that prompts them to act, how much benefit they can derive from engaging in healthy behaviors, susceptibility to illness, the consequences of becoming sick, and confidence in their ability to succeed to a regimen (Boskey, 2020). People tend to use reproductive health services based on their knowledge of the therapeutic regimen. Information learned in school, seminars, trainings, and information dissemination activities such as small-group discussions, as well as from colleagues, all contributed to their motivation to use the services. Thus, these factors are critical because they help people broaden their knowledge of the government's program and contribute to their decision-making in utilizing the services for the improvement of their well-being.

In Table 19 on page 106, it shows the extent of practice on reproductive health services along maternal, infant, and child health and nutrition. The grand mean is 4.01

**Table 19. Extent of Practice along Maternal, Infant and Child Health and Nutrition**

| INDICATORS | Extent of Practice | |
|---|---|---|
| | WM | DI |
| 1. The facility conducts pregnancy testing service to the clients. | 3.89 | HP |
| 2. The facility offers gynecologic examinations to mothers. | 3.26 | MP |
| 3. The facility conducts pap smear and pelvic exam. | 3.37 | MP |
| 4. The facility conducts prenatal, and postnatal care. | 4.08 | HP |
| 5. Healthcare workers regularly conducts home visit for pregnant women and their children. | 3.89 | HP |
| 6. The facility advocates “No Home Delivery” policy of the government. | 4.18 | HP |
| 7. The facility provides anemia testing regularly for pregnant women. | 4.02 | HP |
| 8. The facility provides routine prenatal test such as complete blood. count, hepatitis screening, and urinalysis. | 4.00 | HP |
| 9. The facility gives full dose of iron supplement to pregnant women. | 4.03 | HP |
| 10. Health care workers advocate exclusive breastfeeding. | 3.75 | HP |

| | | |
|---|---|---|
| 11. The facility has a conducive breastfeeding room. | 3.67 | HP |
| 12. Health care workers provide nutrition counseling. | 4.08 | HP |
| 13. The facility provides vitamin A supplementation to infants. | 4.15 | HP |
| 14. Health care workers provide basic oral health care to children. | 3.70 | HP |
| 15. The facility conducts deworming of the children. | 4.26 | VHP |
| 16. The facility provides regular child immunization services like<br>a. Hepatitis A vaccine | 4.28 | VHP |
| b. Hepatitis B vaccine | 4.24 | VHP |
| c. Diphtheria, tetanus, and pertussis vaccine (Anti tetanus, whooping cough, and diptheria) | 4.29 | VHP |
| d. Haemophilus influenzae type b vaccine (Anti pneumonia, meningitis, bone infection) | 4.27 | VHP |
| e. Oral Polio vaccine 1, 2, 3 (Anti polio) | 4.32 | VHP |
| f. Pneumococcal conjugate vaccine 1, 2, 3 (Anti pneumonia and bacterial meningitis) | 4.25 | VHP |
| g. Rotavirus vaccine 1, 2 (Anti severe diarrhea disease) | 4.22 | VHP |
| h. Influenza vaccine (Anti Flu) | 4.24 | VHP |
| i. Mumps, measles, and rubella vaccine | 4.30 | VHP |
| j. Varicella (Chikenpox) vaccine | 4.13 | HP |
| k. Meningococcal conjugate vaccine (Antimeningococcal disease) | 3.45 | HP |
| l. Human papilloma virus vaccine (Anti cervical cancer) | 3.93 | HP |
| m. Japanese encephalitis vaccine (Anti brain inflammation) | 3.55 | HP |
| n. Bacille Calmette-Guérin (BCG) vaccine (Anti tuberculosis) | 4.02 | HP |
| o. Pentavalent Vaccine 1, 2, 3 (Anti diphtheria, pertussis, tetanus, and hepatitis B and Haemophilus influenzae type b) | 4.11 | HP |
| p. Anti-measles vaccine | 4.24 | VHP |
| Grand Mean | 4.01 | HP |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

described as **highly practiced.** The result is attributed to improved and reinforced program of the Department of Health on maternal and childcare in compliance with the Millennium Development Goals of the United Nations. Majority of the services available in the primary health care facilities in the country are geared towards this vulnerable sector of the population. The Department of Health had recalibrated their programs and allotted majority of its human resources on primary health care that includes prenatal and post-natal care to pregnant mothers, ensuring adequate nutrition by providing health education and vitamins supplementation, promoting safety and healthy pregnancy relatively free of complications, complete set of vaccines for the mother and the baby through scheduled home visitation and post-natal follow ups.

The care of mother and the child had a paradigm shift from health care facility to community visitation. In this manner, midwives and nurses assigned in these programs are assured that compliance is high, and proper protocols are carried out and followed by the clientele. In far flung areas like the mountainous

barangays, the availability of community midwives in the barangay health and wellness centers ensured that all programs of the government are running smoothly, and residents have available health care providers to approach in times of emergency situations. But certain factors are still considered hindrance in optimum attainment of the program goals and objectives, like distance to the health centers, financial aspects, beliefs and traditions, low education, and the reluctance of the community people to avail the services provided among others.

The result of this study is congruent with the NDHS report wherein nine in ten Filipino women receive antenatal care from a skilled provider such as a midwife (50%), doctor (39%), or nurse (4%). Three percent of women received no antenatal care. Women with higher levels of education and those from the wealthiest households are most likely to receive ANC from a skilled provider. Seven in ten women have their first antenatal care visit in the first trimester, as recommended. Eighty-seven percent of women make four or more antenatal care. Among women who received antenatal care for their most recent birth, 99 percent had their blood pressure taken, 72 percent had a blood sample taken, and 78 percent had a urine sample taken. Most women were weighed and had their height measured (99 percent and 87 percent respectively). Eighty percent of women's most recent births are protected against neonatal tetanus (National Demographic and Health Survey, 2017).

As far vaccination is concerned, almost all the vaccines mentioned recorded a favorable result. The result is attributed to the program of the DOH on Expanded Program on Immunization that all of these are made available in any health centers in the community and even given in the comfort of the clients' home. Public health nurses and midwives are doing house to house visitation with the help of the barangay health workers to determine the qualified clientele. The vaccines are given to prevent some vaccine-preventable illnesses such as hepatitis, tetanus, whooping cough, polio, pneumonia, and others. These are given for free, and this is one of the reasons that utilization rate is notably high.

According to the NDHS 2017, 70 percent of Filipino children aged 12 to 23 months have received all eight basic vaccinations—one dose each of BCG and measles-containing vaccine and three doses each of DPT-containing vaccine and Polio vaccine. Nine percent of children have received none of the recommended vaccinations. Basic vaccination coverage is slightly higher in urban areas than rural areas (75 percent versus 66 percent). Regionally, basic vaccination coverage ranges from 18 percent in ARMM to 87 percent in Davao. Basic vaccination coverage has fluctuated over time, rising from 72 percent in 1993 to 80 percent in 2008 and then decreasing to 70 percent in 2017.

Meanwhile, the public trust on vaccines was somehow questioned due to issues of dengvaxia vaccine. The plummeting trust can be traced to 2015, when the government of the Philippines began a large-scale dengue fever vaccination program after an increase in cases of the mosquito-borne disease. The findings reflect a dramatic drop in vaccine confidence from 93 percent "strongly agreeing" that vaccines are important in 2015 to 32 percent in 2018. There was a drop in confidence in those strongly agreeing that vaccines are safe from 82 percent in 2015 to only 21 percent in 2018; similarly, confidence in the effectiveness of vaccines dropped from 82 percent in 2015 to only 22 percent. Only 1 in 5 people now believes vaccines are safe (De Figueiredo, et. al., 2018). The dramatic drop in confidence is a real concern about risks to other vaccine preventable diseases. The role of social media in amplifying the perception of risk and fears and their public health consequences was dramatic (Ridgwell, 2018).

Recently, the trusts of the community on vaccines are once again on controversy. The problems on rising mortality associated COVID-19 vaccines markedly affect other forms of vaccine given to the population. Public trust in COVID-19 vaccines is being eroded by politics. In the United States, survey shows the

public trust in vaccines has plummeted since May 2021. Only 51 percent of those surveyed said they would or probably get a vaccine to prevent Covid-19. This is a drop of 21 percentage points. Interestingly, the polarization in the country is reflected in this decision as well. Democrats are 14 percentage points more likely to take the vaccine than are Republicans. Unsurprisingly, blacks are less likely to want the vaccine. Only 32 percent would take it—vs. 52 percent of Whites, 56 percent of Hispanics and 72 percent of Asian Americans (Stone, 2020).

In the Philippines, validated data from different regions of the country by the Epidemiology Bureau of DOH revealed that from 1 January to 9 February of 2021, a total of 4, 302 measles cases have been reported, with 70 deaths. Ages of cases ranged from 1 month up to 75 years old with 1 to 4 years old (34%) followed by less than 9 months old (27%) as the most affected age-groups. Sixty-six percent of them had no history of vaccination against measles. Of the total deaths, ages ranged from one month to 31 years old. Notably, 79 percent of those who died had no history of vaccination. The Department of Health (2021) pointed out that loss of public confidence and trust in vaccines in the immunization program brought about by the Dengvaxia controversy has been documented as one of many factors that contributed to vaccine hesitancy in the country. This refers to mothers who became hesitant to have their children vaccinated with vaccines that were long proven to be effective.

As per safety issue brought by COVID-19 vaccines, Pulse Asia survey conducted between November 23 and December 2, found that 32 percent of 2, 400 respondents said they would agree to receive COVID-19 vaccine shots when available, while 47 percent said they would refuse due to safety concerns. The remaining 21 percent were undecided (Esguerra, 2021). But efforts are made to change the negative image of vaccine use by the government to counteract misinformation and correct mistrust. A lot of information campaign materials are made available in television, printed materials and social media platforms to at least gain once again the trust of the public on the relevant issue where vaccines can spell the difference between life and death, and it is a matter of own choice.

The health workers interviewed during the phone conversation revealed that house-to-house visitation is not applicable to all target communties. The time management and the sensitivity of the vaccines to varying temperature might destroy the integrity of the medicine. Instead they conceptualized the so called, "Barangay Service Points or Fix Point Service" where people in the mountainous area meet with the health care workers in the a designated and agreed place. A health worker during the phone interview mentioned, "*Two way siya .. adda dagijay mapan iti barangay health stations tapos adda met jay mapan house to house through barangay service points".* (It is a two-way process, some people will go to the barangay health stations, then others will conduct house-to-house through barangay service points). This scheme of implementation is also the same with other localities. Another health care care provider claimed during the phone call, "*Ditoy ayan mi ket adda ti fix point para iti services .. sumabat dagijay parents ken annak da ti mysa nga specified location .. church .. day care center .. nga mabalin nga pagurnungan kasjay .. syempre nu ibalay balay mi diyay .. mapirdi jay vaccine .. napudot".* (We have fixed points here in our place for the services where parents together with their children will meet the health workers in specificied locations like church, day care centers and those were mass gathering is possible. Because of course if we will have it house-to-house, the vaccines will not be useful or ineffective).

An initiative were also shared by one of the health care worker in their municipality he said *"Meron kami ditong program na "Panangritna ti Umili" .. one stop shop na yung services na dadalhin sa barangay .. kase yung challenge sa accesibility .. kami na yung pumupunta sa barangay by schedule .. may mga mobile family planning commodities .. para iintroduce yung mga bagong services .. yung MHO pumupunta para*

*mag advocate ng FP .. kapag hihintayin lang namin sila sa RHU .. kaunti lang yung mag aavail for sure".* (We have here a program called "Panangritna ti Umili" where the services are in a one-stop-shop and we will bring it to the barangays as per schedule. We have mobile family planning commodities to introduce new services. The MHO will advocate the FP because it will fail if we will just wait at the Rural Health Center".

This implies that health care professionals with the help of barangay officials are extending their efforts in serving the people by doing some strategies to bring services closer to them such as information drives in the isolated areas, providing immunization services to both the mother and children at the comfort of their homes or by having it in the available barangay facilities to ensure awareness and compliance of the people to these essential services that are expected of them to receive in due time.

In support of the result of the interviews conducted, Cerojano (2020) mentioned that the Department of Health organized a large awareness campaign, reaching out to village heads and community leaders to guarantee that all of the government's services were covered. House-to-house visits and vaccinations of children in public venues such as churches, malls, and markets require long hours, even on weekends. The visits are used by health care personnel to inform parents about vaccinations. They are informing the public that vaccines are safe, effective and free. Also, they are stressing that vaccination is the only way to prevent the disease from spreading, and they are requesting their assistance in spreading the word to other parents. Meanwhile, parents are encouraged to bring their children to health centers or vaccination posts for immunization, and stakeholders, particularly the local media, are encouraged to participate in the campaign by encouraging parents to bring their children to health centers or vaccination posts for immunization (Lazaro, 2014).

Another strategy that the health care providers are using are the health records they have. They list all the possible information about the pregnant mother and her child or children and this gives them idea as to when is the expected schedule of the client to do clinic visit. The participant mentioned, *"Nu gamin masikog da paylaeng sir .. naka record dan .. hanggang nu aganak dan .. syempre ammo mun .. matancha mon .. ney adda ti bakuna ta anak mo nu kastoy .. ibilin dan ah nga iyumay mo ijay .. adda ti record-record .. ammo mun nu katno".* (Since when they are pregnant, they already have a record until they are going to give birth. Of course you know already for you can estimate when your child will be vaccinated and they will advise you to bring your child on this date. We have records and you know when is the schedule).

The barangay captain supported this claim of the residents. During the phone interview he uttered, *"Adda listaan da .. adda record .. kadarato Miyerkules .. nu sino dagijay ag avail to services kasjay".* (They have a list, they have records and every Wednesdays, they can avail of the services). Another interviewee reiterated, *"Sakbay gamin nga adda mapasamak nga immunization kasjay kuma .. umay dan ibaga nga nasapsapa .. itawag da .. itext da .. tapos adda records da .. ammo dan nu katno jay aldaw nga mabakunaan da".* (Before they will do immunization services, they will let the people know earlier through a phone call, text messages and then they have their records and they know when will they receive the vaccines).

This implies that it is necessary on the part of the health care workers to complete and always update this record to ensure that mothers are aware and are complying with the standards of care they must receive. This serves as reminder when to return for clinic visits and reflect all the services availed with date specified and shows the date of their return for follow-ups. Sibiya (2015) mentioned that a standardized maternity case record used by all facilities at all levels of care aims to improve the quality of care for

pregnant women. This facilitates continuity of care for women during pregnancy, labour and post-partum. All information relating to the pregnancy are entered in a patient-held maternity case record. This antenatal record can also serve as a referral letter if a patient is referred to the next level of care and therefore serves as a link between the different levels of care as well as the antenatal clinic and labour ward.

A closer look at the table 19 on page 106, it revealed a weighted mean of 4.18 described as **highly practiced** along the advocacy of the government on "No Home Delivery Policy". This is one of the long-time traditions and practice of the people that was successfully changed over time. The health department had emphasized the importance of delivery on a health care facility to closely monitor the mother and the baby, preventing complications such as infection. With this, the DOH had lessen incidence of maternal and infant mortality which were formerly high in the past decades. This alarming issue where at least diminished, but constant monitoring and sustainability is needed to maintain such status. Barangay health workers also play a significant role in health care utilization and post-partum conditions. Health education on danger signs which is provided not only by professionals, but also by barangay health workers (BHWs), could enhance knowledge and attitudes in postpartum women, which could ultimately enrich their health and encouraged them to deliver in a health care facility (Llave, 2017).

