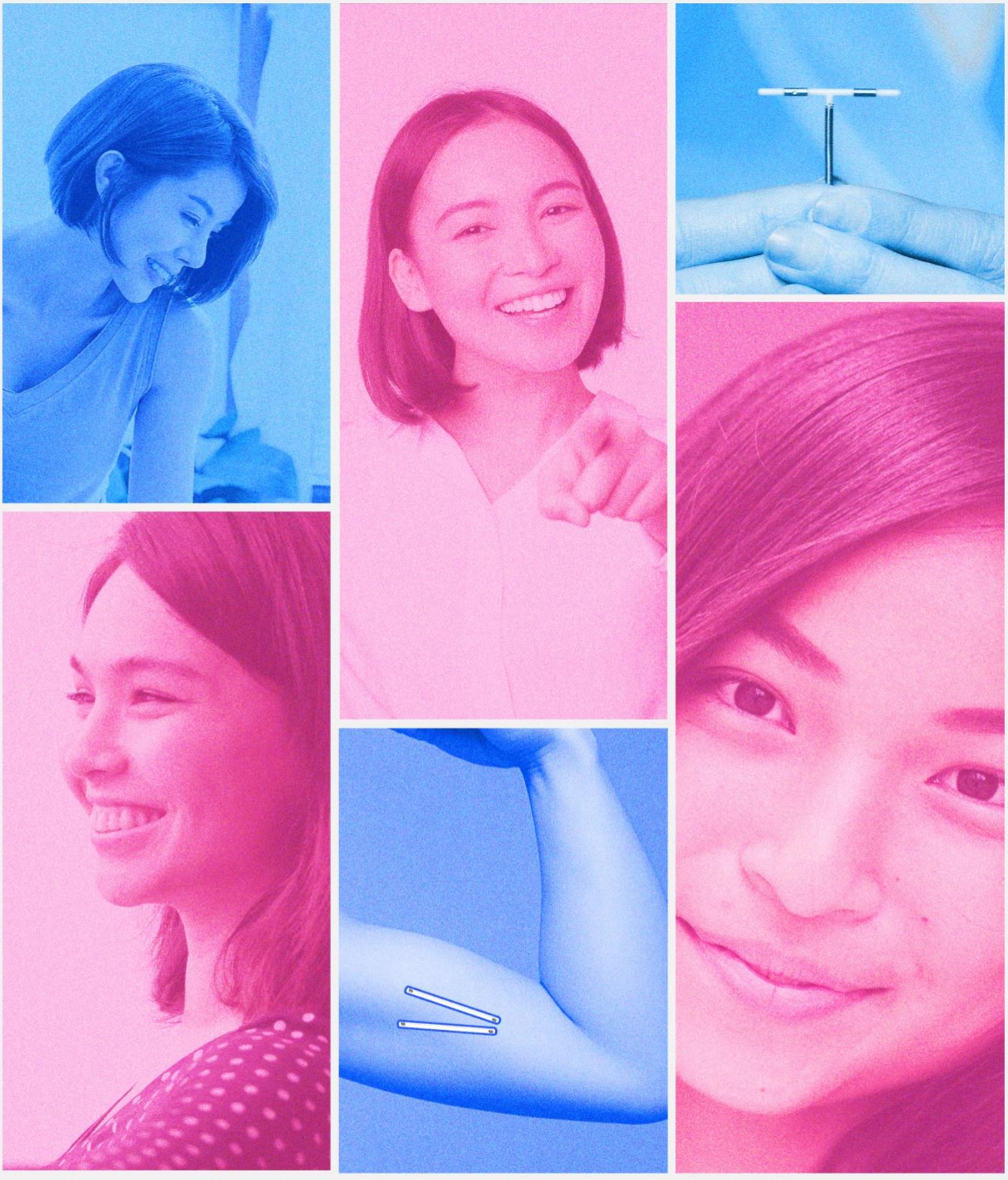

Study on Long-Acting Reversible Contraception (LARC) in the Philippines

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Acronyms

AIP	Annual Investment Plan
AOP	Annual Operational Plan
APMARGIN	Asia Pacific Management and Research Group, Inc.
CPD	Commission on Population and Development
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FGD	Focus Group Discussion
FHSIS	Field Health Service Information System
FP	Family Planning
FPCBT	Family Planning Competency Based Training
FPOP	Family Planning Organization of the Philippines
HRH	Human Resources for Health
IUD	Intrauterine Device
KII	Key Informant Interview
KI/s	Key Informant/s
LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraceptives
LGU	Local Government Unit
NCR	National Capital Region
NGO	Non-government organization
OB	Obstetrician
PhilHealth	Philippine Health Insurance Corporation
PHO	Provincial Health Office
POPCOM	Commission on Population
PTE	Post-Training Evaluation
SDM	Standard Days Method
TNA	Training Needs Assessment
WRA	Women of Reproductive Age

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Study on Long-Acting Reversible Contraception (LARC) in the Philippines

1. Background & Objectives

In the Philippines, the utilization of Long-Acting Reversible Contraception (LARC), such as intrauterine devices (IUDs) and contraceptive Implants, is lower than desired, despite their proven advantages over short acting methods. Research has identified provider bias as a significant barrier, with healthcare providers often favoring less effective methods and withholding LARCs from certain groups without medical justification. This bias has led to a lack of prioritization for LARC promotion, particularly among family planning (FP) providers, community motivators and women of reproductive age. In response, the DKT Philippines Foundation aims to promote the use of modern family planning methods including LARC, specifically IUDs, and introduce a two-rod contraceptive Implant to married women and nulliparous young women. This initiative seeks to revitalize IUD promotion and normalize LARC use among young women.

To achieve these goals, the current study was conducted to determine the training needs of health providers and community motivators; assess the knowledge, attitudes, and practices of the target population and providers regarding LARC; and review the status and current initiatives on LARC promotion and services. The findings from this study will be used to develop targeted strategies and plans for LARC education and training in collaboration with the Department of Health (DOH), development partners, LGUs and other reproductive health partners.

The study was spearheaded by the Asia Pacific Management and Research Group, Inc. (APMARGIN) which has extensive experience in demand generation, outreach activities and service provision of LARC in the country.

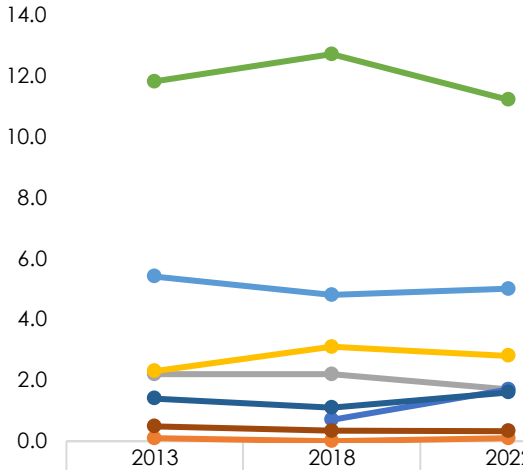
LARC in the Philippines

The IUD and contraceptive Implant are included in the long-acting methods, together with permanent female and male sterilization, which are the most effective methods of contraception that provides near perfect protection from pregnancy (PRB, 2018). Despite this, most women of reproductive age in the Philippines use the short-acting and less-effective modern method of contraception.

As shown in Figure 1, from 2013 to 2022, the percent of women 15-49 in the Philippines using a modern method slightly increased from 23.5% to 24.3%, respectively (PSA & ICF, 2023; PSA & ICF, 2018; PSA & ICF, 2014). For almost a decade, the pill and injectable had

been a popular method among women of reproductive age. There was, however, an increase in the number of women of reproductive age who used contraceptive Implant from less than 1% in 2017 to 1.7% in 2022.

Figure 1. Percent of Current Users of Modern Method by All Women (Ages 15-49), PSA & ICF, 2014 to 2023



	2013	2018	2022
Female sterilization	5.4	4.8	5.0
Male sterilization	0.1	0.0	0.1
IUD	2.2	2.2	1.7
Injectable	2.3	3.1	2.8
Implant		0.7	1.7
Pill	11.8	12.7	11.2
Male condom	1.4	1.1	1.6
Other modern	0.5	0.3	0.3

To provide women access to family planning procedures in the country, the Philippine Health Insurance Corporation (PhilHealth), the country's social health insurance program, covers long-term but reversible birth control measures, specifically, the Insertion of IUD and subdermal contraceptive Implants as stipulated in the PhilHealth Circulars: 038-2015 and 025-2015 (PNA, 2023; PhilHealth, 2015b; PhilHealth, 2015a). In the recent policy of PhilHealth, the case rate is increased to 30% (PhilHealth Circular No. 2024-0012 in PhilHealth, 2024b. The subdermal contraceptive Implant is also included in the list of medical condition and procedures allowed as second rate (PhilHealth, 2024a) with case rate of PhP1,950.00; heath facility fee of PhP1,170.00 and professional fee of PhP780.00.

Goals and Objectives

The current study aims to identify the specific training needs of health providers and community motivators, assess the knowledge, attitudes, and practices of the target population and providers regarding LARC, and review the status and current initiatives on LARC promotion and services. The findings from the study will be utilized to develop targeted strategies and plans for LARC education and training in collaboration with key stakeholders.

The current study has four (4) main objectives:

- Objective 1: Assess the training needs of health providers and community motivators regarding LARC. This was done through the conduct of a comprehensive assessment to identify and understand the specific training requirements of healthcare providers and community motivators about the promotion and provision of LARC.

- Objective 2: Evaluate knowledge, attitudes and practices regarding LARC. This was done through the conduct of a comprehensive assessment to understand the existing knowledge, attitudes, and practices of the target population, including married women, nulliparous young women, concerning LARC. This also included gathering insights from the perspectives and practices of healthcare providers, such as doctors and midwives, regarding the promotion and provision of LARC.

- Objective 3: Review the status and current initiatives on LARC promotion and services in the Philippines. This was done through the evaluation of the current status and ongoing initiatives related to the promotion and provision of LARC to identify areas for improvement and potential gaps in the existing efforts.

- Objective 4: Recommend targeted strategies and plans for LARC education and training in collaboration with relevant stakeholders. The findings of the assessment were used to recommend tailored strategies and plans for LARC education and training aiming to effectively promote the use of LARC, specifically IUDs and contraceptive Implants, among the target population.

Scope and Limitations

The current study collected information on the training needs of health service providers on LARC and assessed their current level of knowledge, attitudes and practices regarding LARC To provide deeper context, the study also assessed the existing knowledge, attitudes and practices of the target population i.e., current users, nulliparous

women and adolescents as well as of selected health service providers from the study sites. There were, however, some information which were not collected in this study and these included: questions on post-training evaluation (PTE) and number of health service providers trained via blended learning; data on current users by age and type of LARC used; distinction of adolescents by whether they are in-school or out-of-school adolescents; and disaggregation of adolescents by whether they are using or not-using FP and, if using, the type of FP method.

2. Methodology

Quantitative and Qualitative Approaches

To achieve its objectives, the current study focused on enhancing the promotion and provision of LARC in the Philippines combining quantitative and qualitative research approaches, including surveys, interviews, focus group discussions, document review, policy analysis, stakeholder engagement and data analysis. This is to ensure a thorough understanding of the factors influencing LARC utilization and facilitate the development of evidence-based strategies and plans for effective LARC education and training. This comprehensive approach, combining data from surveys, interviews, and focus groups, served as the foundation for recommending tailored, evidence-based training initiatives and ensured that recommended interventions were aligned with stakeholders' specific needs and perspectives, ultimately contributing to effective LARC promotion and provision in the Philippines.

- Training Needs Assessment (TNA). To assess the training needs, the TNA tool was developed which can be accessed, completed and sent via online. The tool covered the basic demographic characteristic of the health service providers as well as their level of knowledge, practices, barriers and desired training areas. The questions used in this tool were primarily based on the 2022 FP Global Handbook for Providers (WHO, 2022).

- Interviews: In-depth interviews were conducted with Key Informants within the study site to examine individual experiences, challenges, and perspectives on LARC promotion and provision. The open-ended discussions used for the Key Informant Interview (KII) provided a clear understanding of specific needs and practical obstacles encountered at the level of the health facility.

- Focus Group Discussions (FGD): These group discussions brought together diverse stakeholders to gather collective insights, shared challenges, and innovative solutions to shape training programs based on collaborative input.

Study sites

The study sites were purposefully chosen to capture a spectrum of performance metrics, urban-rural dynamics, and geographic characteristics. These include: the Provinces of Bulacan and Rizal (Luzon); Province of Cebu (Visayas), Province of Misamis Oriental (Mindanao) and District II of Quezon City (NCR).

Table 1. Study sites from regions and provinces, by performance on LARC, APMARGIN 2024

Performance on LARC	Region	Province
Low	Central Luzon	Bulacan
Low	CALABARZON	Rizal
Mid	NCR	Quezon City (District II)
High	Northern Mindanao	Misamis Oriental
High	Central Visayas	Cebu

The classification of the regional study sites by performance in LARC (high or low) was based on the results from the recent 2022 NDHS. For the city/municipality, the basis for such classification was from the endorsement of the Provincial Health Office. Specific to Cebu Province, the Field Health Service Information System (FHSIS) was used for classifying it based on its performance in LARC.

3. Assessment of training needs among health service providers in selected study sites

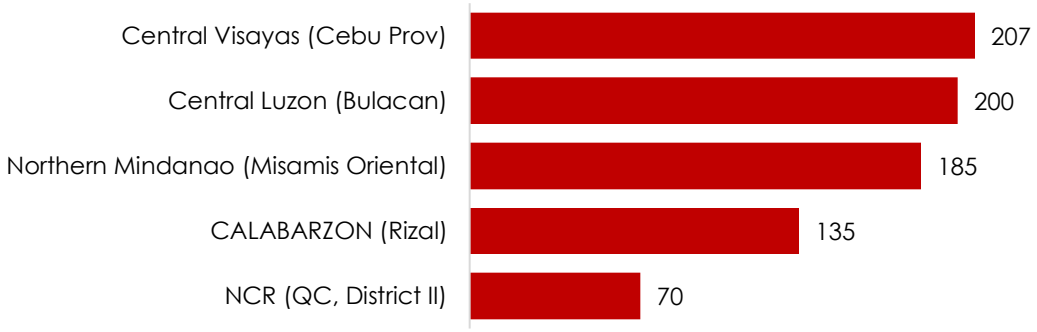
This chapter presents the results of the TNA conducted with 797 health service providers from the study sites. The analysis of the data is purely descriptive since the study sites were purposefully chosen for this study.

Of the 797 HSPs, 26% (n=207) were from the Province of Cebu; 25% (n=200) were from the Province of Bulacan; 23% (n=183) were from the Province of Misamis Oriental; 17% (n=135) were from the Province of Rizal; and 9% (n=70) were from QC District II (Figure 2).

In the administration of the TNA, the actual number of health service providers providing FP services were not readily determined, except for District II of Quezon City. Initially, the study targeted for 764 respondents from all study sites taking into account the number of cities/municipalities in the province and an estimate of six (6) health service providers in each city/municipality providing FP services. There were, however, delays in the

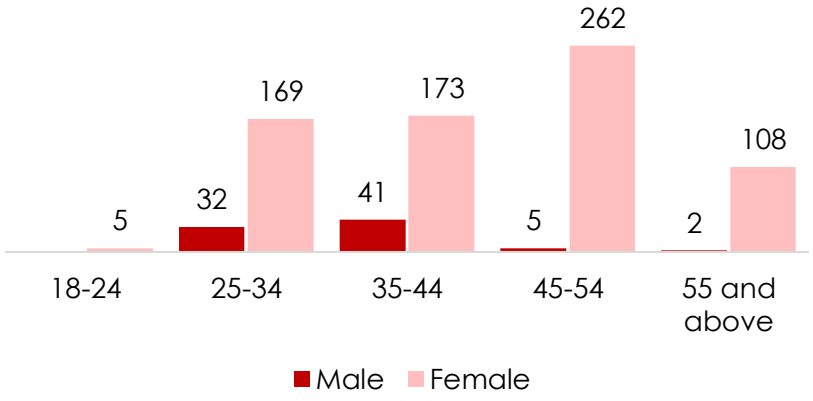
submission of the filled-out TNA forms from the study sites which necessitated intensive follow-up with the province. The original timeline set to complete the TNA in all areas to cover all 764 health service providers was moved to another month. The final count of health service providers, as provided in Figure 2, is the final number of health service providers who completed the TNA which is 797.