The result is in consonance with the report made by the National Demographic and Health Survey in the year 2017. It revealed that more than 3 in 4 births or 78 percent are delivered in a health facility, primarily in public sector facilities. One in five births are delivered at home. Health facility births are most common among women with college education (92%) and 97 percent are those in the wealthiest households. Health facility deliveries have nearly tripled, from 28 percent in 1993 to 78 percent in the year 2017.

A report made by the Philippine Statistics Authority (2018) revealed that the number of births by place of occurrence and by usual residence of mother showed a remarkable proportion on births attended by health professionals in the 16 regions of the country. This is indicative of improving health services in terms of maternal and child health care. Among regions, only Autonomous Region in Muslim Mindanao (ARMM) showed a very low proportion of medically attended births. More than half of the births that occurred in the region were attended by traditional birth attendants (hilot/unlicensed midwife).

Deworming of children is also one of the perennial activities on health that recorded a weighted mean of 4.26 described as **very highly practiced** among the respondents. A remarkable result is associated with a long time successful joint effort of the Department of Health along with the Department of Education. The health services section of the education department is closely coordinating with the partner agency in the determination of prospect clients in different educational institutions most specifically in the elementary level. According to the Department of Health (2017), 43 percent of children took deworming medicines.

As far as breastfeeding is concerned, it recorded a weighted mean of 3.75 described as **highly practiced.** The advocacy is emphasizing the advantages of exclusive breastfeeding to both the mother and the child and its socio-economic impact to the family. More and more mothers are turning to exclusive breastfeeding due to its positive effects on their health and the baby. But several mothers cannot sustain this for long due to some reasons like the need for them to work and the busy schedule hinder them to do it that is why some of them are alternating breastfeeding with bottle feeding. Breastfeeding is very common in the Philippines, with 93 percent of children ever breastfed. More than half or 57 percent of children are breastfed within the first hour of life, and 85 percent within the first day (National Demographic and Health Survey, 2017).

The extent of practiced on vitamin A supplementation recorded a weighted mean 4.15 described as **very highly practiced.** Micronutrients are essential vitamins and minerals required for good health. Vitamin

A, which prevents blindness and infection, is particularly important for children. The result of this study is in congruence with the result of a survey that showed seventy-six percent of children aged 6 to 59 months received a Vitamin A supplement in the first half of the year in 2017. Iron is essential for cognitive development in children and low iron intake can contribute to anemia. Twenty-eight percent of children received iron supplements. Pregnant women should take iron tablets for at least 90 days during pregnancy to prevent anemia and other complications.

In the area of maternal, and child care, the participants all agreed during the interview that they were all encouraged to maximize the practice of the services in the health care facility due to overwhelming support and initiatives of the facility and the barangay officials. They experienced the dedication in the delivery of services by the health professionals with the assisstance of their community leaders. They appreciated their efforts in providing services even at the comfort of their homes and the availability of services in the facility and thus, they enjoy the services of the government on this aspect of reproductive health care. Several interviewees mentioned, *"Jay nurses nga aggapo RHU .. suda ti um-umay ditoy .. agitugot dan dagita .. available met ijay barangay hall .. kaasi ni apo ditoy ayan mi mayat met .. nu adda madamag da nga masikog ket umay da danunen ijay balay da .. bilinen dan .. umay ka agpa prenatal nu kastoy kunam kuma ket .. umay da met piman".* Another was quoted saying, *"Apan kami ta umay da met ibaga .. iremind da met nga un-una .. ti schedule .. adda kastoy nga mapasamak .. umay kayo … kastoy nga aldaw .. mayat.* (Those nurses from the RHU are coming here and bringing needed materials, these are also available in the barangay hall. With God's grace, we get good service in our place, if there are pregnant women, they are immediately informed and they will do home visitation, will give pieces of advice. They will also inform them regarding the need to have the pre natal and they will come).

During the phone interview, a barangay leader mentioned, *"Kaasi ti Apo .. ditoy ayan mi ket naalibtak da .. han da ngay nga bay bay-an ti taga barangay .. nasayaat met ti trabaho da .. adda latta datan ijay tao ta nu madi na agusar .. agallukoy da latta nu sino mayat nga agusar".* (With God's grace in our place, they are all active. They will not neglect the people for they have a commendable work and it is in the people already if they do not want to use the service or they will continue to encourage those who wanted to use it). Another barangay official shared, *"Adda met dagijay kagawad mi nga committees min .. adda jay health … suda metten ah magsusubaybay dagijay BHW .. nu adda projects .. kitaen da jay finance na".* (We have barangay councilors in charge of health with the committee members and they are supervising the works of BHWs if there are projects).

This implies that barangay officials and rural health workers are working closely to ensure that their constituents are receiving the expected services they must avail. The community leaders are contributing much in the success of the implementation of the programs of the government and this is a reflection of their dedicated service to the people prioritizing the welfare of the people under their care. The camaraderie they show guarantees the smooth flow of services with the end goal of improving the quality of life of the people.

To help accelerate and sustain the reduction of unmet need for modern family planning technologies, the government released practical guidelines in the form of a memorandum. This directive stressed that local governments might assist in population management in their communities by educating individuals, particularly the less fortunate, about modern family planning. In light of this, the order directed all provincial governors, city and municipal mayors, and punong barangays to ensure that laws are followed by conducting activities to generate community-based demand for modern family planning services, particularly in geographically isolated and disadvantaged areas, as well as in urban poor communities.

Local Government Units (LGUs) can decide how many barangay health workers and community volunteers to deploy to undertake house-to-house visits to identify clients with unmet contemporary family planning needs. LGUs can organize community volunteers who will be paid a minimal wage and get transportation reimbursement from the LGU in order to ensure that all customers with unmet needs are contacted and referred to appropriate facilities for services (Department of Interior and Local Government, 2017).

In support to the results of the study, the diffusion of innovation model describes how quickly people adopt a new product or service. It investigates how trends emerge and assists policymakers in determining the likelihood of success or failure of new programs. It describes how a new idea, product, or positive health behavior spreads through a community or social structure in health care. Several factors are identified by the model that influence how quickly an idea or behavior is adopted. Adoption of a new idea is influenced by the characteristics of the innovation, communication channels, time, and the social system. This model emphasizes the uncertainties associated with new behaviors and assists public health program implementers in determining how to address these uncertainties (LaMorte, 2019).

It can be deemed in Table 20 on page 121 the extent of practice on reproductive health services along adolescent and youth RH education and counseling. The grand mean is 3.56 interpreted as **highly practiced.** For some clientele, adolescent, and youth population's unwillingness to deal with these urgent concerns poses a high risk on their safety and health. Careful planning must be undertaken in collaboration with other organizations and government agencies to empower the youth on this timely and relevant concern. More importantly, the role of the parents as immediate caregivers must be taken into consideration because they are the once that has a direct supervision of their children. Educating the parents will give them an idea on the importance of this matter and will eventually influence their children to be educated as well. The health facilities are expected to make a serious step on making these services made available by the clientele without any hesitations. In 2015, the DOH reported that only 35 percent of 15 to 24-years old men who are having sex with men (MSM) and transgender women (TGW) had correct knowledge on HIV transmission and prevention and is practicing safe sex. This is indicative of the need to step up HIV information efforts in eliciting behavioral change among people at risk of infection.

The Department of Education had recently made an initiative to include reproductive health education in the basic education curriculum. As it reviews the K to 12 Program, the department is taking into consideration the possibility of including a separate subject on sex education to curb the rising cases of early pregnancy and sexually transmitted diseases in the country. Aside from overhauling the curriculum, DepEd underscored the need to equip not just the learners but the teachers, themselves. The need to enrich and further capacitate the teachers is an important

**Table 20. Extent of Practice along Adolescent and Youth RH Education and Counseling**

| INDICATORS | Extent of Practice | |
|---|---|---|
| | WM | DI |
| 1. The facility provides informational and/or audiovisual materials on RH services and concerns of youth clients. | 3.29 | MP |
| 2. The facility has counseling and examination rooms to ensure privacy for youth clients. | 3.60 | HP |

| | | |
|---|---|---|
| 3. Education materials are available, printed and displayed for the youth clients. | 3.59 | HP |
| 4. The facility has available counseling and/or mental health services. | 3.75 | HP |
| 5. Information campaign materials are distributed to the barrios' health centers for adolescent and youth information. | 3.44 | HP |
| 6. Health personnel provides referral information for obtaining services. | 3.73 | HP |
| 7. Health care workers conduct parent education sessions among parents of adolescents. | 3.76 | HP |
| 8. The facility provides psychosocial risk assessment and management. | 3.38 | MP |
| Grand Mean | 3.56 | HP |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

matter because they are not comfortable discussing sex education among the students. Despite challenges in curriculum and medium of instruction, DepEd underscored the need for strengthened efforts to instill among learners the importance of reproductive health education (Malipot, 2019).

But several people including the church are objecting with this idea. Public consultations are made if the step is ethical weighing the positive effects and its negative consequence on the young minds of the students. Around 80 percent of the Philippine population identifies as Roman Catholic. Accordingly, the Catholic Church largely influences the state of sex education in the country. The Catholic Church opposes sex outside of marriage and fears sex education will increase sexual relations. The Catholic Church consequently remains critical increasing difficulties in putting this matter into concrete action. Additionally, the Catholic Church opposes implementing sex education in schools as well as the distribution of contraceptives. The Church prefers to rely on parents to teach their kids about reproductive health. However, many families are either unequipped to do so or will not address the subject directly with their children (Nichols, 2020).

To attain its vision to be the "Safest Space for the Youth in the Ilocandia Region by 2022", the Sangguniang Kabataan Federation of the City of San Fernando, La Union has aimed to establish SK Teen Centers in every barangay of the city that provides quality comprehensive youth care and services in a safe and peaceful environment. Boasting several features such as the youth desk, audio-visual, e-library, reading zone, and chat hub, the teen centers will be an avenue to provide the adolescents of the city not only information and services on their overall health and development, be it mental, reproductive, sexual, emotional, spiritual, or physical but also on aspects such as education, employment, and gender-based violence (City Government of San Fernando, 2020). With this noble program, the challenge is on the encouragement of the youth to utilize and support the noble cause of these initiative.

The Department of Health- CALABARZON (2019) conducted "Peer Education Training on HIV" for students in Cavite. The program targeted students for the workshop because more new HIV cases are being reported among youths between age 12 to 24 years old. The need to empower students and give them the proper and accurate information on the basics of HIV/AIDS is timely and relevant for them to avoid acquiring the virus. The objective is to educate the youth and hear-out their concerns on age-appropriate issues particularly adolescent reproductive health and ensure wellness of DepEd personnel through the provision of basic medical care for better productivity. Peer education training programs are believed to

be an effective way to deliver risk reduction information because of the trust and confidence youths rely on their peers for information and they prefer to receive information on most subjects, including sensitive issues such as reproductive health and HIV. This kind of information dissemination activities must be sustained to increase awareness of the youth as a vulnerable group along this issue of concern.

In support of the result of the interview conducted, Ngwenya (2016) mentioned that there is a need for appropriate communication channels which take into account the technical formats of messages; information needs behavior, norms, values, beliefs and socio-cultural context of rural communities. These factors play pivotal roles in influencing adolescents' decisions regarding their sexual health as stipulated by the excellence in communication model that understanding audiences and building relationship with them are important components for behavioral change.

One of the participants even voiced out her concern over the necessity of this activity to these vulnerable groups, she exclaimed, *"Diyay kuma nga agpayso ket masurwan dan .. ag seminar da kuma .. ta tatta ket ubbing payen ti agsisikog"*. (In reality, they should have been taught and attended a seminar because today, very young teenagers get pregnant). She added, *"Ngamin ti center .. para nanang ken ubbing lang .. dapat nga agpyso nga adda met kadagita nga tawen .. 14 .. 15 .. ta suda payen ti agsisikog .. addan tupay ditoy .. high school paylang"*. (The health center is for the mother and child only, but supposedly those ages 14 to 15 should be considered because they are the once who get pregnant at an early age as early as high school. Digging further in the conversation, she mentioned, *"Nu kuma nasursurwan da idi .. ngem diyay garod ta high school .. naad-adal da metten dagitan .. ti science .. ti iskwelaan .. ngem kayat da talaga nga maaramid"*. (The young should have been taught seriously about it even if they have already learned it in science subject in school, but still, they chose to get pregnant). She also reiterated the inadequacy of the information materials distributed to the youth. She mentioned, *"Awan met dagita brochures dita ti STD .. nga makitkita .. sabagay awan met ditoy ta dagita nga saksakit ket ijay met Manila .. awan met ti nadamdamag mi nga kakasta nga kaso ditoy .. ngem masapol latta ah"*. (There are no brochures for STD that are visible because we do not have that disease which is a common disease in Manila. Even if there are no cases here, we did not heard anything, but still, it is a necessity to have brochures like that).

This implies that family members and authorized people to provide basic and essential information about these sensitive issues are expected to be visible and ready to give assistance to the youth and adolescent population. They play a crucial role in providing extended help to prevent the emergence of negative consequences brought by rising reports of teenage pregnancy and sexually transmitted infections among the young population. Opportunities given to them to develop health literacy were ignored and were sometimes deliberately undermined by these people ending up in a problematic situation like those who were got pregnant at a very young age.

In support to the result of the study, Mataboge and Masemola- Yende (2015) emphasized that orientation and health programs are expected to be provided in schools primarily to educate young people about sexuality and sexual relationships, including prevention of teenage pregnancy. The school is regarded as a captive setting in which to reach a large audience of young people, hopefully before they initiate sexual activity. It is in schools were children are taught about life skills, reproductive health, coping skills and sex education, like prevention of STD and HIV. Also, peers are also considered as providers of information because females discuss many topics freely with their colleagues which they would rarely discuss openly with their mothers, sisters or healthcare providers. Some teenagers were geared toward pregnancy

prevention and shared such information with their peers. Friends and boyfriends are also regarded to be providers of information.

Health care workers admitted during the phone interview that they have difficulty of initiating activities for the youth population. One of them were quoted saying, *"Aminado kami dita nga awan services kenyada .. nag fo-fall short kami jan .. aminado kami jan na neglected .. although han met nga maigagagara".* "We admit that we do not have services for them. We fall short on that aspect. We are very honest we have neglected them, although it is not intentional. Another health care worker shared their difficulties in extending services to the youth. According to him, *"Mahirap ang mga adolescent na iencouarge .. kung iinvite mo sila sa seminars .. walang pupunta .. kaya ang naging strategy namin dito ay individualized .. kase mahirap talaga. Ang nakikita kong rason nila eh waste of time .. available naman yung information sa internet .. technological .. peer pressure .. mabain da kasjay .. IEC meron .. pero sa testing .. jan kami nahihirapan kase may legal implications yan .. hindi basta basta na magttest kalang dun sa barangay .. may mga permit pa yan at legal requirements sa DOH".* "It is really difficult for us to encourage the adolescents. If you will invite them to attend seminars, nobody will go, that is why we strategized it to be individualized due to its difficulty. I can see some reasons like it is just a waste of time that they can just browse over the internet, technological pressure, peer pressure, they are ashamed reasons like that. We have IECs, but for testing, we have difficulties in that aspect due to legal implications of it because you can not just simply conduct testing in the barangay for it needs permit and other legal requirements from the DOH).