Figure 2. Number of health service providers, by region and province, APMARGIN 2024



About 90% (n=717) and 10% (n=80) of the health service providers were females and males, respectively. A little more than one-third (34%) of the health service providers (n=267) belonged to the 45 to 54 ages followed by 27% who belonged to the 35 to 44 age group (n=214); 25% who belonged to the 25 to 34 age group (n=201); 14% (n=11) who were at least 55 years old; and less than 1% (n=5) who belonged to the 18 to 24 years old (Figure 3).

Figure 3. Number of health service providers, by age group and by sex, APMARGIN 2024

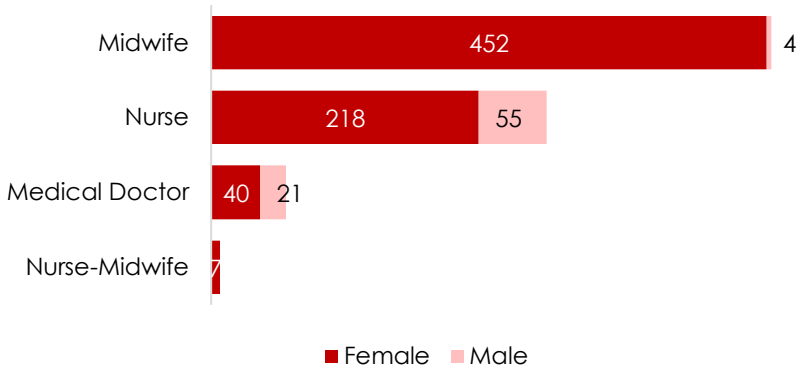


Practice of profession

Profession in the healthcare field

About 57% of the 797 health service providers (n=456) who completed the TNA were midwives of which 452 were females and four (4) were males. A little more than a third (n=273) were nurses; 8% (n=61) were medical doctors and less than 1% (n=7) were nurse-midwives (Figure 4)

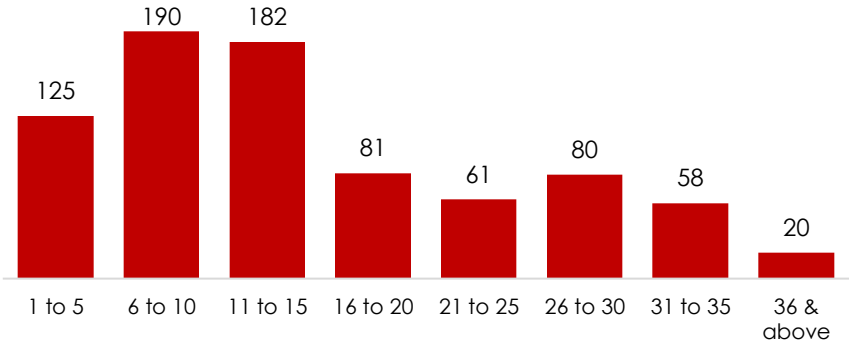
Figure 4. Number of health service providers, by profession, APMARGIN 2024



Duration of practice of profession

Of the 797 health service providers, 24% (n=190) have been practicing their profession for 6 to 10 years; 23% (n=82) have been practicing their profession for 11 to 15 years and 16% (n=125) have been practicing their profession for five years or less (Figure 5). About 38% have been practicing their profession for at least 16 years. The practice of profession was asked in reference to the respondent's response on the question regarding their profession in the healthcare field.

Figure 5. Number of health service providers, by number of years practicing their profession, APMARGIN 2024



On average, the health service providers have been practicing their profession for 15 years ranging from 1 to 50 years. The midwives have been practicing their profession for 18 years and ranged from 1 to 44 years (Table 2). As for nurses, they have been practicing

their profession for 11 years, on average, which ranged from 1 to 50 years. Medical doctors have been practicing their profession for an average of nine (9) years ranging from 1 to 34 years.

Table 2. Average, minimum and maximum number of years in the profession, by profession of health service providers, APMARGIN 2024

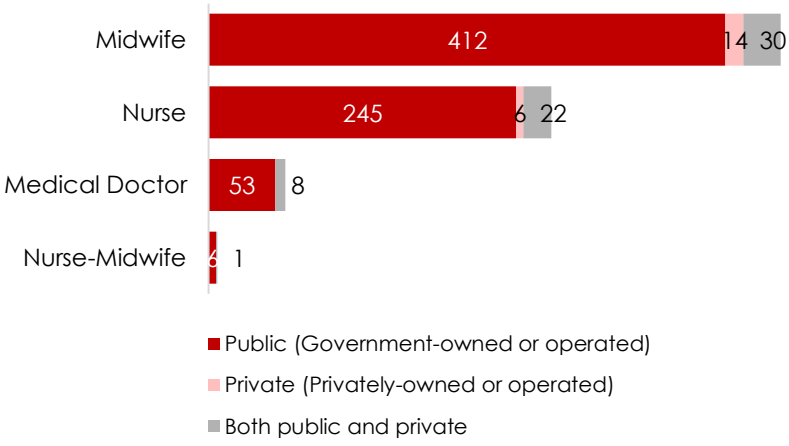
Profession	Mean	Min-Max	N
Midwife	18	1 to 44	456
Nurse	11	1 to 50	273
Medical Doctor	9	1 to 34	61

Note: Statistics not shown for nurse-midwife because of very small number of cases

Primary area of practice

The primary area of practice of 90% of the 797 health service providers (n=716) was in public or government-owned operated facilities: 90% among midwives (412 of 456); 90% among nurses (273 of 245) and 87% of medical doctors (53 of 61) (Figure 6).

Figure 6. Number of health service providers, by profession and primary area of practice, APMARGIN 2024



Current designation

Table 3 shows the current designation or job title of the health service providers. About 84% of the midwives were designated as Public Health Midwives (382 of 456); 12% were designated as Lying-in Midwives (54 of 456); 2% were designated FP Coordinators (11 of

456); and about 2% were designated in other positions (9 of 456). Among nurses, 91% were designated as Public Health Nurses (248 of 273); 4% were designated as FP Coordinators (12 of 248); 3% were designated as Lying-in Nurses (9 of 273); and less than 2% held other positions (4 of 273). As for medical doctors, 43% were designated as Medical Officers (26 of 61); 25% were designated as Health Center Physicians (15 of 61); 20% were designated as Municipal Health Officers (12 of 61); and about 13% held other positions (8 of 61). Note that the responses for this question were no longer validated with the health service providers and were accepted as is.

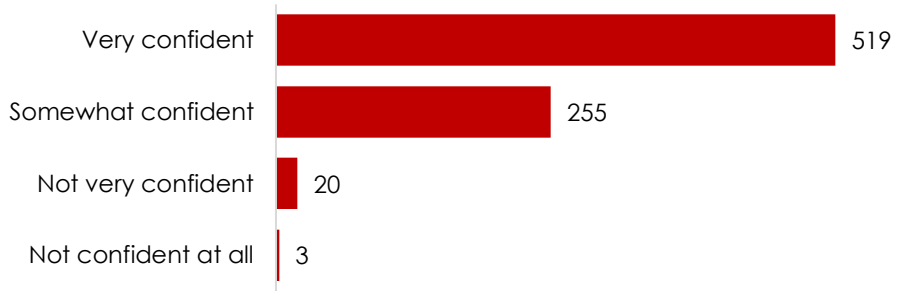
Table 3. Current designation or job title within the healthcare facility, by profession of health service providers, APMARGIN 2024

Current designation or job title	Profession				Total
	Medical Doctor	Nurse	Nurse-Midwife	Midwife	
Assistant City Heath Officer	1	-	-	-	**1**
Assistant Provincial Health Officer	1	-	-	-	**1**
City Health Officer	-	-	-	3	**3**
Family Planning Coordinator	-	12	-	11	**23**
General Medical Practitioner	1	1	-	-	**2**
Health Center Physician	15	-	-	1	**16**
Lying-in Midwife	-	-	-	54	**54**
Lying-in Nurse	-	9	-	-	**9**
Medical Officer	26	-	-	-	**26**
Municipal Health Officer	12	1	-	3	**16**
OB-GYN Consultant	4	-	-	-	**4**
Provincial Health Officer	-	-	-	2	**2**
Public Health Midwife	-	2	6	382	**390**
Public Health Nurse	1	248	1	-	**250**
Total	**61**	**273**	**7**	**456**	**797**