Also, a health care worker emphasized the need to work closely to the barangay officials. She said, *"Ang isa pa kaseng problema ay LGU, provincial, at DOH levels lang gumagalaw .. dapat na nangunguna ang barangay officials .. may mga barangay service point officers namang trained ti POPCOM .. adda met jay kagawad on health nga laging kasali ti trainings".* (Another problem is that only the LGU, provincial and DOH are actively working. Barangay officials should be in the frontline and they have barangay service point officers trained by POPCOM. They also have barangay councilor incharge of health who is always attending several trainings). In terms of the Sangguniang Kabataan intiatives, the interviwee voiced out her concerns saying, *"Sa SK municipal level .. mayat met .. pero pagdating sa barangay levels .. inactive .. tapos nu SK gamin ket ti activities da ket haan nga about health .. more of sports da".* (In the SK municipal level, it is good, but at the barangay level, they are inactive. And SK activities are not about health, but more of sports". This was seconded by another health worker saying, *"Dapat gamin katulungan mi kuma met ti SK .. kase adda met sarili nga fund .. ngem dagitoy SK officials .. lalo nu estudyante da .. han da nga unay nga mapagtuunan ti pansin dagitoy .. nu agpaayab kami ket bassit lang umay .. adda talaga met pagkurangan ti RHU .. ijay part mi nga talaga".* (The SK should work closely with us because they have the fund, but the SK officials tend to ignore those and only few will come if we will call for activities. We fall short on the part of the RHU).

Alongside with this, personal issues and concerns on the part of the adolescent and youth population were also shared by the barangay officials during the phone interview. One of them said, "*Talaga nga mabain da .. lalo nu ti topic ket teenage pregnancy ket nagsiksikog dan .. talaga nga mabain da .. basta nagrigat ngay .. han mi talaga mapag tuunan ti pansin talaga".* (They are really ashamed, most especially if they already got pregnant. They are really ashamed and it is difficult because we can not give our full attention to it). One of the interviewee also shared the strategy they did, he said, *"Ang information drive ay dapat sa ground level .. sa mga schools hindi sa mga barangays .. may mga heart to heart talk kaming ginawa .. my mga lectures about adolescent health .. STDs .. mga ganyan .. pero yun ngay mga out of school youth ..*

*yun ang problema".* (Information drives should be at the ground level, in schools not in the barangays. We had heart to heart talk with them, lectures on adolescent health, STDs, like that, but how none for the out-of-school youth which is the problem).

This implies that adolescent and youth members of the population are deprived of the relevant information that they need to have to ensure good reproductive health. It is through this information drives that they are informed on the services intended for them which can help them to be holistically healthy. The lack of information greatly influence their utilization rate and thus putting them at risk of possible problems such as premarital sex and sexually transmitted infections among others. In relation to the results generated in the study, Asio (2019) concluded that the most vital part of the study they conducted falls into the idea that adolescent's information needs to be met to raise awareness of the issues and concepts of reproductive health. The crucial role of educators and health practitioners to disseminate important facts, timely and religiously, so as to guide the youth of the next generation is essential to counter the problem in this area of reproductive health among this vulnerable member of the population.

In support with the results of this study, the social ecological model of health takes a broad view of health and focuses on a variety of factors that may influence health. This broad perspective on health considers physical, mental, and social well-being. It considers health to be influenced by the interaction of the individual, group, or community with the physical, social, and political environments to which people are exposed. The core principles that underpin the model's contributions to community engagement efforts include health status, emotional well-being, and social cohesion, all of which are influenced by the physical, social, and cultural dimensions of an individual's or community's environment and personal attributes. The same environment can have different effects on an individual's health depending on a number of factors, including perceptions of environmental control and financial resources. Individuals and groups operate in a variety of environments, which "spill over" and influence one another. There are personal and environmental "leverage points" that have a significant impact on health and well-being, such as the physical environment, available resources, and social norms (U.S. Department of Health & Human Services, 2015).

Table 21 on page 130 shows the extent of practice on reproductive health services along prevention and management of sexually transmitted diseases. The grand mean is 3.39 described as **moderately practiced.** The results are in consonance with the low levels of practice along RH education and counseling. Stigma had brought a huge problem in the access of services in these areas of concern. People do not want to avail of the services because of the fear to be discriminated by other people. Because of these, there is a constant increase of cases of STD- HIV/ AIDS in the country most especially in the younger people. Ninety-four percent of women have heard of HIV/AIDS in the year 2017. However, only 62 percent know that the risk of getting HIV can be reduced by using condoms and limiting sex to one monogamous, uninfected partner. Misconceptions about HIV transmission are still common in the Philippines. Only one quarter of women have comprehensive knowledge about HIV. Seventy-one percent of women display discriminatory attitudes towards people living with HIV. Forty-five percent know where to get an HIV test. Regionally, knowledge of where to get an HIV test ranges from 29 percent in ARMM to 61 percent in Western Visayas. Only 5 percent of women have ever been tested for HIV and received their results, and 95 percent of women have never been tested for HIV.

In 2016, only 2 percent of women have been tested for HIV and received their results. Recent HIV testing has changed little since 2013 when only 1 percent of women were tested for HIV in the 12 months before

the survey and received their results (National Demographic and Health Survey, 2017). As of June 2020, there is approximately 79 thousand number of people living with HIV/AIDS in the Philippines.

**Table 21. Extent of Practice along Prevention and Management of Sexually Transmitted Diseases**

| INDICATORS | Extent of Practice | |
|---|---|---|
| | WM | DI |
| 1. The facility provides STD/ HIV risk assessment. | 2.96 | MP |
| 2. The facility provides diagnostic exam such as gram staining and culture and sensitivity. | 3.50 | HP |
| 3. The facility provides risk reduction counselling. | 3.65 | HP |
| 4. The facility offers FREE sexually transmitted disease/ HIV/ AIDS screening. | 3.19 | MP |
| 5. The facility provides easy access to condoms. | 3.71 | HP |
| 6. The facility conducts STD- HIV/ AIDS awareness campaigns and information drives. | 3.34 | MP |
| 7. The facility has a well-established social hygiene clinic with fully trained personnel. | 3.40 | HP |
| Grand Mean | 3.39 | MP |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

The number of people infected in the country has increased over the last years (Sanchez, 2020).

It can be gleaned from the table that sexually transmitted diseases screening got a weighted mean of 3.19 described as **moderately practiced.** The underutilization of this initiatives despite of being free of charge is linked with some of the personal issues and concerns relative to its access. The need for holistic management in education, detection, and therapeutic management is needed to control the continuously growing issues along HIV/AIDS. Gepte (n.d.) mentioned that for MSM clients, there were concerns about apprehensions in going to the social hygiene clinics due to the following reasons: possible clients might be mistaken as sex workers, other people might judge them as being ill, they may face rejection and discrimination when they become aware that they are sick, and clients want to be assured that their privacy will be respected and the results of testing will be confidential.

These statements were supported by the results of the study conducted by the United Nations Development Program in the Philippines last 2017. It highlighted some of the reasons why people do not get tested for HIV. The most important reason was not seeing the need to get tested despite of some episodes of risky behavior in the past, they consider themselves healthy due to a good physical shape, having a healthy lifestyle, not feeling ill, busy work schedule and other commitments, and the fear of what happens when a person tests positive.

The easy access to condoms to prevent HIV transmission obtained a mean of 3.71 described as **highly practiced.** For some areas in the country, the constant increase in the cases of HIV/ AIDS is associated with the difficulty of the public to avail of this product due to government policies, personal choice not to used it, and supplies are sometimes inadequate in the health care facilities. These are long standing issues that are fueling up the epidemic. Several laws in the country prohibits the diagnostic procedures to people

below 18 without the consent of the guardian. The age restriction is a serious obstacle to testing, counseling, and treatment for adolescents and young men which are described as the most vulnerable, and a barrier to accurately measure the epidemic's growth.

The Roman Catholic Church has also a long-standing opposition to RH. They have personal attacks against government officials who are in favor of it on the basis that condom use promotes promiscuity. The absence of effective promotion and retail marketing of condoms also limits the utilization, particularly among MSM populations. Manufacturers blames obstacles created by the Ad Standards Council because they discourage the use of even the word "condom" in billboard ads, let alone an actual photo of a condom or any overt display of same-sex affection (Human Rights Watch, 2016).

In support of the study, the Behavioral Theory of Health Care Utilization sought to understand how and why people use healthcare services, as well as to assess disparities in access to health care. The model focused on an individual's proclivity to use acute healthcare services, enabling factors that facilitate use, and one's perceived or influenced need for care to predict or explain one's use of healthcare services. With this model, one can assess access measures such as equitable, inequitable, effective, and efficient, as well as comprehend the environment, whether external or healthcare system-related, that influences access and utilization of healthcare services (Hirschman, et. al., 2020).

It can be gleaned from Table 22 on page 133 the extent of practice on reproductive health services along male responsibility and involvement in reproductive health. The grand mean is 3.73 interpreted as **highly practiced.** For some people, they perceived that majority of the services on reproductive health made available in the health centers are for women. The sense of involvement of males on RH is less considered and there are limited programs specific for them. This concern is even aggravated by personal reasons and issues related to psychosocial aspects that hinder them to avail such services. This needs immediate action to let them involve on this matter concerning their family welfare.

Barangay officials shared their concerns on this matter during the phone interview. One of them mentioned, *"Jay dadduma nga agassawa, babae lattan ti pagusaren da kase it is a responsibility ti babae .. FP commodities ket haan nga para kanyada nga lalaki .. itudo da lattan nga ni misis dan to agusar".* (For some couples, they will let the woman use it because it is her resposibility. FP commodities are not for the males. They will just pinpoint their wife or partner to use it). The health care workers also shared her insights about this during the phone interview saying, *"low ti male involvement ti family planning jay dadduma .. dun lang sa activity ng pantawid pamilya .. maforce da nga umay .. or else awan maawat da .. ngem nu dakami lang solely .. nagado reasons da nga haan nga umay .. actually .. awan mairep report mi ti vasectomy .. naiinform damet nga han nga agpyso data nakakabawas nang pagkalalaki*

**Table 22. Extent of Practice along Male Responsibility and Involvement in Reproductive Health**

| INDICATORS | Extent of Practice | |
|---|---|---|
| | WM | DI |
| 1. Facility services are offered to both male and female clients. | 3.77 | HP |
| 2. Health care workers conduct parenting classes. | 3.75 | HP |
| 3. Health care workers provide infertility consultations. | 3.65 | HP |
| 4. Several training on male involvement in reproductive health are conducted on a regular basis. | 3.66 | HP |

| | | |
|---|---|---|
| 5. Campaigns are initiated on promoting male roles on:<br>a. avoidance of unwanted pregnancy | 3.67 | HP |
| b. violence prevention | 3.81 | HP |
| c. promotion of responsible fatherhood | 3.83 | HP |
| 6. The facility conducts minor operations such as male sterilization or vasectomy to prevent pregnancy. | 3.71 | HP |
| Grand Mean | 3.73 | HP |

Legend: WM- Weighted Mean; DI- Descriptive Interpretation: Very Highly Aware (VHA); Highly Aware (HA); Moderately Aware (MA); Fairly Aware (FA); Not Aware (NA)

*.. awan met to kasjay nga effect na .. pero uray man pay .. han da latta mamati .. narigat mi nga maconvince .. zero talaga kami dita".* (Male involvement in family planning is low. They will participate only in the activity of the pantawid pamilya. They will be forced to participate or else they will not receieve any benefits (financial benefits from the government), but if we alone will do it, we can not. They have a lot of reasons not to participate. Actually we have zero reports for vasectomy. They were informed that decreasing masculinity as a side effect of vasectomy is not true, but still they do not believe. They can be hardly convinced .. we are zero on that matter or service).

In the study conducted by Fisher, et. al. (2020), results showed that most health workers have not been adequately trained to provide male-friendly services or to mobilize men. Interventions are highly dependent on external aid and support, which in turn renders them unsustainable. Community and religious leaders, and men themselves, are often left out of the design and management of male involvement interventions, and communication and feedback mechanisms were found to be inadequate.

It can be gleaned in the table 22 on page 133 that campaigns initiated on the promotion of male roles on the prevention of violence got a weighted mean of 3.81 (highly practiced). In some areas, spousal and sexual violence are still rampant, and incidents are unreported, and majority are undocumented. That is, reported cases of violence against women represent only a very small part of the problem when compared with prevalence data (European Institute for Gender Equality, 2018).

One in four married women aged 15 to 49 experienced spousal violence. Emotional violence registered 20 percent while three percent experienced violence during pregnancy. Fifteen percent of divorced, separated, and/or widowed women have experienced sexual violence, compared to 6 percent of married women. Seventeen percent of women experienced physical violence since age 15. Experience of physical violence is higher among divorced, separated, or widowed women at 33 percent than married women at 19 percent. The most common perpetrator of violence is the current husband/partner. One-third of women who have experienced physical or sexual violence sought help to stop the violence, while 41 percent of women never sought help nor told anyone. The most common sources of help are women's own families at 65 percent (National Demographic and Health Survey, 2017).

Campaigns initiated on the promotion of male roles in the avoidance of unwanted pregnancy got a weighted mean of 3.67 described as **highly practiced.** In relation to this, promotion of responsible fatherhood obtained a weighted mean of 3.83 described as **highly practiced.** In other areas, low levels of practiced linked to a continuous rise in cases of teenage pregnancies where involvement of the males are markedly less. The number of Filipino minors who gave birth in 2019 increased to 62, 510 which was slightly higher than the 62, 341 minors in 2018 and persists at an alarming rate (Perez, 2021).

Connor, et. al. (2018) identified several reasons why there is a less involvement of males in reproductive health. It includes a very limited support available to any adolescent males who do intend to stay involved

in the pregnancy and take on the role of fatherhood, males feel excluded from being involved in the pregnancy and fatherhood by the health care providers, they were not considered to be relevant in the context and that the focus is on supporting the adolescent mothers with unintended pregnancies, and the traditional masculinity norms that reinforce beliefs around the male body being strong.

According to Bukusi, et. al. (2013), men are key decision-makers around use of contraceptives and usually want to be involved in reproductive decision-making. There are improvements in the uptake of contraception when men are involved in family planning. Furthermore, reproductive health programs that target couples are more effective at increasing contraceptive use than those directed to individuals. It has been pointed out that among the major weaknesses of family planning program is its focus on women and corresponding lack of male contraceptive responsibility, and therefore, the need for men's shared responsibility and involvement in all aspects of reproductive health.

In support of the results of the study, transcultural care theory focuses on structures that are dynamic patterns and features of interrelated factors such as religion, political, legal, economic, educational, technological, and cultural values, and how these factors can influence human behavior in various environmental contexts (Gonzalo, 2021). People's attitudes toward health are strongly influenced by factors such as socioeconomic status, gender roles and responsibilities, sexual behavior, pregnancy and birth practices, general health regulations, professions, religion, habits, and self-healing strategies, among others. The beliefs and practices of individuals are woven into the fabric of the society in which they live. Cultural characteristics should be considered a dynamic factor in health and disease. To provide better health care, it is necessary to first understand how patients perceive and respond to disease and health, as well as the cultural factors that influence their behavior (Deger, 2017).

In addition, the Theory of Reasoned Action is used to explain and predict behavior based on attitudes, norms, and intentions. The construct is as follows: behavioral beliefs, evaluation of behavioral outcomes that lead to attitudes, then normative beliefs, motivations to follow, and subjective norms. Both attitudes and subjective norms lead to the intention to carry out the action, which leads to the action. In this study, the motivation for people to learn new things about reproductive health services is determined by their attitudes, social norms, personal beliefs, and environmental barriers (Salgues, 2016).