Confidence in understanding job responsibilities

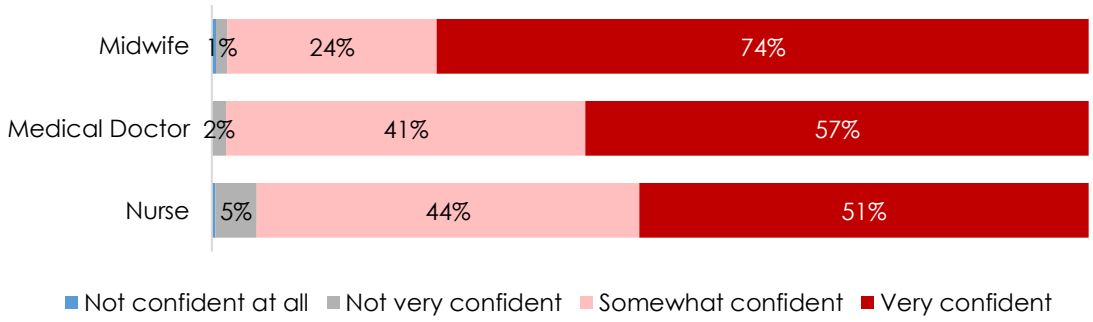
When asked how confident they are in understanding their job responsibilities, 65% (519 of 797) said that they were very confident; 32% (255 of 797) said that they were somewhat confident; 3% (20 of 797) were not very confident; and less than 1% (3 of 797) were not confident at all (Figure 7).

Figure 7. Level of confidence of health service providers in understanding their job responsibilities, APMARGIN 2024



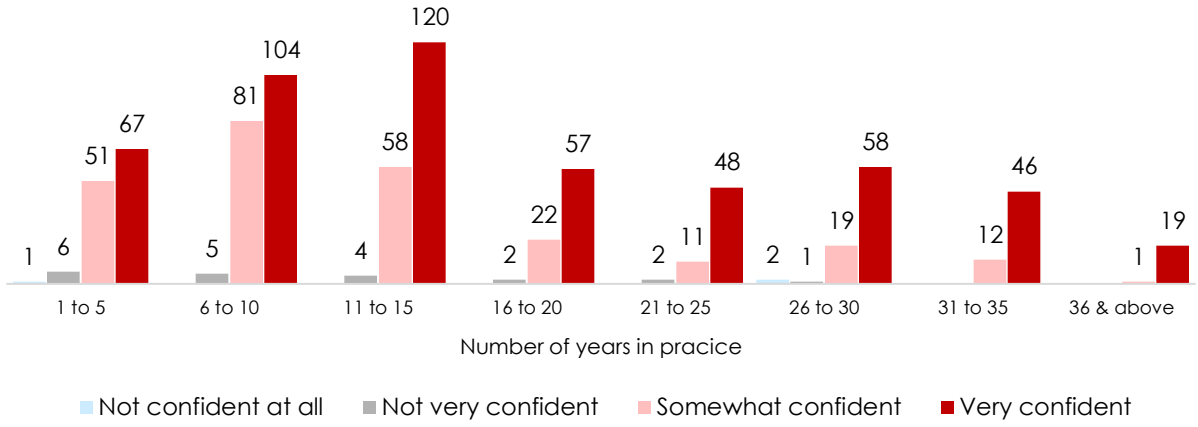
As shown in Figure 8, the percentage of those who felt very confident in understanding their job responsibilities among midwives is higher at 74% (339 of 456) than the medical doctors at 57% (35 of 561) and nurses at 51% (140 of 273). Health service providers who felt somewhat confident were slightly higher among medical doctors and nurses compared to the midwives.

Figure 8. Level of confidence of health service providers in understanding their job responsibilities, by profession, APMARGIN 2024



Across grouped number of years in practice, the number of health service providers who were somewhat confident and very confident was higher than those who were not confident at all as shown in Figure 9. Note that the TNA only included question on how confident they are in understanding their job responsibilities with the categories not having any distinction from each other i.e., no indicators to differentiate each of the category.

Figure 9. Level of confidence of health service providers in understanding their job responsibilities, by number of years practicing their profession (5-year grouping), APMARGIN 2024



Main sources of information that helped health service providers understand their job description

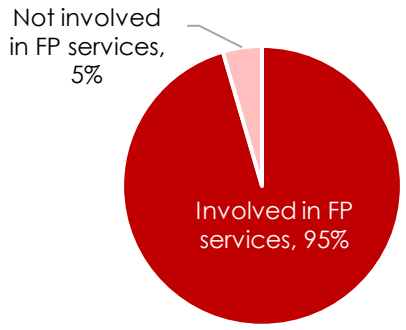
The sources of information that helped the health service providers understand their job description were as follows: government regulation/guidelines at 76% (607 of 797); job description document at 64% (512 of 797); information from direct supervisor or manager at 49% (392 of 797); onboarding or training materials at 45% (361 of 797); colleague or peers at 45% (356 of 797); professional association or organization resources at 42% (333 of 797) and company handbook or policy manual at 28% (220 of 797).

Figure 10. Main sources of information that helped health service providers understand their job description, APMARGIN 2024

Provision of family planning services

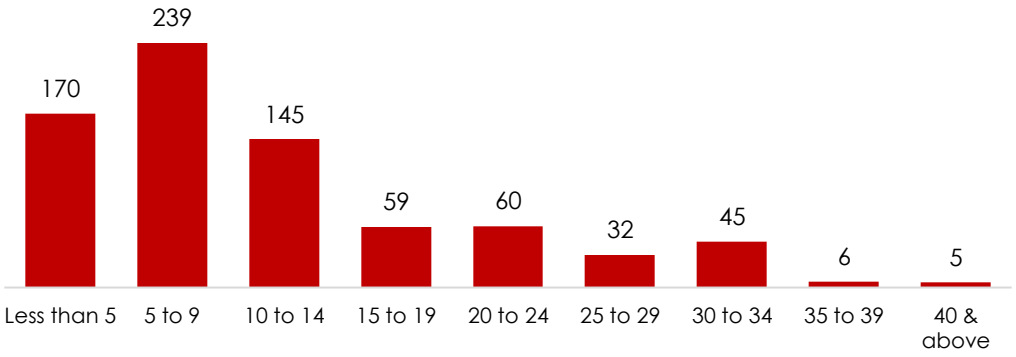
Of the 797 health service providers, 95% (n=761) were involved in providing FP services while 5% (n=36) were not involved in providing FP services (Figure 11).

Figure 11. Health service providers involved in providing FP services, APMARGIN 2024



Among the 761 health service providers, on average, the number of years they have been involved in providing FP services was 11 years ranging from 1 year to 42 years. About 31% (239 of 761) have been involved in providing FP services for 5 to 9 years followed by 22% (170 of 761) who have been involved in providing FP services for less than five years and 19% (145 of 761) who have been involved in providing FP services for 10 to 14 years. Less than a third (207 of 761) have been involved in providing FP services for at least 15 years (Figure 12).

Figure 12. Number of years health service providers were involved in providing FP services, (5-year grouping) APMARGIN 2024

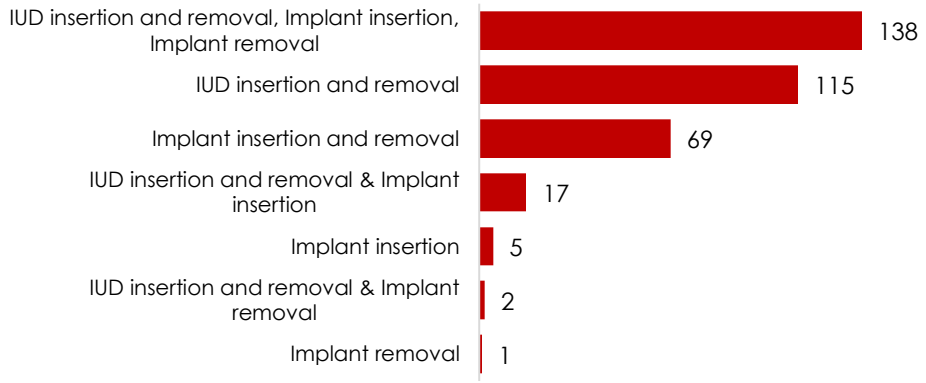


Training on IUD/contraceptive Implant insertion and removal

Health service providers were also asked whether they have formal training on IUD and/or contraceptive Implant insertion and removal to assess their experiences in providing these services. In this study, formal training means that the health service providers have received a certificate of training.