**Relationship Between the Sociocultural Profiles and Level of Awareness of the Respondents on RH services**

A chi-square test of independence in Table 23 on page 137 was performed to examine the relation between the religion of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was significant, $X^2 = 20.846$, $p = .000$. Those who

**Table 23. Relationship between Sociocultural Profiles and Level of Awareness**

| Profile Variables | $X^2$ (chi-square statistic) | *p*-value |
|---|---|---|
| Age | 8.44 | 0.076 |
| Gender | 0.865 | 0.352 |
| Family size (Based on the number of children) | 12.854 | 0.169 |
| Highest educational attainment | 7.441 | 0.114 |
| Income | 15.063 | 0.004* |

| Religion | 20.846 | 0.000* |
|---|---|---|
| Ethnicity | 6.465 | 0.011* |

*Significant at .05 level of significance

belong to the Roman Catholics were more likely to be aware on RH programs than those who belong to other religious groups. Religion, thus plays a crucial role in informing the public about the pros and cons of RH and is a determinant in the easy understanding and acceptance of this information. Their faith and the teachings of the church where they are affiliated with has a huge influence in their decision-making as far as RH is concerned. Indeed, religion has a significant impact in the education and lifestyle of its adherents.

In congruence with the results of the study, it was noted in Islamic societies that some social practices are outlawed or considered unacceptable. Sexual and reproductive health issues are rarely discussed among Muslim people because they are considered sensitive subjects. There is a widespread belief in Islam that unmarried women do not need to know about their own sexual reproductive health. This assumption is based on society's high regard for women's virginity prior to marriage, as well as the belief that discussing SRH would encourage premarital sexual interactions (Alomair, et. al., 2020).

Research conducted by Sundararajan and Yoder (2019) revealed that women who regularly attend religious services are less likely to receive information on family planning from healthcare facilities. It was previously showed that church attenders are eager to learn about and discuss reproductive health interventions in the context of their religious beliefs and that the uptake of the services could be increased when church leaders received education about this health topic, which they then imparted to their congregations.

A chi-square test of independence in Table 23 on page 137 was performed on Table 21 on page 139 to examine the relation between the income of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was significant, $X^2 = 15.063$, $p = 0.004$. This means that the socioeconomic status of the respondents affects the way they receive information on RH. Several information about RH is present in both print and social media which the wealthier members of the population have easier access with. This thus help them to be more informed and knowledgeable about several essential concepts regarding sexual and reproductive health.

Favorable working conditions, such as income, benefits, and job security, have the greatest impact on women's health in general. Improved living conditions will lead to female economic empowerment, which will aid in the resolution of health issues at any stage of life. Furthermore, it has the potential to improve women's values, increase access to information databases because of social connections, and increase their decision-making capacity in relation to many aspects of reproductive health. As a result, women have a better understanding of reproductive health. Because employment and income are the most important indices of social and economic standing, they can have an impact on women's reproductive health (Khazaeian, 2018).

Family planning information via television or print media is unequally distributed in favor of wealthy population. This is unsurprising since money facilitates access and assimilation of information. Thus, higher income improves family planning media messages. Although few people receive family planning information through media messaging, people with low income have less access to family planning information through television or print media (Groot, et. al., 2018).

A chi-square test of independence in Table 23 on page 137 was performed to examine the relation between the ethnicity of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was significant, $X^2 = 6.465$, $p = 0.011$. The result signifies the stronghold and influence of ethnicity and associated culture and customs of the community people in their acceptance of RH information and education. Ethnic beliefs that have been passed from their ancestors related to their culture significantly affect their willingness to participate in the programs of the government which limit their capacity to learn new information about the essentials of sexual and reproductive health.

It was mentioned by Karver (2016), that ethnic groups lag in most social indicators such as sexual and reproductive health. Low levels of awareness about human sexuality, as well as inappropriate or poor-quality reproductive health information and services, the prevalence of high-risk sexual behavior, and discriminatory social practices, are all factors that affect many people in disadvantaged situations and are important in explaining ethnic people's poorer sexual and reproductive health outcomes.

According to Crivelli (2013), high maternal death rates are common among them, and despite the lack of accurate data on reproductive health and voluntary family planning, there is evidence of lower rates of voluntary contraception use among adults of reproductive age. Also, young mothers frequently drop out of school, which negatively affects their right to education and access to information on health, including sexual and reproductive health. There are limits in the education and health infrastructure to meet ethnic people's special demands. This adds to the youth's lack of access to information, as well as the early detection of sexually transmitted infections and the prevention of pregnancies.

Furthermore, adolescents and youth have little understanding about HIV, its transmission, prevention, and diagnosis, treatment options. The shortage of bilingual medical personnel is exacerbated by the prevalence of discriminatory attitudes towards women and youth (Inter-agency Support Group on Indigenous Peoples' Issues, 2014).

A chi-square test of independence in Table 23 on page 137 was performed to examine the relation between the number of children of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 12.854$, $p = 0.169$. The result signifies that whether the respondents have only one child or many children, it does not have an impact on the awareness on reproductive health that they have.

Idoko, et. al. (2016) concluded that despite the availability of modern contraceptive methods, grand multiparity is still extremely common and the desire for more children was the most common reason reported for the current pregnancy. Thus, women should be aware about the dangers of grand multiparity and encouraged to use appropriate family planning strategies to avoid having more children. However, it is critical to emphasize the importance of high-quality antenatal care that successfully includes the concepts of birth preparedness and complication readiness, as the impacts of these difficulties can be mitigated with proper antenatal care. It will also be critical to disseminate proper contraceptive information to dispel common misconceptions about contraception.

A chi-square test of independence in Table 23 on page 137 was performed to examine the relation between the age of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 8.44$, $p = 0.076$. This means that age does not influence the awareness of the people on reproductive health. The findings of Faludi and Rada (2019) contradicts the result of this study. It reveals that sexual and reproductive health issues can be improved during adolescence and is the most effective strategy to reduce risk behaviors, medical costs,

and the health repercussions of sexually transmitted illnesses. Health conversations were typically initiated by a parent of the same gender, and they frequently occurred following significant milestones in a young person's sexual life, such as first menstruation or sexual debut. Younger people and those who have had discussions about sexual and reproductive health in their family had a higher probability of experiencing a healthy sexual onset. As a matter of fact, in terms of sexual intercourse, younger generations are becoming increasingly well-informed. Furthermore, young individuals in urbanized areas have easier access to information and modern contraception than young people in rural locations.

Most adolescent women have frequent access to television and radio, and these mediums could be useful for disseminating accurate sexual and reproductive health information. Furthermore, as more teenagers utilize the Internet, the ability to harness new forums, such as social media, might help them become more conscious of reproductive health. Conversely, Heidari (2016) reveals that there is a lack of information about HIV and other sexually transmitted infections among older persons, thus researchers are looking into how age affects the process of knowledge acquisition through time. Because of misconceptions regarding their low risk, HIV testing and counselling programs frequently prohibit or discourage older people from participating in screening and diagnostic procedures.

A chi-square test of independence in Table 23 on page 137 was performed to examine the relation between the highest educational attainment of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 7.441$, $p = 0.114$. The result of the study reveals that education has nothing to contribute to the level of awareness of the respondents on reproductive health.

The result of the study is in contrast with the study conducted by Alsonini and Masood (2017). They mentioned that people with a college education knew more about family planning methods and information sources than those with only a high school education. People with a secondary education were more likely than those with a basic education to know more about health services for family planning, methods of FP, the meaning of FP, and information sources. Higher educational levels are linked to more learning opportunities, and an individual's perspective of health results may improve, leading to more efforts for maintaining health in all aspects (Khazaeian, 2018).

Meanwhile, Yitbarek et. al. (2018) highlighted the importance of health information among the people and found that adolescents who had ever discussed RH concerns with relatives, family, or health workers were 3.63 percent times more likely to use services than those who had never discussed RH issues with anyone else. Therefore, cultivating a community-wide culture of dialogue and education about RH issues may assist teens in being more aware of the services that are available.

A chi-square test of independence in Table 23 on page 137 was performed to examine the relation between the gender of the respondents and their level of awareness on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 0.865$, $p = 0.352$. The result implies that the gender of the respondents is not a factor in their awareness of the RH services available and is provided by the government.

The result of this study is inconsonance with Faludi and Rada (2019). They emphasized that males are high-priority population for sexual health care since they participate in more risky sexual activities than girls. They are, however, less likely to seek out sexual health information or to seek out sexual health services. Conversely, girls are more likely than boys to participate in discussions about sexual and reproductive health. When it comes to communicating with females about SRH, parents are more cautious and focused on the negative consequences of sexual engagement.

**Relationship Between the Sociocultural Profiles and Extent of Practice of the Respondents of RH Services**

A chi-square test of independence in Table 24 on page 145 was performed to examine the relation between the highest educational attainment of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables were significant, $X^2 = 15.543$, $p = 0.003$. The result implies that education contributes to the knowledge of the people and aids in their decision-making thus enable them to use RH services based on their perceived benefits to them.

**Table 24. Relationship between Sociocultural Profiles and Extent of Practice**

| Profile Variables | $X^2$ (chi-square statistic) | *p*-value |
|---|---|---|
| Age | 9.002 | 0.061 |
| Gender | 0.9025 | 0.342 |
| Family size (Based on the number of children) | 12.559 | 0.183 |
| Highest educational attainment | 15.543 | 0.003* |
| Income | 0.6567 | 0.956 |
| Religion | 11.714 | 0.019* |
| Ethnicity | 4.326 | 0.037* |

*Significant at .05 level of significance

The result of the study is congruent with the result of the study conducted by Yitbarek & Morankar (2018). It was found out that people with a primary level of education were 57 percent less likely to use RH services than those with a secondary or higher level of education. In-school adolescents were 2.39 percent more likely than out-of-school adolescents to use family planning services. This demonstrates that education is a key determinant of service usage, and health information, on the availability and need for RH services, should be provided to people on a regular basis.

Meanwhile, discussion with sexual partner and peers was among the predictors of reproductive health services utilization (Tlaye, 2018). Thus, people who have knowledge and acquire good and right thoughts and attitudes are more likely to engage in healthy activities and habits. Women with insufficient RH knowledge may be uninformed of the risks of gynecological diseases and may refuse medical care because they believe such diseases will have no impact on their lives (Liu, Wang, & Lu, 2014).

Also, women's educational attainment is a significant indicator of their capacity to make strategic life decisions. These decisions include whether to use contraception, go to the hospital for antenatal care, and give birth in a medical institution. Similarly, educated women are more likely than their uneducated counterparts to be more efficient in the production of health through access to and utilization of health-related knowledge. Education may have an impact on household decision-making and, in some cases, control over the choice and use of reproductive health care. As a result, it is possible that partners have more decision-making power when it comes to contraception. Hence, partners who are educated are more likely to have a say in the decision to use modern contraception (Abor and Abekah-Nkrumah, 2018).

Also, a chi-square test of independence in Table 24 on page 145 was performed to examine the relation between the religion of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables was significant, $X^2 = 11.714$, $p = 0.019$. The result signifies that religious faith contributes to their utilization of RH services provided by the government. The teachings of the church are being considered by their adherents and thus affects their

decision-making whether they will patronize these services intended for them. Although several religious groups are available elsewhere, they have an impact in the way of living of the people.
Christian teachings vary depending upon the denomination. The result of the study is incongruence with O'Loughlin (2016) when he mentioned that some followers of Roman Catholicism rejected the church's stance on the practice of reproductive health care. They are teaching that the fundamental goal of sexual intercourse in marriage is procreation. As a result, the faithful are prohibited from using medical or physical contraception techniques. Abstinence and the rhythm method, which are both natural contraceptive methods, are still legal.
The need to reproduce is a literal interpretation of the Bible among conservative Protestant groups, however, it is normal for members to take birth control. While liberal Protestants support procreation, they recognize that it is not the main aim of sexual relations and thus, no specific forms of contraception that are prohibited according to them. Similarly, Islam encourages big families and expects parents to ensure that their children's basic rights are respected. Although family planning is not outlawed, traditional believers prefer to utilize it to space out their children's births rather than to limit the overall size of their households. Even though contraception is legal in Islam, not all Muslims are aware of it. Despite the importance of religion in influencing decisions, practitioners of a faith do not necessarily adhere to the prescribed doctrines of their faith. Similarly, the research conducted by Bakibinga (2015) concluded that religion does not have impact in the family planning approval.
Religious affiliations on the matter concerning reproductive health really differs. During the interview, when participants were asked about their idea about how religion affects their RH awareness and practiced, some of them introduced the controversial issue regarding the misunderstanding of the church and the government about the RH. One of the participants stated, "*... mostly Catholics gamin .. madi da kayat .. han nga maiyannatup iti pammati da .. ngem ti sabali nga relihiyon ket haan met .. awan ngay .. di kami met mamati .. ni father ko garod pastor .. han nga mamati dagita .. aramiden .. aramiden .. siguro nu diyay lang maka apektar .. it affects .. isu diyay .. Open met ti born again .. han da met ipagpagel"*. (Mostly in the Catholics, they do not want it because does not fit with their faith, but it is not for other religions. We do not believe especially my father who is a pastor, he does not believe in those. Maybe only those that affects us but for Christians, it's open and they do not stop us). This was supported by another participant, she voiced out, *"Born again ako .. wala namang pinagbabawal .. parang open-minded naman .. wala namang sinasabe na huwag"*. (I am a Born Again Christian, nothing is prohibited, we are open minded).
One participant even mentioned that one of the main reasons in the opposite belief of the church and the state is rooted in the interpretation of the bible passages. She pointed out, *"Kuna gamin ti bibliya ket .. go and multiply .. datoy met gobyerno .. syempre concern met ti kinaado ti ado tao ken rigat iti panagbiyag .. isu kunada nga agkontrol"*. (The Bible said, go and multiply, but the government's concern is on the number of people and the issue on poverty that is why they said that, there is a need for birth control). Going deeper in the conversation, the participant voiced out, *"Diyay met gamin Catholics ket suda lang met iti kumonkontra .. ngem uray pay anya ibaga da ijay ngato ket dagitoy followers ket agus-usar da met latta"*. (The Catholics are the only ones that are against it, but even what the higher officials may say, the people are still using contraceptives). A participant also verbalized his personal take on the matter saying, *"Sabali gamin ajay .. naka set aside jay government ken espiritwal .. han met nga bawal ijay religion mi .. palpalubusan dakami latta"*. (The government and spiritual people have different beliefs as to this, but our religion does not stop us, they let us use contraceptives).

During the phone interview, one of the barangay official shared his insights about this concern. He said, "*Haan nga makaapektar data .. adu metten ti ammon ti tattaon .. idi ah ta talaga nga ignorante ti tattao .. ket tatta nagbaliw metten ti tiyempon .. maadalan da metten .. ken dagita mabuybuya dan ti TV*". (It does not have any effect at all because people are already informed. Maybe in the past when people are still ignorant, but now time has changed and they were already taught about it, and those that they can see in the television). In support of this, a health care worker during the phone interview clarified, "*Haan nga mairelate solely nga jay haan da nga panag usar ket because of religion .. kase adda met dagijay members nga ag av avail da latta met .. nu maiformed da ti kakastoy .. umay da met .. han da ikkwa ti religion".* (One can not relate solely the non-use of contraceptives to religion because there are also members who are willing to avail. If they are informed, they come and not to consider religion an issue). This impies that despite of the religious teachings, it is still the couple's choice as to whether they will use contraceptives or not depending on their perceived benefits of the services. It is still on the decision of the couple as to how many children they will have considering their current socioeconmic status and their capacity to sustain and provide the needs of their family.