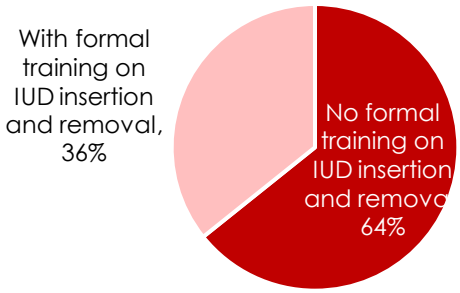
In summary, of the 761 health service providers involved in providing FP services, 347 (46%) were trained in either IUD insertion and removal or Implant insertion and removal or both. Of the 347 health service providers, 40% (n=138) were trained in both IUD and Implant insertion and removal; 33% (n=115) were trained in IUD insertion and removal only; and 20% (n=69) were trained in Implant insertion and removal only. The remaining 25 health service providers (7%) were trained in one or both IUD/Implant insertion and removal (Figure 13).

Figure 13. Number of health service providers with training in IUD/Implant insertion and removal, APMARGIN 2024



Training on IUD insertion and removal. Among the 761 health service providers who were involved in providing FP services, 36% (n=272) had formal training on IUD insertion and removal while 64% had no formal training on IUD insertion and removal (Figure 14).

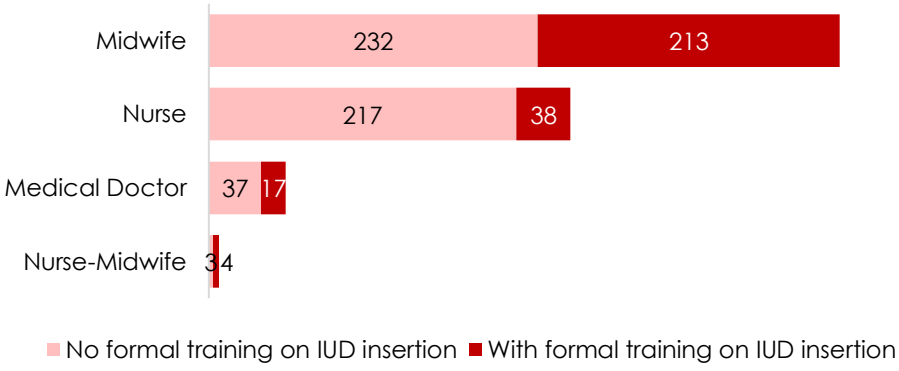
Figure 14. Training in IUD insertion and removal of health service providers who were involved in providing FP services, APMARGIN 2024



Of the 272 health service providers with formal training on IUD insertion and removal, 78% (n=213) were midwives; 14% (n=38) were nurses; 6% (n=17) were medical doctors; and about 2% (n=4) were nurse-midwives.

As for those without training in IUD insertion and removal, although the absolute number is higher among midwives (n=232) than nurses (n=217), the proportion of untrained nurses to total nurses (85%) exceeded that of the proportion of untrained midwives to total midwives (52%) (Figure 15).

Figure 15. Training in IUD insertion and removal of health service providers who were involved in providing FP services, by profession, APMARGIN 2024



Of the 761 health service providers who were involved in providing FP services, 25% (n=193) were trained in Accredited Basic FPCBT Program; 16% (n=124) were trained in Accredited Comprehensive FPCBT Program; 12% (n=93) were trained in IUD insertion and removal certification program; 7% (n=56) were trained via mentorship program with a qualified healthcare provider; and 2% (n=14) were trained via online training module from a reputable source (Figure 16).

Figure 16. Formal training received by health service providers on IUD insertion and removal, APMARGIN 2024

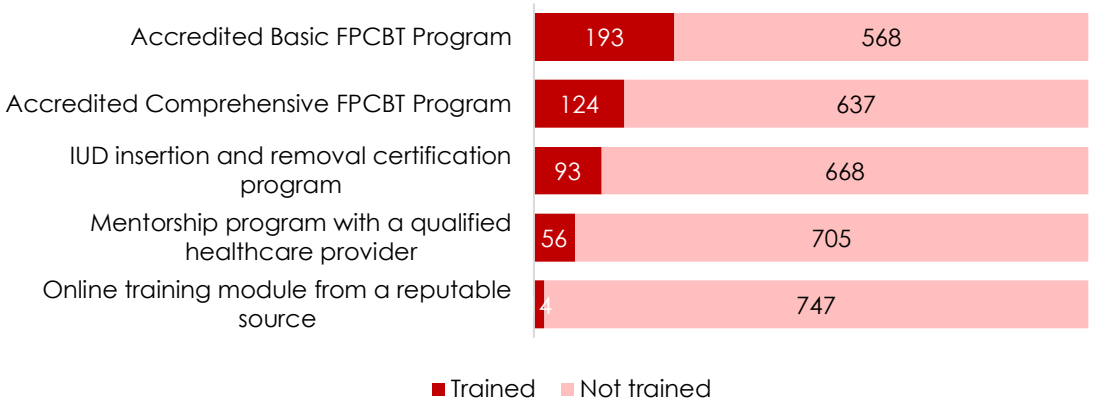


Table 4 provides the different training in IUD insertion and removal and the health service providers trained for each, by profession. In all trainings, there are more midwives trained in terms of absolute number.

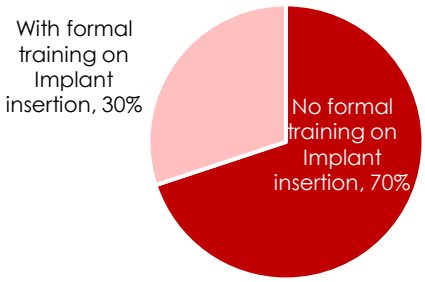
- In Accredited Basic FPCBT Program, the following were trained: 15% of doctors, 11% of nurses and 34% of midwives.
- In Accredited Comprehensive FPCBT Program, the following were trained: 9% of doctors; 5% of nurses and 23% of midwives.
- In IUD insertion and removal certification program, the following were trained: 9% of the medical doctors; 3% of nurses and 17% of midwives.
- In mentorship program with a qualified healthcare provider, the following were trained; 13% of medical doctor; 4% of nurses and 9% of midwives.
- In online training module from a reputable source, the following were trained: 2% of doctors; and 3% of midwives.

Table 4. Formal training received by health service providers on IUD insertion and removal, by profession, APMARGIN 2024

Training in IUD insertion and removal	Profession				**Total (n=761)**
	Medical Doctor (n=54)	Nurse (n=255)	Nurse-Midwife (n=7)	Midwife (n=445)	
Accredited Basic FPCBT Program	8	29	3	153	**193**
Accredited Comprehensive FPCBT Program	5	13	2	104	**124**
IUD insertion and removal certification program	5	7	4	77	**93**
Mentorship program with a qualified healthcare provider	7	10	1	38	**56**
Online training module from a reputable source	1			13	**14**

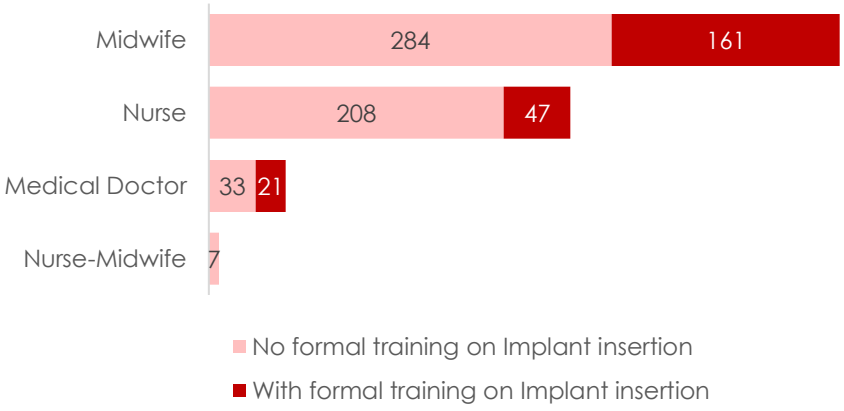
Training on contraceptive Implant insertion. Of the 761 health service providers who were involved in providing FP services, 30% (n=229) had formal training on contraceptive Implant insertion (Figure 17).