In strong support to the Roman Catholic faith, former Senator Francisco Tatad reiterated that the the state's imposition on people's utilization of reproductive health services denies the basic right of married couple to procreate on their own free will. Futhermore, the Senator clarified that it is not equally protecting the right of the mother and right of the unborn and this is simply putting the family under state supervision and control (Tupas, 2013). The church reiterated its stance on birth control and emphasized the rejection of artificial methods but encouraged the use of natural family planning methods (Narang, 2015).

On the other hand, the government stands mainly about the control of population, Pro Choice and Pro Chance, RH education for the youth and maternal care. Some of the participants are actually knowledgable about this, one even said, *"Ok naman .. kase nung medyo bata pa ako .. wala pa akong gaanong knowledge sa contraceptives kaya di ko masyadong pinapansin .. wala namang nag aadvise sakin .. kase bata nga din akong nabuntis .. kaya ganon .. di ako naturuan .. di naman ako ganon ka-active na bumisita sa health center .. lage lang akong nasa bahay .. wala namang mga seminar seminar about family planning .. syempre ayon .. diko nga alam .. kaya ayun sunod sunod na sila .. atleast ngayon alam kuna".* (It is ok because when I was younger, I do not have enough knowledge yet about contraceptives that is why I am ignoring it. Nobody is advising me that is why I got pregnant at an early age. I am not that active in visiting clinics, I always stay at home and there are no seminars conducted about family planning, that is why I do not know, but now, seminars come one after another, atleast now I know). Another participant mentioned that because of the the family planning services she availed, it helped her to lessen the possibility of producing more children. She said, *"Innem annak kon .. nakatulong met ah .. tanu di ak nagus usar ket .. ad-adu kuma pay .. hanggang tatta pay siguro".* (I have six kids and it helped a lot. If I did not use contraceptives, it should have been more until now).

These manifestations clearly show that religion do have a little impact on the utilization of the people to family planning services. People consider their immediate need when deciding to use the services. One of them stated, *"Haan sir .. awan sir .. awan epekto na .. awan dagita .. depende kenka .. desisyon mo latta ta sika met agar- aramid ta pamilyam .. sika mangplano pamilyam .. syempre .. sika met mangkontrol nu kayat mo agusar tapno han ka aganak ulit".* (No sir, it does not have any effect, it is nothing, it depends on you and it is your decision to make and plan for your own family. Of course, it is you who controls, if you wanted so that you will not get pregnant again).

Some even claimed that their religious congregations do not have any specific teachings or order as to the practice of using family planning services provided by the government. This was supported by several participants saying, *"Pentecostal religion ko .. han da met ibawal .. adda latta kenyam sir"* .. *"Awan met ti kasta nga pannursuro ti Anglican".* (Pentecostal is my religion and they do not forbid, it is still your decision).

This means that it is on the current condition or situation that is being considered by the couples when deciding wheather to use reproductive health services or not. The necessity is based on their perceived benefits that greatly affect the type of service they will utilized. A lot of them claimed that they believe in the teachings of the religious organization they belong, but not less on the aspect of family control. Their own decision will always prevail based on their convenience and the need of their family.

In support to the result of the study, Yen (2021) highlighted that Anglicanism and Protestantism are the two most prominent Christian denominations that stand on the belief that birth control is permissible because it is not expressly forbidden within the Scriptures. However, these denominations preach that it is critical for followers to use birth control within a mindset that is Biblically aligned. Today, the Catholic Church is the only Christian denomination that adheres to a historical standard on birth control or contraception, which is, any form of contraceptive use is against the faith. This includes any form of artificial contraception such as the pill and all hormonal methods of birth control, sterilization specifically permanent pregnancy prevention from removal of sex organs, condoms and other barrier methods.

Meanwhile, a chi-square test of independence in Table 24 on page 145 was performed to examine the relation between the ethnicity of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables was significant, $X^2 = 4.326$, $p = 0.037$. This means that ethnic group and its associated culture, norms, and traditions positively influence the utilization of RH services for the people. It serves as their way of living and thus impact their view on this program of the government.

Sutton (2021) emphasized that despite significant strides in women's reproductive health, disparities in access to RH services remain, especially for ethnic minorities. It includes several areas of reproductive health, such as contraceptive use, sexually transmitted infection care and vaccination among younger women and maternal morbidity and mortality. Ethnic disparities in reproductive health access, services, and outcomes are prevalent and require heightened awareness and strategies to close these long-standing disparity gaps.

In contrast, when interview was conducted to the participants and other key-informants, all of them agreed that culture does not have a strong hold and influence in their RH services utilization. One of the participants mentioned, *"Awan epekto na diyay .. talaga nga kayat ko latta met agusar .. awan epekto ti kultura .. awan diyay".* (Culture does not affect the use of Rh service).

Also, others shared their insights that following the customs they have will not affect them one key-informant uttered, *"Haan kami mamati .. ngem sumursurot ka latta metten ahh .. awan met dakes na".* (We do not believe with that but we are still following it because we see no harm in it).

One participant was very firm that she is not aware of it and verbalizes that their culture does not have such belief, she exclaimed, *"Awan ah sir .. ta nu Igorot .. dakami ket kasla ngay awan ti pamma pammati mi .. uray ni mama'k .. di na met ammo dagita".* (For us Igorots, we do not have any beliefs as to the effect of culture for even my mother does not know about those).

One of the participants even mentioned that modernization and technological advancement help in the eradication of practice which shaped the current understanding of the people about reproductive health

services. One of them mentioned, *"Awanen dagita kakasta nga banag .. idi ah ngata .. adu metten gamin dagita makitkita ti tattaon ti internet .. mabuy-buya iti TV .. ken mysa educated ti tattao tattan .. nagbaliwen ti tiyempo"*. (Those concerns are already gone, maybe before, but a lot of things can already seen by the people from the internet and something that they can watch in the television. And besides people are already educated and time has already changed). A community leader during the phone interview reiterated, *"Haan met ta han met nga kasla idin nga conservative .. awan met pakainnaidan na ti kultura .. ta nu ibagam .. agusar da met gapo ta kasapulan da"*. (It is not the same like it was before that people are conservative, that culture does not have any effects because people use it because they need it).

This implies that time changes the view of people regarding cultural practices that was once taught and passed on to the current generation. Print, mass, and social media which includes newspaper, radio, television, and online sources of information greatly affected the cognitive and behavioral aspects of the people. Several traditional beliefs and practices as part of culture dysfunctional to society were discarded and many new customs, institutions and social practices were adopted.

In support to this, Japhet (2014) mentioned that technology has markedly changed the way people interact with their healthcare providers, changing the status quo when it comes to accountability and taking control of decisions. The factors that technology apart from other forms of communication include its immediacy and interactivity. It helped improved health literacy such as comprehension, understanding, and decision-making. There is an enormous amount of information available that has been created along health services. It is clear that techology is having a marked effect on healthcare systems, and that its impact is relevant. Healthcare service providers face a significant opportunity in the chance to leverage this in order to provide better healthcare to a greater number of people, while consumers are able to use it to empower themselves, their families and their communities.

According to Gandolfo and Hall (2016), cultural ethnic minorities have poorer health, are more likely to have impairment and a lower quality of life and die younger than others. They suffer particularly extreme rates of ill health. Immunization coverage is recorded to be considerably low. Under five children suffer from malnutrition and stunted in growth. Infant and maternal mortality rates among them are higher and the distance to facilities limit their access to health care. A distinct challenge that ethnic group face in exercising the right to health is related to their traditional knowledge and health practices. Women as primary holder of such knowledge, continue to hold on their traditional practices on health that inherited from their ancestors. Ethnic women play critical role in ensuring the health situation of the children in their communities. They share and continue to practice similar traditional healing knowledge, including in relation to pregnancy, post-natal care, child rearing and healing, including for childbirth methods such as the use of traditional healers.

Also, the Inter-agency Support Group on Indigenous Peoples' Issues (2014) revealed that ethnic women are less likely to benefit from the government's gender-based violence prevention and response efforts. Even though these services are available, they are frequently not intended to match the cultural needs of the people, or service providers' prejudiced attitudes and unfavorable stereotypes prevent them from using it.

Also, a chi-square test of independence in table 24 on page 145 was performed to examine the relation between the number of children of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2$ =

12.559, $p$ = 0.183. The result reflects that family size based on the number of offspring has nothing to do with the usage of RH services by the people.
Solanke (2018) contradicts the results of this study. It was mentioned that co-wives competition within polygynous households in Islamic cultures may influence reproductive attitudes that discourage contraceptive use. Given their low contraceptive use, the desire of each woman to avoid a pregnancy termination will influence her decision to take contraceptives. Also, regardless of previous number offspring, remarried women are expected to raise additional children in the new marriage for the purpose of optimal marital satisfaction. This has an impact on their parity, as well as their desire to utilize contraception. Furthermore, men have a stronger fertility desire than women, and many women lack the authority to plan their fertility due to male domination of reproductive decisions in households. A mistimed or undesired pregnancy among these women is more likely to raise their parity, necessitating a re-evaluation of future birth control use. It was also noted that women who have many children and had no complications in previous pregnancies are more likely to delay seeking medical care. Furthermore, due to the time limits imposed by their big and demanding families, women in this category find it difficult to visit clinics.
It was also noted that women who have many children with no problems in previous pregnancies often delay seeking medical care. Further, women in this category find it difficult to attend clinics due to the time constraints imposed by their large demanding families (Bezircioglu, 2013).
Meanwhile, a chi-square test of independence in Table 24 on page 145 was performed to examine the relation between the age of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 9.002$, $p$ = 0.061. The result means that age does not have any impact in the decision of the people to use RH services.
The result of the study contradicts with Abekah-Nkrumah and Abor (2018). The result of their study revealed that modern contraceptive methods are more commonly used by women in the 20 to 24, 35 to 39, and 40 to 44 age groups. The first antenatal visit happened in the first trimester, health facility deliveries, and deliveries assisted by health professionals all have a favorable link with age. It is worth noting that the effect of age on the use of pregnancy-related reproductive health services rises with age, peaks at 40 to 44, and then drops from 45 onwards. In comparison to the younger population, older women reported more perceived barriers to health care access. This is because older women's health may be harmed by distance travel to receive healthcare in outlying places. In addition, financial difficulties and dependency are more prevalent in elderly people than in younger people (Tamirat, 2020). Thus, age is significantly associated with the use of reproductive health education and service utilization (Zhou, 2019).
Also, a chi-square test of independence in Table 24 on page 145 was performed to examine the relation between the gender of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 0.9025$, $p$ = 0.342. This implies that gender is not a determinant or is not considered by the respondents when they are using RH services such as family planning methods, among others.
In contrast, McPerson (2014) concluded that access to HIV testing, treatment, and care is influenced by gender roles and relationships. It was noticed that women obtain services at a higher rate than men, and that when men do receive treatment, it is generally at a later stage. This could be due to dominating masculine standards that not only encourage men to avoid playing the sick role, but also discourage them from getting help for fear of being labeled weak. Gender roles, which influence women's access to economic resources, can also increase vulnerability to sexually transmitted diseases because women may

be more economically dependent on men and therefore less able to negotiate the terms RH services used. Also, men as providers or decision-makers, and women as dutiful caretakers, are stereotypes that impact family planning attitudes and decisions. The community's decision-making powers were extended to FP, with the belief that it is the man's responsibility to talk and discuss family planning and the family would only listen (Butt and Valerio, 2020).

Meanwhile, a chi-square test of independence in Table 24 on page 145 was performed to examine the relation between the income of the respondents and their extent of practice on the reproductive health programs provided by the government. The relation between these variables was not significant, $X^2 = 0.6567$, $p = 0.956$. The result implies that socioeconomic status, whether the respondents are poor or belongs to wealthier population does not consider it as a factor that will stop them in utilizing RH services. The result contradicts with the findings of Zhou (2019). The research conducted mentioned that average personal monthly income had a significantly beneficial effect on the use of reproductive health services. People with enough money are more likely to use contraception, specifically modern method of preventing unwanted pregnancies. People from low socioeconomic backgrounds are also unable to make independent reproductive decisions. As disparity in the usage of services develops in favor of their rich counterparts, poor households have grown increasingly disadvantaged (Groot, et. al., 2018).

Poor and vulnerable people are often worst affected, deprived of the information, money or access to health services that could help them avoid and treat diseases. Thus, the economic and political structures which sustain poverty and discrimination need to be transformed for poverty and poor health to be tackled (Roberts, 2018).

**Significant Difference in the Level of Awareness on RH Services Grouped According to Sociocultural Profiles**

As shown in Table 25 on page 160, the level of awareness of the respondents differs significantly (p-value 0.000) when grouped according to religion. This may be attributed to religious influence that affects the capacity of the people to receive information and the decision-making of the faithful.

In support to the results of the study, the religious acceptability of family planning information was crucial, however, different groups interpret the religion's stance on reproductive health differently. Ultimately, discussions of family planning among religious organizations devolved into a moral conflict between the need to have as many children as God provides versus the responsibility to care for and safeguard children in their families by restricting family size. Different religious organizations have different interpretations of the Bible, and the lack of direct pronouncements on this matter within biblical writings allows a space for debate, resulting in differing interpretations when people try to apply the teachings of these scriptures to the issue of family planning. Other followers were delighted about the thought of having their religious leaders talk on this topic, attributing this to providing guidance on difficult concepts, and the inherent authority of information from such a source, due to their faith and confidence in their religious leaders (Sundararajan and Yoder, 2018).

**Table 25. Difference on the Level of Awareness when Grouped according to Religion**

| Religious Groups | Mean |
|---|---|
| Roman Catholicism | 3.92[a] |
| | |
| Protestantism | 4.29[b] |

| | |
|---|---|
| Religious Sect | $3.40^{ab}$ |
| | |

*Means followed by the same letter are not significantly different at 0.05 level of significance (Scheffe'); F-ratio = 9.738; p-value = 0.000

The level of awareness of respondents differs significantly as well when grouped according to number of children (p-value = 0.037) as shown in Table 26 on page 161. The difference lies between those who do not have children and those who have only one child. This implies that the presence of a child may affect the tendency of the parents, most especially the mother, to seek reproductive health information. This information may help them improve the quality of care they render to their children.

In support of this, many men and women were not using any family planning method due to lack of information, primarily because they desired more children, had negative perceptions about family planning, or were concerned about side effects, and planned to use contraception only when they reached their desired family size, considering their ability to provide adequate food, health care, and education. In contrast, there were few who control number of pregnancy and are properly educated about it, thus ensuring better health of the mother and child. Contraceptive use rises with age and the number of children, reaching a peak when couples have reached their ideal family size. Men and women do not utilize contraception, since they are either newly married or

**Table 26. Difference on the Level of Awareness when Grouped according to Number of Children**

| Groups | Mean |
|---|---|
| No child | $3.75^{a}$ |
| | |
| One child | $4.15^{b}$ |
| | |
| Two to four children | $3.97^{ab}$ |
| | |
| More than four children | $3.90^{ab}$ |
| | |

*Means followed by the same letter are not significantly different at 0.05 level of significance (Scheffe'); F-ratio = 2.861 and p-value = 0.037

have a small family. Furthermore, increased awareness among both men and women, as well as financial pressure, were the two main causes driving couples to reduce their family sizes. In addition, a lack of information, sociocultural pressures, and shyness influenced attitudes of family planning and discouraged its use (Mustafa, 2015).