Figure 17. Training in contraceptive Implant insertion of health service providers who were involved in providing FP services, APMARGIN 2024



Seventy percent of health service providers who were providing FP services and who were trained in contraceptive Implant insertion were midwives (161 of 229); 21% (47 of 229) were nurses; and 9% (21 of 229) were medical doctors (Figure 18). The proportion of untrained nurses to total nurses is higher at 82% (208 of 255) compared to the proportion of untrained midwives to total midwives which is at 64% (284 of 445).

Figure 18. Training in contraceptive Implant insertion of health service providers who were involved in providing FP services, by profession, APMARGIN 2024



Of the 761 health service providers who were involved in providing FP services, 21% (n=163) were trained in Accredited FPCBT Program; 16% (n=124) were trained in contraceptive Implant insertion certification program; 11% (n=87) were trained via mentorship program with a qualified healthcare provider; and 2% (n=16) were trained via online training module from a reputable source (Figure 19).

Figure 19. Formal training received by health service providers on contraceptive Implant insertion, APMARGIN 2024

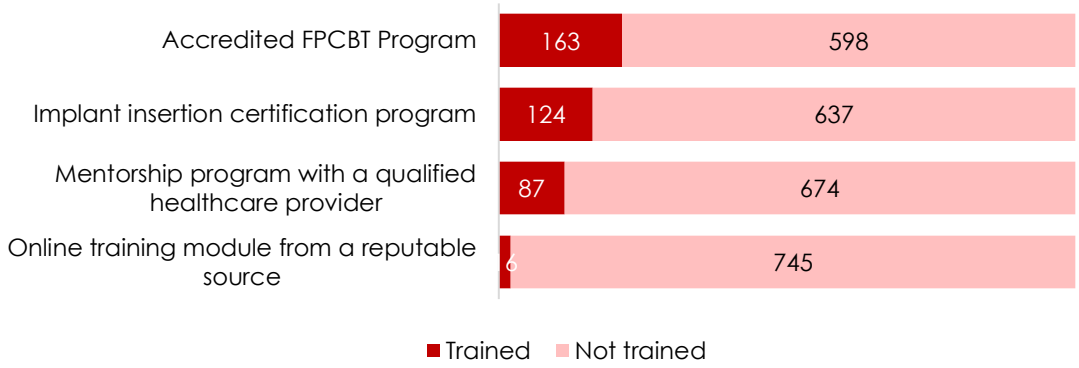


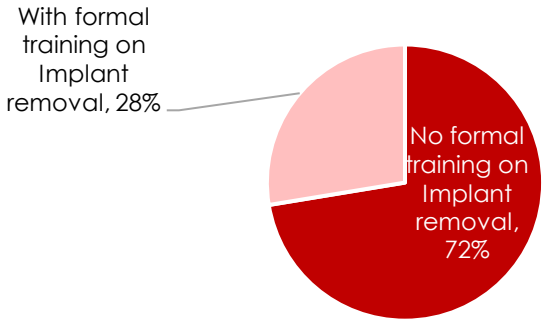
Table 5 provides the different training in contraceptive Implant insertion and the health service providers trained for each by profession. In all trainings, there are more midwives trained.

Table 5. Formal training received by health service providers on contraceptive Implant insertion, by profession, APMARGIN 2024

Training in contraceptive Implant insertion	Profession				**Total (n=761)**
	Medical Doctor (n=54)	Nurse (n=255)	Nurse-Midwife (n=7)	Midwife (n=445)	
Accredited FPCBT Program	11	29	0	123	**163**
Contraceptive Implant insertion certification program	13	25	0	86	**124**
Mentorship program with a qualified healthcare provider	8	24	0	55	**87**
Online training module from a reputable source		2		14	**16**

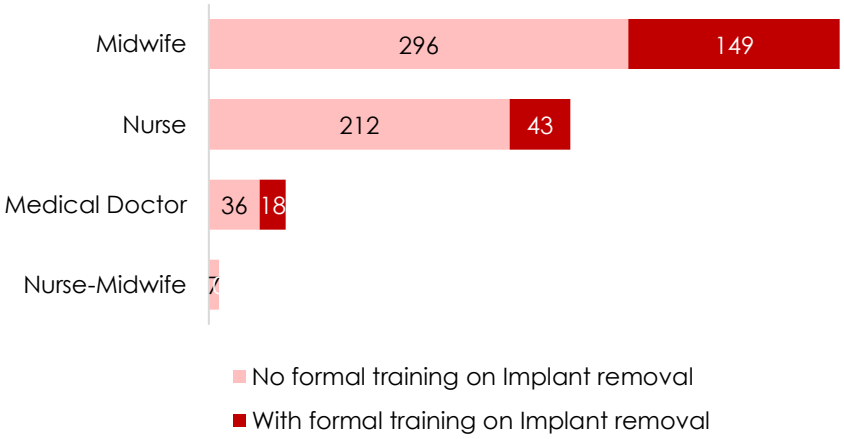
Training on contraceptive Implant removal. About 28% of 761 health service providers who were involved in providing FP services (n=210) had formal training on contraceptive Implant removal (Figure 20).

Figure 20. Training in contraceptive Implant removal of health service providers who were involved in providing FP services, APMARGIN 2024



About 71% of health service providers who were providing FP services and who were trained in contraceptive Implant removal were midwives (149 of 210); 20% (43 of 210) were nurses; and 9% (18 of 210) were medical doctors (Figure 21). The proportion of untrained nurses to total nurses is higher at 83% (212 of 255) compared to the proportion of untrained midwives to total midwives at 67% (296 of 445).

Figure 21. Training in contraceptive Implant removal of health service providers who were involved in providing FP services, by profession, APMARGIN 2024



Of the 761 health service providers who were involved in providing FP services, 20% (n=150) were trained in Accredited FPCBT Program; 14% (n=104) were trained in contraceptive Implant removal certification program; 12% (n=89) were trained via mentorship program with a qualified healthcare provider; and 2% (n=14) were trained via online training module from a reputable source (Figure 22).

Figure 22. Formal training received by health service providers on contraceptive Implant removal, APMARGIN 2024

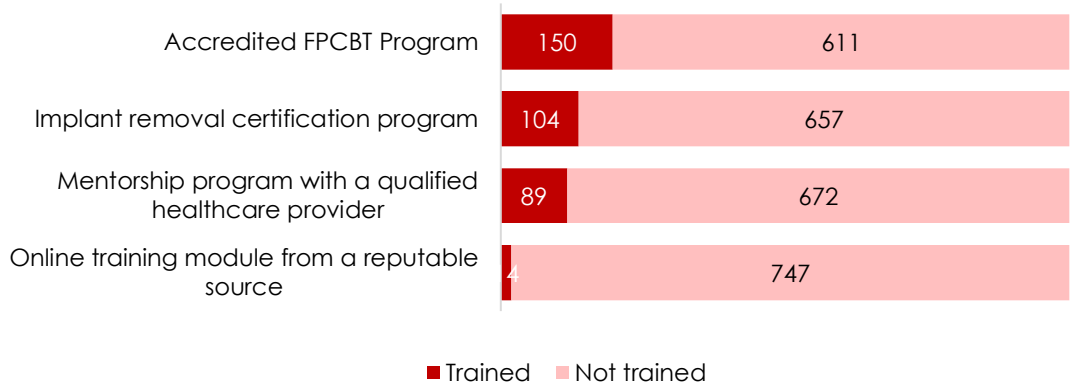


Table 6 provides the different training in contraceptive Implant removal and the health service providers trained for each by profession. In all trainings, there are more midwives trained.

Table 6. Formal training received by health service providers on contraceptive Implant removal, by profession, APMARGIN 2024

Training in contraceptive Implant removal	Profession				**Total (n=761)**
	Medical Doctor (n=54)	Nurse (n=255)	Nurse-Midwife (n=7)	Midwife (n=445)	
Accredited FPCBT Program	10	27	0	113	150
contraceptive Implant removal certification program	8	21	0	75	104
Mentorship program with a qualified healthcare provider	7	23	0	59	89
Online training module from a reputable source		3		11	14

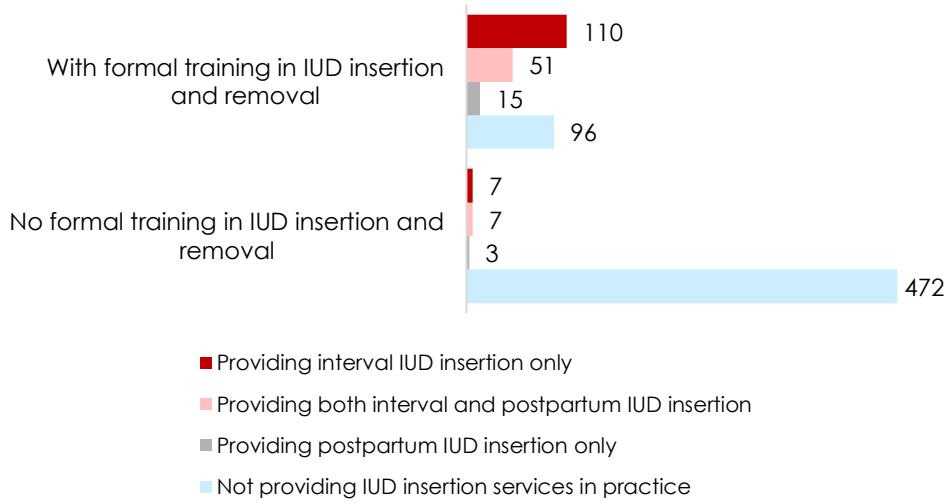
It is worth noting that of the 229 who had formal training in contraceptive Implant insertion, 90% (n=207) had formal training on contraceptive Implant removal. The 10% of health service providers who were not trained on Implant removal may be because, initially, this was not included in the training because there were no clients for removal yet.

Actual provision of IUD and contraceptive Implant insertion and removal services

Actual provision of IUD insertion. Of the 272 health service providers who were involved in providing FP services and with formal training in IUD insertion, 65% (n=176) were actually providing services on IUD insertion in practice while 35% (n=96) were not providing this service in practice (Figure 23).

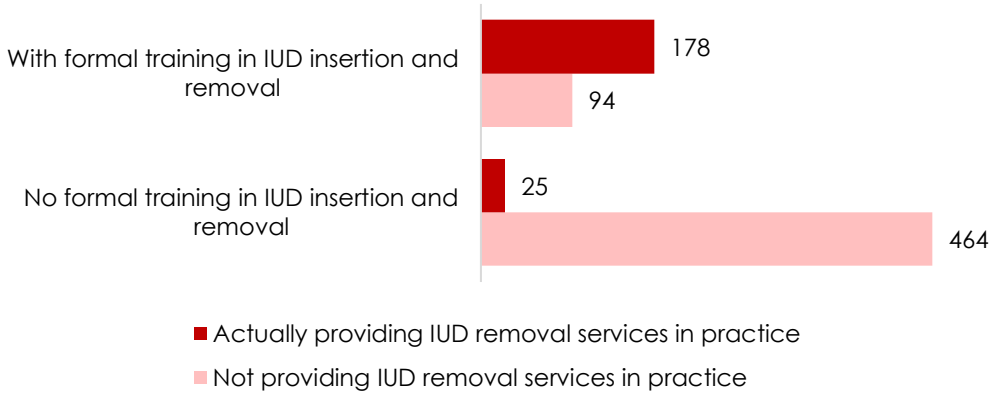
Of the 176 health service providers with formal training on IUD insertion and removal and who were providing IUD services, 63% (n=110) provided interval IUD insertion only; 29% (n=51) provided both interval and postpartum IUD insertion; and less than 10% (n=15) provided postpartum IUD insertion only.

Figure 23. Provision of IUD insertion by health service providers who were involved in providing FP services, by whether they have formal training in IUD insertion and removal, APMARGIN 2024



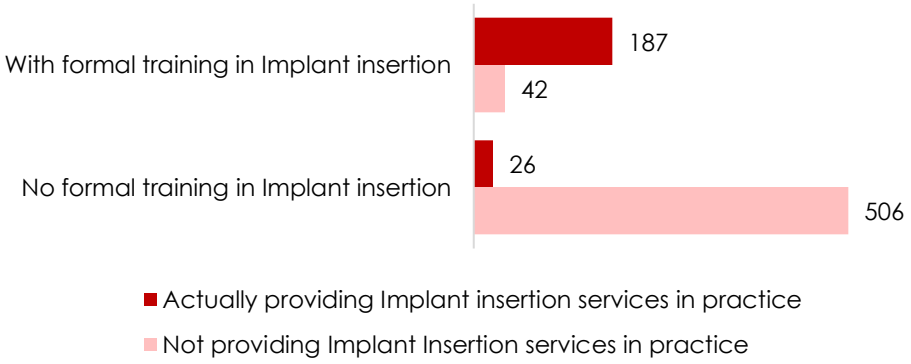
Actual provision of IUD removal. Of the 272 health service providers who were involved in providing FP services and with formal training in IUD insertion and removal, 65% (n=178) were actually providing IUD removal in practice while 35% (n=94) were not providing said service in practice (Figure 24).

Figure 24. Provision of IUD removal services by health service providers who were involved in providing FP services, by whether they have formal training in IUD insertion and removal, APMARGIN 2024



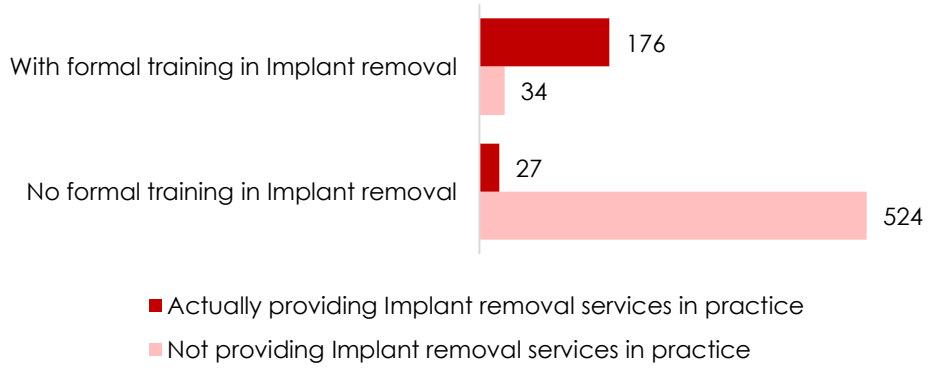
Actual provision of contraceptive Implant insertion. About 82% of the 229 health service providers who were involved in providing FP services and with formal training in contraceptive Implant insertion (n=187) were actually providing contraceptive Implant insertion services in practice while 18% (n=42) were not providing this service (Figure 25).

Figure 25. Provision of contraceptive Implant insertion by health service providers who were involved in providing FP services, by whether they have formal training in contraceptive Implant insertion, APMARGIN 2024



Actual provision of contraceptive Implant removal. As for contraceptive Implant removal, of the 210 health service providers who were involved in providing FP services and with formal training in contraceptive Implant removal 84% (n=176) were actually providing contraceptive Implant removal services in practice and 16% (n=34) were not providing contraceptive Implant removal services in practice (Figure 26).

Figure 26. Provision of contraceptive Implant removal by health service providers who were involved in providing FP services, by whether they have formal training in contraceptive Implant removal, APMARGIN 2024



Clients provided with FP services

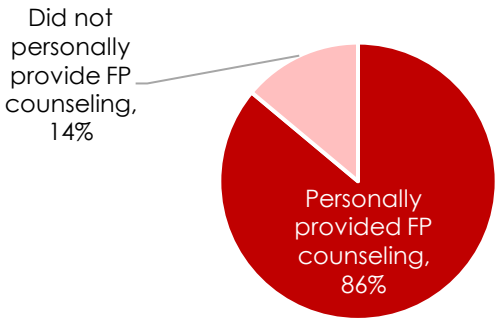
In the TNA, health service providers were asked about the number of clients whom they personally provided with FP counseling, postpartum IUD insertion, interval IUD insertion, IUD removal, Implant insertion and Implant removal. In the succeeding discussion, this information was compared with formal training in IUD/Implant insertion and removal.