Differences in the level of awareness were found between gender profiles. The level of awareness of female respondents on the RH programs differ significantly (F-ratio 4.669, p-value 0.031) from the level of awareness of male respondents. This may be attributed to the willingness of the females to learn more and acquire information about the services because they are the most frequent recipient of care along with

this program. Majority of the services are intended for the female population and thus, they seek information about these that aids in their decision making to utilize services provided by the government. People's perceptions are not uniform and show variation between boys and girls as well as for type of service delivery. Girls seeking antenatal care and family planning services at health facilities characterize the available services as good and staff as helpful. However, boys perceive services at health facilities as designed for women and children, and therefore feel uncomfortable seeking services. In youth centers, boys' value the non-health benefits including availability of recreational facilities, prevention of idleness, building of confidence, improving interpersonal communication skills, vocational training, and facilitation of career progression. Girls are involved in conversations about sexual and reproductive health to a greater extent than boys. Regarding communication with girls, parents' messages about SRH tend to be more cautious and focused on the negative effects of sexual activity (Godia and Olenja, 2014).

Meanwhile, the level of awareness of Ilokano respondents on the RH programs differ significantly (F-ratio 8.378, p-value 0.004) from the level of awareness of Igorot respondents. This may imply that the difference in the awareness is associated with the accessibility to reproductive health information that is affected by cultural influences. Sexual literacy focuses on proper knowledge regarding pregnancy risk, pregnancy fatalism, and perceptions of contraceptive side effects and is affected by ethnic differences. Sources of health knowledge, sexual views and experiences, and socioeconomic circumstances are all potential explanatory factors for difference in sexual literacy. People will be less likely to use contraception, particularly more effective hormonal methods, if they underestimate the risk of becoming pregnant, do not feel their contraceptive activities would impact their odds of pregnancy, and overestimate the adverse effects of contraception. Unintended fertility discrepancies may be caused by a lack of appropriate understanding about sexual and reproductive health, as well as attitudes regarding sexuality and fertility (Guzzo and Hayford, 2012).

On the other hand, significant difference also exist in the level of awareness of the respondents in the reproductive health services in between municipalities (F-ratio 29.7046, p-value 0.000) as shown in Table 27 on page 164. This can be associated with several factors including attendance to information dissemination drives and other health education sessions due to so distance from the health care facility, lack of transportation, financial problems, low exposures to broadcast, printed, and social media, and low levels of education, among others. Thus, low awareness on the available services will have an effect in their decision to patronize and use the services of the rural health unit provided to the people.

Despite efforts of the health care providers and barangay officials to encourage people to participate in information dissemination drives initiated by the government, still it is up to the residents wheather or not they will participate in these activities due to numerous reasons.

During the interview, respondents were asked on how were they informed of the services available in the healh care facility. One of them uttered, *"Umay da agibaga nga adda ijay health center .. ngem dagijay piman han nga mapan .. umay da met ag house to house … apan kami ta umay da met ibaga .. iremind da met nga un-una .. ti schedule .. adda kastoy nga mapasamak .. umay kayo … kastoy nga aldaw".* (They will come and inform us that they will be in the Health Center, but for those who can not come, they will go house- to- house visits. For us, we will go if they will inform us). Also, some of the participants mentioned that there were information drives that were organized by the

**Table 27. Level of awareness of the Respondents when Grouped according to Municipality**

| Municipality | Mean |
|---|---|
| Santol | 4.21[a] |
| San Gabriel | 3.65[b] |
| San Fernando | 4.21[c] |
| Burgos | 3.79[d] |
| Bagulin | 3.60[e] |
| Tubao | 4.07[f] |
| Pugo | 4.22[g] |

*Means followed by the same letter are not significantly different at 0.05 level of significance (Tukey); F-ratio = 29.7046; p-value = 0.000

health center in which they participated. They claimed, *"Um-umay da ah agpapaseminar ditoy .. agpaayab da ijay barangay hall"*. (They will come and facilitate seminars and will ask people to go to the barangay hall). Another mentioned, *"Adda met ah ti im-immay idin nga nagle-lecture ijay barangay hall .. han met nga kanayon .. kasla mamin tallo lang makatawen"*. (There were those who came and gave lecture at the barangay hall, it is not always. It is like three time a year). Seminars were conducted to let the people know about their programs most especially on the facet of family planning services. This gives an idea to the people as to what type of family planning methods they will avail. One of them voiced out, "*Adda metten dagijay im-immay idi from munisipyo .. nagdidiscuss .. maawatan mi met .. ngem adda latta kenka nga agpili nu anya kayat mo kadagijay nga usaren"*. (There were those who came from the town hall, they discussed and we understood, but still it is up to you which you prefer to use).

The claim was supported by the community leaders when asked during the phone interview. One of them was quoted saying, *"Ipaseminar damet dagita .. karkaro dagijay 4Ps .. tinawen data nga adda latta umay ag explain .. ipalaw lawag da .. agpaayab da .. ditoy ngay barangay hall"*. (They will conduct seminars especially those 4Ps members. It is a yearly activtity were they will explain and englighten the people and convene at the barangay hall). Community leaders even claimed that participation of 4Ps beneficiaries in these programs are mandatory or else they will not receive their monthly financial assistance from the government. This is their way of encouraging the people to actively participate in the government's initiative to reproductive heatlth services intended for them. A health worker during the phone interview agreed also with this claim of other interviewees. According to her, *"Usually agcoconduct da met ti information drive regarding FP .. isabsabay da ti sabali nga programs .. nu adda met lang information drives da .. narigat gamin ag gather ti tao .. maymaysaen min amin .. nu dadduma maisali mi met nu adda marriage counseling"*. (Usually they conduct information drives regarding FP and do it simutaneously with other programs like information drives. It is very difficult to gather people, that is why we will do it at once, sometimes it can be incorporated in the marriage counseling).

No significant difference exists in the level of awareness among age groups. This implies that the awareness of the respondents is not dependent to their age. Research conducted by Alsonini and Masood (2017) contradicts the results of this study. It was found out in their research that more than half of the participants in their study was aged 20–24 followed by the younger which is 27 percent. And that, the knowledge about contraceptive methods among older people and adults was more than the younger and the differences were highly significant. Likewise, for knowledge about reproductive health and family planning indices, older people and adults had more statistical awareness compared to the younger. This can be associated with the more experience and information older people obtained compared to the

younger population. Moreover, adolescents often lack basic RH information, knowledge, and access to affordable confidential services for RH. They often have less access to information, services, and resources than those who are older. Adolescents tend to be less informed than adults. They often have a sense of having unlimited power, feelings of invulnerability and impulsiveness that can lead to reckless behavior. They are curious and have a natural inclination to experiment. There is conflict between their own emerging values and beliefs and those of their parents and so adolescents may be trying to demonstrate these differences by experimenting with several activities.

In contrast, Bekuma and Tilahun (2021) claimed that in the results of their study conducted, it was found out that when compared to those who had never heard of reproductive health services, the youth who have heard about them had used them more than eleven times. People who had heard about the service were more likely to use it than those who have never heard about it. This shows that SRH and its services are becoming more well-known. This indicates raising awareness on SRH and its services.

On the other hand, no significant difference exists between level of awareness and educational levels. The result of the study is incongruent with Alsonini and Masood (2017). It was found out in their study that the awareness among people who had college education was higher for all indices than those who had basic education. People who had college education had more knowledge about methods of family planning and sources of information than those who had secondary school education.

Also, no significant difference exists between income profiles. As opposed with the result of this study, Groot, et. al., (2018) revealed that people from wealthy families are more likely to be exposed to family planning information through the media. Family planning information in print and on television is notably unequal, implying that such information on reproductive health is to the detriment of women in low-income households. Knowledge on family planning is unequally distributed in favor of women in wealthy households, which is predictable given that money is linked to education, which improves information access and assimilation. Prior studies showed people with a better socioeconomic status are more likely to employ family planning media messaging. Even though media messages about family planning reach a small percentage of the population, women in lower socioeconomic strata have less access to family planning information via the above-mentioned platforms.

**Significant Difference in the Extent of Practice of RH Services Grouped according to Sociocultural Profiles**

The extent of practice of the respondents to RH services differs significantly when grouped according to number of children (F ratio 3.288, p-value = 0.021) as shown in table 28 on page 168. The difference lies between those who do not have children and those who have only one child. This implies that the intention to use the RH services is common when people do have a child compared to when they do not have. In support to this result of the study, the desire to utilize contraceptive differs from a change in parity from primiparity to grand multiparity.

**Table 28. Difference on the Extent of Practice when Grouped according to Number of Children**

| Groups | Mean |
|---|---|
| No child | $3.46^{a}$ |
| | |
| One child | $3.91^{b}$ |

| | |
|---|---|
| Two to four children | 3.77[ab] |
| | |
| More than four children | 3.59[ab] |
| | |

*Means followed by the same letter are not significantly different at 0.05 level of significance (Scheffe'); F-ratio = 3.288; p-value = 0.021

Child mortality experience, fertility desire, and ideal family size affects decisions of using contraceptives. Meanwhile, it was noted that contraceptives utilization is low among grand multiparous women. They do not use modern contraceptives for various reasons thus still face the risk of unintended fertility which may not only further aggravate their reproductive health and well-being, but also sustain current high birth rates. Also, this is not good enough for population and women's reproductive health for two reasons. First, non-intention to use contraceptives implies that they remain vulnerable to unintended pregnancies and high-risk fertility or induced abortion if they have no fertility desire (Solanke, 2018).

On the other hand, it was also noted that women who have many children with no problems in previous pregnancies often delay seeking medical care. Further, women in this category find it difficult to attend clinics due to the time constraints imposed by their large demanding families (Bezircioglu, 2013).

The extent of practice of the respondents to RH services differs significantly when grouped according to religion (F ratio 10.508, p-value = 0.000) as shown in table 29 on page 170. The difference lies between those who belong to Roman Catholic and Protestantism. This implies that the utilization of RH services greatly affects religious affiliations where there is a difference in the teachings of the church because of the different interpretation of the Bible.

Religion influence disparities in sexual and reproductive health outcomes. The Catholic Church follows a long-standing tradition on birth control and contraception, which states that any kind of contraception is against the faith (Yen, 2021). Within Catholic hospitals, clinics, and doctors' offices that rent space from a Catholic facility, contraception, including permanent sterilization, is prohibited. Instead, hospitals should provide instruction in both the Church's teaching on responsible parenthood and natural family planning options for married couples and the medical staff who counsel them. This applies to all patients getting care in a Catholic facility, not only Catholic spouses, or patients, resulting in limits that go against what many people expect (Freedman and Stulburg, 2016).

On the other hand, Yen (2021) mentioned that for Protestant and Anglican groups, birth control pills are permissible. While liberal Protestant support procreation, they recognize that it is not the main aim of sexual relations and thus, no specific forms of contraception that are prohibited among them. For Islam believers, they encourage big families and expects parents to ensure that their children's basic rights are respected. Although family planning is not outlawed, traditional believers prefer to utilize it to space out their children's births rather than to limit the overall size of their households.

**Table 29. Difference on the Extent of Practice when Grouped according to Religion**

| Religious Groups | Mean |
|---|---|
| Roman Catholicism | 3.64[a] |
| | |
| Protestantism | 4.18[b] |
| | |
| Religious Sect | 3.29[ab] |

| | |
|---|---|

*Means followed by the same letter are not significantly different at 0.05 level of significance (Scheffe'); F-ratio = 10.508; p-value = 0.000

The Quran does not forbid Muslims from using birth control. It is also worth noting that Islam's conception of birth control is framed within the context of marriage and family, as both play a significant role in the faith. While procreation is an important component of marriage, Islam claims that it is not the only cause for sexual activity. When a couple does decide to start a family, they should do so when they are ready. Contraception enables a Muslim family to have children whenever they choose and when they are ready. But despite of this, some women exhibited negative attitudes towards RH education and felt that they do not need to be educated about these matters as their religious practices provided them with enough protection against reproductive health problems (Alageel and Alomair, 2020).

It was also noted that the extent of practice of female respondents on the RH programs differ significantly (F-ratio 7.463, p-value 0.007) from the extent of practice of male respondents. This may be attributed to fact that majority of the services are intended for females, thus, enables them to visit and avail the services of the facility more frequently than their partners. Also, the belief that it is only the women's responsibility to secure family planning services and the responsibility of care of the infant and children are put to them that hinders their partner to participate in such activities.

In contrast to the result of the study, Bekuma and Tilahun (2021) revealed that people who ever had sexual intercourse were more than five times likely to use the services compared to those who never started sexual intercourse. Both males and females always come after practicing unprotected sexual intercourse. Males come for condoms, and HIV testing and counseling while females come for pregnancy tests once they noticed missed menstrual cycle. Sexually active youths, both male and female, were more likely to use the youth-friendly services.

It was also noted that there is a significant difference in the extent of practice of the respondents when grouped according to municipality (F-ratio 28.0599; p-value 0.000) as shown in Table 30 on page 172. The difference is associated with the motivation of the people to utilize the services provided by the government due to some personal, social, geophysical, and economical reasons. Some of the respondents consider personal knowledge and perception about reproductive health that affect their maximum use of the services while others consider money, distance from the facility, lack of transportation, and other factors that hinder them to go for clinic visits. These thus affect the difference in the percentages of succesful implementation of the local government units on the several aspects of reproductive health care. In relation to the study, reports from the Provincial Health Office of La Union for the year 2020 reveals that Burgos had 86.04 percent of its eligible children population where fully immunized. This was followed by Tubao with 74.15 percent, and San Gabriel with 71.98 percent. Santol recorded 67.19 percent, while the City of San

**Table 30. Extent of Practice when Grouped according to Municipality**

| Municipality | Mean |
|---|---|
| Santol | 3.93[a] |
| San Gabriel | 3.49[b] |
| San Fernando | 3.79[c] |
| Burgos | 3.28[d] |

| | |
|---|---|
| Bagulin | 3.25[e] |
| Tubao | 3.85[f] |
| Pugo | 4.15[g] |

*Means followed by the same letter are not significantly different at 0.05 level of significance (Tukey); F-ratio = 28.0599; p-value = 0.000

Fernando recorded 66.32 percent, compared to Bagulin with 63.88 percent. On the other hand, Pugo had 50.98 percent who received the service from the rural health unit. Along the area of antenatal care for pregnant women, Tubao recorded 85.49 percent clients from its eligible population who had atleast four prenatal check-ups in the health care facility.

This was followed by Burgos and San Fernando with 66.85 percent and 65.57 percent, respectively. San Gabriel had 60.82 percent compared to Santol with 57.35 percent. Meanwhile, Pugo had 56.40 percent while Bagulin had 51.98 percent who did clinic visits.

Meanwhile, no significant difference exists in the extent of practice of RH services along age groups. The result of this study contradicts to the findings of Alsonini & Masood (2018). It was found out that young people in a variety of contexts have reported that access to contraception and condoms is difficult compared to older population. Health services are rarely designed specifically to meet their needs and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health. It is perhaps not surprising therefore that there are particularly low levels of health-seeking behavior among young people. Also, they concluded that younger people, particularly those who are unmarried and not in school, have difficulty in accessing reproductive health information and services. Many adolescents are less informed, less experienced, and less comfortable accessing health services for RH than adults.

Also, no significant difference exists in the extent of practice of RH services between respondent's educational attainment. In contrast, a finding of one similar study reveals that adolescents with a secondary education or higher were nine times more likely than those without a formal education to use family planning services. Similarly, maternal education was found to be linked to the use of family planning services. Other characteristics that were significantly and independently linked with the use of the service includes discussions about family planning with family/relatives, peer group/friends, sexual partners, and teachers. Educated women are more willing to talk to their children about family planning issues. They are also more adaptable when it comes to dealing with issues that arise with their children's use of reproductive health services. The mother's educational attainment (secondary and higher) was also found to be a major predictor in service consumption. (Koye and Feleke, 2013). This can be justified by the fact that discussing services with various groups of people helps adolescents to have more opportunity to share information, experiences, and have a broad understanding of family planning. It may also provide opportunity to address teenage issues related to its utilization.

Furthermore, no significant difference exists in the extent of practice of RH services between respondent's income. In contrast with the result of the study, Ranji (2019) concluded that many women are struggling to satisfy necessities due to poverty and a lack of employment opportunities, leaving them with limited resources to seek reproductive health services. Women frequently prioritize food and shelter over preventive health care and family planning because of socioeconomic stress. Poverty traps women in situations that limit their ability to make their own decisions. Meanwhile, mothers from the wealthiest families receive antenatal care, assisted delivery by medically trained professionals, institutional deliveries, and HIV/AIDS counseling and testing. Income therefore is a key indicator of reproductive health service utilization, implying that wealth disparity is a significant risk factor for other poor people's

low reproductive health service utilization. With regards to employment, working women use contraception more frequently than non-working women (Rahman, 2011).
More so, no significant difference exists in the extent of practice of RH services between respondent's ethnicities. In contrast to the results of the study, Alageel and Alomair (2020) noted that ethnic variations in reproductive health service utilization and outcomes have been documented and are a major public health concern. Some are less likely to attend sexual health clinics and less likely to use emergency contraception and are more likely to delay antenatal care. Ethnic differences existed due to explanatory factors such as socioeconomic status and sexual behavior. Filipinos are known to share strong family values and patriarchal culture, which in certain situations could benefit young individuals and protect their well-being. However, this can also be a barrier to women's access to RH information and services. Unmarried women faced greater difficulties accessing RH services compared to married women. Although both groups faced barriers accessing information and services, being unmarried by itself was a significant barrier. The social unacceptability of pre-marital sex limits young women's RH knowledge and access to services.

**Barriers in Reproductive Health Services Used**
It can be gleaned from Table 31 on page 176 that the barriers in reproductive health services used. It can be gleaned from the table that geographical accessibility and lack of transportation ranked the highest with 13.04 percent and 12.74 percent, respectively. The difficulty is experienced by both the service providers and the residents. Since the residents are living in far flung areas, the health care providers must walk for several hours just to reach each household. The lack of transportation due to difficult to access locations hinders the residents as well to obtain family planning services such as contraceptives among others and most especially during emergency situations.
These results are in congruence with the study conducted by Henok and Tekele (2017). They claimed that women continue to deliver at home due to a range of factors including distance, poor roads, and the difficulty of obtaining and paying for transport. Even the service providers will have difficulty in reaching the community. The fact that they need to travel for hours just to reach their destination is a big challenge in the

**Table 31. Barriers in Reproductive Health Services Used**

| Barriers | Frequency | Percentage |
|---|---|---|
| 1. Age (edad) | 126 | 7.54 |
| 2. Gender (kasarian) | 76 | 4.55 |
| 3. Financial (pera o pinansiyal) | 212 | 12.68 |
| 4. Low education (mababang edukasyon) | 109 | 6.52 |
| 5. Quality of RH services (kalidad ng serbisyo sa reproduktibong pangkalusugan | 86 | 5.14 |
| 6. Lack of transportation (kakulangan sa transportasyon | 213 | 12.74 |
| 7. Health providers' attitude (pag-uugali ng mga manggagawa sa pangangalaga ng kalusugan) | 71 | 4.25 |

| | | |
|---|---|---|
| 8. Availability of RH services (pag-uugali ng mga manggagawa sa pangangalaga ng kalusugan) | 69 | 4.13 |
| 9. Geographical accessibility (layo ng tirahan sa health center) | 218 | 13.04 |
| 10. Taboos (e.g. hindi sanay sa pakikipag-usap tungkol sa pakikipagtalik) | 78 | 4.67 |
| 11. Peer pressure (e.g. pagkadala sa mga kasamahan) | 44 | 2.63 |
| 12. Religion (relihiyon) | 54 | 3.23 |
| 13. Physical threat by the partner (pisikal na banta ng asawa) | 44 | 2.63 |
| 14. Tradition/ beliefs (tradisyon at paniniwala) | 73 | 4.37 |
| 15. Fertility preferences ((i.e. kagustuhan sa bilang ng anak) | 95 | 5.68 |
| 16. Stigma (e.g. karamdaman o sakit na may kinalaman sa sekswal) | 104 | 6.22 |
| Total | 1672 | 100.00 |

delivery and access by the people of the services provided by the government. Depending on the region, it may be too expensive, dangerous, or time-consuming for a clients and health service providers to travel. Physical access to health facilities is an important determinant of modern family planning services use (Ettarh and Kyobutungi, 2012).

In Sudan, women and young girls living in Nuba mountains of Southern Kordofan have little or no access to contraception, adequate antenatal care, or emergency obstetric care—leaving them unable to control the number and spacing of their children and exposing them to serious health complications and sometimes death (Wheeler, 2016). Also, the result of the research conducted by Shiferaw, et al. (2017) revealed that modern contraceptive use was significantly higher among women who lived relatively close to facilities that have a wider range of contraceptives available. The finding on access and proximity to facilities is consistent which demonstrated that distance plays a key role in determining physical access to family planning services and other maternal health services using geo-referenced information. Indigenous women often live in geographically isolated areas with poor health services. They also tend to have fewer education and economic opportunities, which can limit their access to family planning (United Nations Population Fund, 2018).

Meanwhile, it can be seen in the Table 31 on page 179 that 12.68 percent of the respondents considered financial issues as a problem in the access to reproductive health services. One major cause of inequity is the cost associated with obtaining and the inability of disadvantaged people to pay. Aside from that, transportation costs can have a significant impact on expenditures when seeking care. The share of transportation costs is a large component of the total cost of healthcare most especially for those who are residing in far flung areas. This will then affect the willingness of the people to seek care. The loss of income or the opportunity cost of seeking care is also a problem. This is particularly hard for the people where the choice is between earning an income or seeing a doctor. The consequence of this is that patients wait to seek care until their conditions become more serious, and difficult to treat due to complications (FutureLearn, 2021).

During the interview, one of the respondents verbalized, *"Yung kulang ang transportasyon .. lalo na yung mas malalayong lugar .. kase mahal ang pamasahe dito .. yung iba di na pumupunta kase nasa sulok-sulok sila .. mamamasahe pa sila"*. (The lack of transportation most especially those from far places do not come because fare is expensive and some of them will come from far-flung areas). The lack of resources such as money and vehicles that will add up in their difficulty accessing the services were highly regarded by the people. In consonance, another interveweee mentioned, *"Libre ah .. ngem nu adda bayad na .. syempre (laugh) .. karkarko nu mapan da pylang baba .. awanen ah .. madi dan .. awan pagplete da .. nagastos"*. (It is free, but if they need to pay, of course they will not come (laugh) most especially if they will still go down from mountainous areas .. nothing .. they do not wanted .. they will not have money for the fare .. it is expensive). Also, one of the respondents exclaimed that there are instances wherein stocks of contraceptives are not available in the barangay health center, and there is a need for them to personally spend their own money just to continue using the product. She said, *"Nu dadduma kasla kuma jay DMPA .. awan stock .. dakami ah ti mapan gumatang"*. (Sometimes there are no stocks of DMPA, we are the ones who will buy). With regards to the screening examinations such as laboratory tests, a participant emphasized that it is not given for free. According to her, this adds up to their burden along with other expenses such as their fare in going to the health center. She verbalized, *"Libre dagijay agas nga ited da .. ngem dagijay tests ket mabayadan diyayen .. bulsa ti marigatan .. (laugh) .. jay laenen plete nga mapan .. nag ngina talaga"*. (The medicines are given free, but laboratory tests are not and fare is already expensive).

In contrast to the claims of some of the residents, a health care provider mentioned, *"Libre ti services iti rural health unit .. ijay district hospitals ti adda bayad na especially dagijay screening tests .. ngem minimal lang .. nababbaba kesa private hospitals. Haan da lang kayat nga mapan gamin ti RHU ta jay atiddog nga pila .. maymaysa met garod ti doktor ditoy ayan mi"*. (Services in the RHU are all free but not in the district hospitals most especially for the screening tests, but it is minimal and cheaper as compared to the private hospitals).

This signifies that socioeconomic aspect and other physical conditions posed a threat in the success and ultimate rise in the programs of the government as far as maximum RH services utilization is concerned. The need to address these barriers are imperative and prompt action and intervention of the government is needed. This factors are difficult to address and the Department of Health with the help of the Local Government Units are looking into the possibility of bringing the services closer to the people so that high contraceptive prevalence and medical services rates will be met.

The finding is in congruence with the results of the study using the survey questionnaire. A total of 12.68 percent of the respondents considered financial issues as a problem in the access to reproductive health services. The cost of obtaining and the inability of disadvantaged people to pay is a major source of inequity. Aside from that, transportation costs can have a significant impact on healthcare expenditures. The cost of transportation is a significant component of the total cost of healthcare, particularly for those who live in remote areas. This will have an impact on people's willingness to seek care. A problem is also the loss of income or the opportunity cost of seeking care. This is especially difficult for those who must choose between earning a living and seeing a doctor (FutureLearn, 2021).

Age is also a barrier to reproductive health services as shown in Table 31 on page 179 for the 7.54 percent of the respondents. It was generally concluded that family planning services are low as the people aged. This is attributed with older women less likely to become pregnant due to infrequent sex, marital disruption, lack of a regular partner, menopausal status, or their perception that they are infertile. They

therefore do not consider that they have a need for contraceptives, either to prevent any unwanted pregnancy or for prevention of sexually transmitted diseases (Ama and Olaomi, 2018). For younger population, the age plays an important role in the process of deciding when women will start and finish the process of giving birth and how long to wait after the birth of the next child. Younger women often have a stronger fertility desire than older women (Aylie, 2020). The use of pills and condoms are preferred more when the average age is lower. Contraceptive behavior is often made by young adults in the context of specific relationships, the relational context likely influences use of contraceptives (Agnew, et. al., 2018).

Similarly, low levels of education can significantly affect reproductive health sevices used with 6.52 percent of the respondents considered it as a barrier as shown in table 31 on page 179. Women's attitudes toward family planning are influenced by experiences such as education and pregnancy. The reason for this can be explained by the opportunity to learn about family planning and to raise awareness about the issue. Education contributes significantly to the quality of women's lives. Improving women's access to education and encouraging continuous and constant exposure would significantly increase use of family planning and reduce unmet need (Liu and Raftery, 2020). Similarly, women's education can be used to empower them. It also helps to change their attitudes and practices towards family planning, thus, leading to better quality of life (Sultan, 2018).

On the other hand, 6.22 percent of the respondents as shown in Table 31 on page 179 considered stigma as a threat to full utilization of the RH services. The fear to be judged by other people, fear to side effects, and the fear to be diagnosed with some possible diseases related to RH hinders them to go for clinic visits. For adolescent groups, stigma and discrimination have been recognized as major barriers to accessing HIV prevention, care, and treatment services. The stigma on how people might think about them if they do promiscuous activities affects their ego especially for male clients. Stereotypical thinking is also prevalent in society about reproductive health services for unmarried women. The fear of being judged and labeled by others is a constant issue. The concern comprises two notions of fear like being labeled for having premarital sexual intercourse and being labeled a flawed woman. The shame they experience because of receiving reproductive health services is part and has a stronghold in their health-seeking behavior (Gholami, et.al, 2016).

Fertility preference also obtained 5.68 percent as a barrier to RH used as hown in the table 31 on page 179 . People tend to decide on the number of children they will have and is less influenced by healthcare providers and other people's advice. The government is emphasizing the need for a limited number of children as it affects the health of the mother and child, and at the same time the difficulty in providing the immediate needs of a large family. According to ti Aung (2019), among men who ever had sex, 39 percent were currently using modern contraception and 60 percent married would like to have more than two children. Perceived or actual partner's fertility preferences, attitudes to contraception and communication may influence woman's decision-making autonomy. Opposition of the partner to contraception in general can be a barrier to use. Fertility preferences agreed among most couples. However, when there were substantial differences, couples were less likely to use contraception. There is a significant drop in contraceptive use among couples when the couple's fertility aspiration differed (Machiyama, 2017).

In supoort to this, one of the participants mentioned during the interview, *"Uray pay mano nga dosena nu kayak nga biagen .. apay ta pigilan dak ngay. Maymayat ketdi ah ta adu ti mangi-kwa ti puli .. karkaro nu mapa adal mo amin suda .. maymayat ah .. proud ka .. isu ti pagbatnangan ti anak .. apay ngay ta kunam*

*nga putdem ti pagbatnangan iti tao".* (Why deprive us to bear children, I can even have a dozen if I can raise them all and finish their education. You will be proud of them for they will be your source of wealth). The response of this participant is also in congruence with the other key-informants. They share the same view, as to their own decision as to the number of children they will have. One participant said, *"Siyak met latta agdesisyon nu mano anak ko .. pagdesisyunan mi met ah nga duwa dagita".* (It is me and my husband who will decide as to the number of our children). Some respondents also mentioned that despite the efforts of the rural health facility to encourage them to practice family planning, still, it is the choice of the family as to how many children they want to have. This was supported by one respondent when he claimed, *"Han da met nga maipilit .. uray pay anya ibaga da ijay center .. sikami latta ah nga agassawa ti agdesisyon".* (They can not force or even instruct us because it is the decision of the couple). Another respondent also voiced out that,*"Dakami lattan ah nga agdesisyon nga agassawan nu mano annak mi .. han nga tay adda agdikdiktar .. ta talaga nagtungtungan mi idi .. uppat lang anak tan ahh .. (laughs)".* (It is the decision of us, as to the number of children we will have, it is not somebody else's because we agreed about having four children even before (laughs)".

This means that couples decide the number of children they wanted as they see it as a form of personal fulfilment and satisfaction. The essence and joy of being parents are felt and is highly regarded by the couple. In support of this claim, Dhel (2020) mentioned the several reasons why people wanted to have a bigger family. There are a lot of people who wanted to keep the family name and ideals alive. Many parents desire to carry on their family's tradition. They take pride in the fact that their child will carry their surname and continue the family tradition that is based on societal norms. Also, people who grew up in a happy home with a stable family, desire to share that experience with their significant other. They want to build a happy, loving family in which they may be affectionate with their children. Furthermore, another compelling motivation for couples to desire to have more children is the delight of bringing another human into the world and watching that person grow up. Parents want their children to grow up to be contributing members of society.

Aside from the desire to bear the number of children they wanted, partners also consider their capacity to provide the needs of their family when using the family planning services. One of them said, *"Nagtulagan yumet data nga duwa nga agassawa ehh .. ti rigat gamin ti biyag .. ubbing met lang ti kakaasi .. han lang nga sika .. mas pay suda ta nu agsasaruno da … nagado da ngaruden .. syempre nu sika han ka met nabatnang .. agkontrol ka ah tapno masuportaram panagadal dan to nu basbassit da".* "You (couple) have agreed with the number of children to have because of the difficulty of living, it is the children who will suffer much more especially if they will bw born one after the other.If you are not rich, you need to control so that you can support all of them especially their education).

During the phone interview, a barangay official reiterated the necessity of RH services and its impact to poverty on the families. He mentioned, *"Data gamin kinarigat ti biyag .. ammo da metten nga nu aganak ti adu .. han mo masuportaan ti ubbing mo .. isu diyay .. agkontrol dan .. idi ket makammo da .. aganak ka ti adu .. tatta naedukaran ti tattao tattan .. talaga nga masapol ti information dissemination".* (It is because of poverty that they already know the effect when they have a lot of children and they can not support them so they will control because they are already educated about it). Another official mentioned, *"Data gamin pammati da nga kaya da nga biyagen .. tunukan han met gayam .. nu farmer da .. farmer tumetlang jay anak da .. nagrigat nga biyag".* (Their belief that they can sustain the needs of their children, but then they can not since they are farmers. Eventually their children will become farmers too).

A barangay captain also uttered during the phone interview, *" Uray ta nu kayak nga biyagen kunada .. nu*

*kwa .. marigrigatan tumet lang gayam .. ditoy ayan mi ket dagijay adda pay kaya na ket .. duwa .. tallo lang anak da .. tapos nu sino dagijay kapos ket .. lima .. innem".* (They say that they can provide for their children, but then they end up having difficulty. In our place, those who are wealthy have only two to three children, but those who are poor have five to six". This implies that couples are taking into consideration their capacity to provide the needs of their children when deciding the number of children they will have. The stability of financial status determines the provision of comfort and necessity of the family is what they are prioritizing. For families who have limited source of income, they wanted a smaller family to ensure that they will sustain the needs of their members. In consonance with the result of the study, parents' socioeconomic status will determine many things about children's early development: how they view the world; what, how much, and how often they eat; the type of early childhood education; overall health; or how others view them. It also give impacts as to their later success or failure in life later. Arguably, a lot of the course of their lives is set by what happens between the ages of two to five when they are discovering and understanding the world (Baron, 2018).

Meanwhile, availability and quality of health services provided obtained 4.13 and 5.14 percent, respectively as shown in the Table 31 on page 179 . These two factors were considered whether clients will go for clinic visits or not. Apart from distance, clients would sometimes still travel for so long, sacrificing their time and effort if they are contented with the services provided for them and if the service, they will have is surely available in the health care facilities. With the lack and scarcity of resources most especially in the barangay clinics, as well as the availability of the health care providers who will cater their needs, sometimes prospect clients will not go and will just do the usual things they are doing such as not using contraceptives, among others.

It has been noted that rural women are less likely than urban women to use a modern contraceptive method for several reasons, including poor quality of family planning services and limited choice of contraceptive methods (Ndayizigiye, et. al., 2017). In Sudan, the reasons for not fulfilling the adolescents' needs were mainly poor quality of the provided services and inadequate response to health services to their needs as adolescents. It is also indicated that the reproductive health services for adolescents are inadequate with poor utilization and accessibility. The barriers to adolescent access to reproductive health services were categorized as individual, socio-cultural, structural and policy barriers (Elnimeiri, et. al., 2020). According to Naanyu (2019), barriers of accessibility mainly insufficient availability of youth-friendly health clinics hinder young clients to go for clinic visits.

Taboos were also considered by 4.67 percent of the population as a barrier to RH optimal services utilization as shown in Table 31 on page 179 . A perceived negative cultural attitude towards sexual activity was especially felt by females. Jaymalin (2019) mentioned that parents actively discouraged relationships among youth, and topics like relationships and sex were taboo to discuss with parents. Filipino parents still refuse to discuss and teach the rudiments of sexuality to their adolescent children. According to Thongmixay (2019), shyness and shame caused by the cultural lack of acceptance of premarital sex were mentioned as the main reasons that adolescents felt reluctant to access RH services and to talk about it with a health provider. This affected females more than males. However, they were mainly afraid of being seen by others from the community when accessing the services. Aside from negative comments from community members, adolescents feared that if someone saw them, their parents would be informed, would be disappointed in them and may get angry.

Tradition/ beliefs and religion are considered by 4.37 percent and 3.23 percent of the population, respectively, as an obstacle to the access of reproductive health services as shown in Table 31 on page

179. Its prevalence can contribute to the unmet need for family planning by influencing cultural norms. Many religions, discourage premarital sex or the use of contraceptive methods (Adamczyk and Hayes, 2012). Family planning services are limited to women in religious communities due to the power of the leaders to inhibit or facilitate effective adoption of contraceptive methods to support family health (Adedini, et. al., 2018). According to Sensoy (2018), having a strong religious identity affects willingness of the clients to discuss contraception with their partners and families and an unwillingness to consider accessing it and eventually using it. Religious dynamics strongly influence the uptake of family planning, with a wide range of interpretations affecting its perceived acceptability. Religion plays a strong hold in the non-utilization of family planning services provided by the government to the people (Sundararajan, 2019).

Health care providers attitude, with 4.25 percent of the respondents, also played a significant role in the client's access to RH services a shown in Table 31 on page 179. How they deal with the people would either encourage them to avail of the services and hinder them for clinic visits. Jonas (2017) emphasized that lack of respect for women's opinion and preferences for birthing options, including adolescents' privacy and confidentiality, and the ill treatment by healthcare workers were some of the reported negative behaviors that discouraged women from giving birth at the healthcare facility, and sexually active adolescents from seeking the services. Adolescents also face difficulties obtaining contraceptives at public health facilities due to healthcare workers' negative attitudes associated with the general social stigma towards adolescent who seek contraceptive services. Undesirable healthcare providers' attitudes are common to marginalized user groups, like the unmarried and adolescent users. Negative attitudes such as shouting, scolding, not allowing clients to explain their side effect experiences, and giving preference to socially accepted family planning services existed in some of the health facilities (Silumbwe (2018).

It was also noted that physical threat by the partner were considered by 2.63 percent of the respondents as a barrier to reproductive health services used a shown in table 31 on page 179. Improper communication may severely affect not just the compliance of the women to the family planning regimen but also the overall health and safety. Results of the study conducted by Bergmann and Stockman (2015) revealed that significant number of women experienced reproductive coercion either in the form of birth control sabotage or pregnancy coercion, which limited their contraceptive efficacy. With birth control sabotage, women may have believed they were using contraception, while their partners either were not using condoms or had sabotaged the condoms. Male partners also removed access to oral contraceptives either through disposing of pills or not allowing women to purchase pills, which eliminated a woman's ability to access contraception. Finally, male partners used pressure or pregnancy coercion to get women pregnant and this can be done through threats of abandonment among others which also eliminated a woman's uninhibited choice to use contraception and eventually increase risk for unintended pregnancy (Alexander, et. al., 2020).

On the other hand, peer pressure is also considered as a barrier to RH services used as claimed by 2.63 percent of the population as shown in Table 31 on page 179. Colleagues has the tendency to affect their decision making considering the time spent together. They may serve as a source of information based on personal experience and can influence the knowledge levels. Peer influence is also related to sexual risk behavior and adolescent contraceptive behavior is also influenced by peer norms. They may be at risk of engaging in unprotected sexual behavior as well most especially if they have colleagues which are adolescent mothers. Govender, et. al., (2019) mentioned that adolescents who associated with friends who were adolescent parents were more likely to become adolescent parents themselves. This poses a

serious treat in the overall health and wellness of the youth. Indeed, social influence can adversely affect behavior of the people.

# Chapter 4
# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS
## Summary

This study determined the sociocultural implications of Reproductive Health programs in the Province of La Union. Specifically, it answered the following objectives: (1) to determine the sociocultural profiles of the respondents along age, gender, number of children, educational attainment, income, access to social media, religion, ethnicity, health-seeking behaviors, pregnancy and birth practices/ beliefs, and superstitious beliefs; (2) to determine the level of awareness of the respondents on reproductive health services along: family planning information and services, maternal, infant, and child health and nutrition, adolescent and youth reproductive health education and counseling, prevention and management of sexually transmittable infections; & male responsibility and involvement in reproductive health; (3) to determine the extent of practice of respondents on reproductive health services along the mentioned areas; (4) to determine if there is significant relationship between the sociocultural profile of the respondents and the following: level of awareness of the respondents on the RH services and extent of practice of the reproductive health services; (5) to determine if there is a significant difference in the level of awareness and extent of practice when group according to sociocultural profiles; and (6) to determine the barriers in the reproductive health used.

The results collected from the respondents were tabulated, analyzed, and interpreted using statistical tools such as frequency and percentage, mean, Pearson moment of correlation r, chi square, t- test, analysis of variance, and post hoc analysis. 0.05 percent level of significance were used to test the null hypotheses. A focus group discussion and an in-dept interview were also conducted to validate the gathered data.

The following were the salient findings of the study:

1. Majority of the respondents are 19 to 40 years old, comprising of 66.14 percent of the age groups, 70.34 percent of them are females, 49.34 percent have 2 to 4 children, 60.63 percent of them are high school graduate, 81.89 percent of them receive less than P10, 481 as a monthly income, 76.64 percent of the respondents profess the Roman Catholic faith, 65.62 percent of them belongs to Ilokano ethnic group, 41.94 percent has access to television; 37.93 percent of the respondents consult a physician when health problems arises, 43.14 percent of them are taking medications as per doctor's advice, 61.58 percent of them experienced self-medicating more than twice, and majority of them follow still some of pregnancy and birth practices/ beliefs, and superstitious beliefs.
2. Results revealed that the respondents are highly aware of the family planning information and services with 3.88 computed weighted mean. Also, they are highly aware in terms of maternal, infant and child health and nutrition (4.17), highly aware along adolescent and youth RH education and counseling (3.68), highly aware along prevention and management of sexually transmitted diseases (3.55), and highly aware along male responsibility and involvement in reproductive health (3.93).
3. Meanwhile, the extent of practice on the same parameters revealed that the respondents moderately practice services along family planning information and services (3.38), highly practiced services along maternal, infant and child health and nutrition (4.01), highly practiced services along adolescent and youth RH education and counseling, moderately practiced services along prevention and

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management of sexually transmitted diseases (3.39), and highly practiced services along male responsibility and involvement in reproductive health (3.73).

4. Significant relationship exists between awareness and religion (p-value is 0.00034 < 0.05), awareness and ethnicity (p-value is 0.010999 < 0.05), and awareness and income (p-value is 0.004571 < 0.05). Meanwhile, no significant relationship exists between level of awareness and age (p-value is 0.076694 > 0.05), awareness and gender (p-value is 0.352156 > 0.05), awareness and number of children (p-value is 0.169293 > 0.05), awareness and education (p-value is 0.114317 > 0.05). Also, significant relationship exists between extent of practice and education (p-value is 0.003697 < 0.05), extent of practice and religion (p-value is 0.019608 < 0.05), and extent of practice and ethnicity (p-value is 0.049142 < 0.05). Meanwhile, no significant relationship exists between extent of practice and gender (p-value is 0.404664 > 0.05), practice and number of children (p-value is 0.18357 > 0.05), extent of practice and income (p-value is 0.956555 > 0.05), extent of practice and age (p-value is 0.061026 > 0.05).
5. Significant difference exists between awareness and gender (p-value is 0.031 < 0.05), awareness and religion (p-value is 0.000 < 0.05), awareness and number of children (p-value is 0.037 < 0.05), awareness and ethnicity (p-value is 0.004 < 0.05), and awareness and municipality (p-value is 0.000 <0.05). No significant difference exists in the level of awareness of the age groups (p-value is 0.272 > 0.05), awareness and education (p-value is 0.245 > 0.05), and awareness and income (p-value is 0.479 > 0.05). Significant difference exists between extent of practice and gender (p-value is 0.007 < 0.05), extent of practice and religion (p-value is 0.000 < 0.05), and extent of practice and number of children (p-value is 0.021 < 0.05), and extent of practice and municipality (p-value is 0.000 <0.05). No significant difference exists between extent of practice and age (p-value is 0.222 > 0.05), extent of practice and education (p-value is 0.440 > 0.05), extent of practice and income (p-value is 0.934 > 0.05), extent of practice and ethnicity (p-value is 0.178 > 0.05).
6. Geographic accessibility tops the list of the barriers to reproductive health services used with 13.04 percent, followed by lack of transportation with 12.74 percent, and financial constraints with 12.68 percent. Meanwhile, peer pressure with 2.63 percent, physical threats of the partner with 2.63 percent, and religion with 3.23 percent, were the least considered reasons for not using the reproductive health services provided by the government.

## Conclusions

Based on the salient findings and observations gathered by the researcher, the following conclusions were derived:

1. Majority of the respondents who took part in this study are female, young adults and in their reproductive age. They belong to the poor sector of the society and attain low levels of education. Many of them have a medium-sized family consists of the father, mother, and two to four children. Majority of them belongs to Ilokano ethnic group and professed the Roman Catholic faith.
2. Generally, the respondents are highly aware of the reproductive health services provided by the government. Contributory factors to the awareness of the respondents includes access to social media platforms such as television, radio, and internet.
3. The respondents highly practiced and utilized the reproductive health services provided by the government. Availability, accessibility, affordability, adequate knowledge about the service, prior

experience, referrals from relatives and friends, and health teachings from health personnel are some of the elements the residents consider in the utilization and practice of the RH services.
4. The level of awareness of the respondents on the reproductive health services is associated with demographic characteristics such as age-appropriate, gender-specific, comprehensive RH education, the use of mass media, provision of safe and service-friendly programs, expanded access to information, community connectedness, peer behaviors, influence, and support groups.
5. The extent of practiced on the reproductive health services among the respondents vary in age or maturity, gender role perception, attained level of education, stability of financial sources, locality, ethnic groups affiliation and its associated beliefs and practices, choice in the number of children, religious influence.
6. Despite government efforts to improve the delivery of RH services to the people, several problems may hinder the people to utilize services. These key-determinants play a crucial role in the attainment of success in the provision of efficient service to the people.

**Recommendations**

Based on the conclusions derived from the study, the following recommendations are offered for consideration:

1. Strategies to improve people's access to sexual and reproductive health services are needed. Age and gender-appropriate, as well as religion and ethnicity-sensitive SRH education, could have a favorable impact on their understanding and access to services, resulting in overall SRH improvements.
2. Religious leaders have the power to influence the health behavior of the entire community, making them potentially effective allies in advocating health interventions. Religious leaders must be on board while promoting SRH education and community involvement.
3. Unmarried women have a difficult time receiving SRH services since they are thought to be for sexually active married women. Interventions targeting modifiable barriers to reproductive health education and services are urgently needed to promote knowledge, informed choice, and access to services, allowing people to enjoy better sexual and reproductive health.
4. Adolescents should have access to information about reproductive health and family planning through their school's curricula. There should be more intensive access to information for out-of-school teenagers and residents with low levels of education through trained barangay health professionals to educate the population. Improving teenage service utilization requires developing life skills, improving parent-child dialogue, and establishing and sustaining school reproductive health groups.
5. The establishment and operation of youth-friendly spaces, such as Sangguniang Kabataan Teen Centers, in each barangay is a crucial support and convergent intervention. This facility aims to increase youth and adolescent health access by providing a dedicated, specialized, and easily accessible center that provides a wide range of age- and development-appropriate information, services, and programs to help them improve their health and well-being.
6. Male partners can have a huge impact on women's access to sexual and reproductive health education and services. Existing interventions, however, mostly target women. Plans should include male partners, with a focus on empowering women to manage their own reproductive health.
7. It is necessary to pay attention to women's beliefs and opinions, provide them with more information about the importance of using contraceptives to avoid unwanted pregnancies and sexually transmitted infections, inform them about the various contraceptive methods available and their side effects, and

expand their access to a variety of contraceptive methods.

8. Policies promoting family planning must consider the various reasons for not utilizing contraceptive techniques, as well as contextual factors affecting women of reproductive age, such as social norms and constraints that restrict women from accessing and using contraceptives.