FP counseling. Of the health service providers who were involved in providing FP services, 86% (655 of 761) personally provided FP counseling while 14% (106 of 761) did not personally provide FP counseling (Figure 27).

Of the 106 who did not personally provide FP counseling:

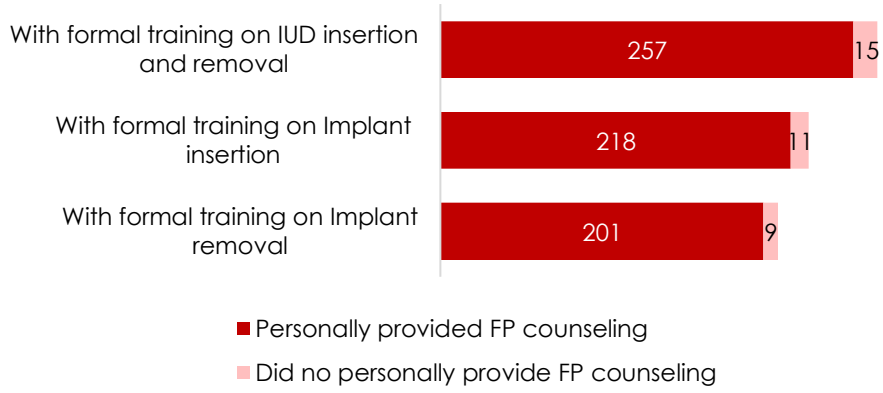
- 14% (n=15) had formal training in IUD insertion and removal while 86% (n=91) had no formal training in IUD insertion and removal; and
- 10% (n=11) had formal training in Implant insertion while 90% (n=95) had no formal training in Implant insertion.

Figure 27. Proportion of health service providers who were involved in providing FP services and who personally provided FP counseling, APMARGIN 2024



Of the 272 health service providers who had formal training In IUD insertion and removal, 96% (n=257) personally provided FP counseling. As for the 229 health service providers who had formal training in contraceptive Implant insertion, 95% (n=218) personally provided FP counseling. Of the 210 health service providers who had formal training in contraceptive Implant removal, 94% (n=201) personally provided FP counseling (Figure 28).

Figure 28. Health service providers who had formal training in LARC, who were involved in providing FP services and who personally provided FP counseling, APMARGIN 2024



Health service providers were also asked of the number of clients they personally provided with FP counseling during the past month. Table 7 shows the average, minimum and maximum number of clients whom they personally provided with FP counseling. Of the 761 health service providers providing FP services, 86% (n=655) provided FP counseling to an average of 20 clients in the past month. Those with formal training in IUD insertion and removal personally provided FP counseling to an average of 20 clients; those with formal training on contraceptive Implant insertion personally provided FP

counseling to an average of 24 clients; and those with formal training on contraceptive Implant removal personally provided FP counseling to an average of 23 clients. The number of clients served by these health service providers ranged from one (1) to 49 clients.

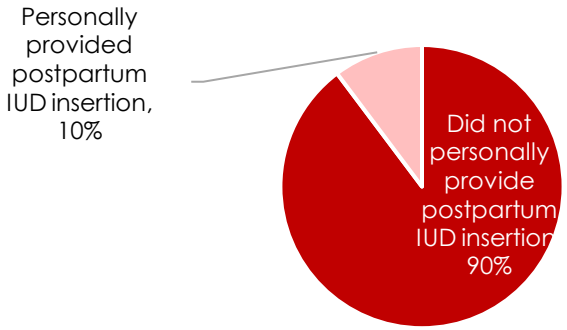
Table 7. Average, minimum and maximum number of clients provided with FP counseling by health service providers providing FP services, APMARGIN 2024

Involvement in FP service provision and training in IUD and contraceptive Implant insertion and removal	Clients provided with FP counseling		
	Mean	Min-Max	N
Involved in FP services (Total)	20	1 to 49	655
With formal training on IUD insertion and removal	22	1 to 49	257
With formal training on contraceptive Implant insertion	24	2 to 49	218
With formal training on contraceptive Implant removal	23	2 to 49	201

Postpartum IUD insertion. Of the health service providers who were involved in providing FP services, 10% (78 of 761) personally provided postpartum IUD insertion while 90% (683 of 761) did not personally provide postpartum IUD insertion (Figure 29).

Of the 78 who personally provided post-partum IUD insertion, 71% (n=55) had formal training in IUD insertion and removal; and 29% (n=23) had no formal training in IUD insertion and removal.

Figure 29. Proportion of health service providers who were involved in providing FP services and who personally provided post-partum IUD insertion, APMARGIN 2024



On average, six (6) clients were personally provided with postpartum IUD insertion by 78 health service providers who were involved in providing FP services and personally provided postpartum IUD insertion in the past month. The clients ranged from one (1) to 35 (Table 8).

Those with formal training in IUD insertion and removal had an average of six (6) clients in the past month which ranged from one (1) to 35 while those with no formal training in IUD insertion and removal had an average of seven (7) clients in the past month ranging from one (1) to 30 clients.

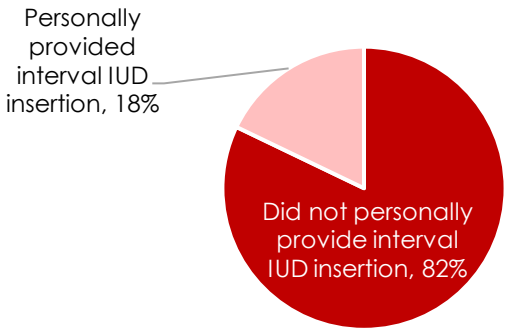
Table 8. Average, minimum and maximum number of clients provided with postpartum IUD insertion by health service providers providing FP services, APMARGIN 2024

	Mean	Min-Max	N
Involved in providing FP services and who personally provided postpartum IUD insertion	6	1 to 35	78
No formal training in IUD insertion and removal	7	1 to 30	23
With formal training in IUD insertion and removal	6	1 to 35	55

Interval IUD insertion. Of the health service providers who were involved in providing FP services, 18% (136 of 761) personally provided interval IUD insertion services while 82% (625 of 761) did not personally provide interval IUD insertion services (Figure 30).

Of the 136 who personally provided interval IUD insertion 82% (n=112) had formal training in IUD insertion and removal; and 18% (n=24) had no formal training in IUD insertion and removal.

Figure 30. Proportion of health service providers who were involved in providing FP services and who personally provided interval IUD insertion, APMARGIN 2024



On average, six (6) clients in the past month were personally provided with interval IUD insertion by 136 health service providers who were involved in providing FP services and personally provided interval IUD insertion (Table 9). The clients ranged from one (1) to 49.

Those with formal training in IUD insertion and removal had an average of six (6) clients in the past month which ranged from one (1) to 49 while those with no formal training in IUD insertion and removal had an average of five (5) clients in the past month ranging from one (1) to 30 clients.

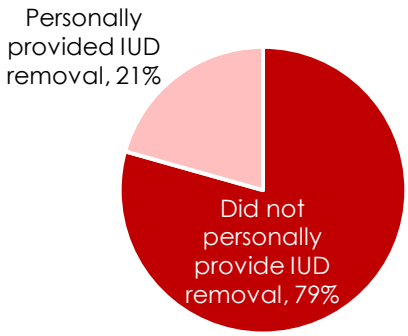
Table 9. Average, minimum and maximum number of clients provided with interval IUD insertion by health service providers providing FP services, APMARGIN 2024

	Mean	Min-Max	N
Involved in providing FP services and who personally provided interval IUD insertion	6	1 to 49	136
No formal training in IUD insertion and removal	5	1 to 30	24
With formal training in IUD insertion and removal	6	1 to 49	112

IUD removal. Of the health service providers who were involved in providing FP services, 21% (157 of 761) personally provided IUD removal services while 79% (604 of 761) did not personally provide IUD removal services (Figure 31).

Of the 157 who personally provided interval IUD insertion 85% (n=134) had formal training in IUD insertion and removal; and 15% (n=23) had no formal training in IUD insertion and removal.

Figure 31. Proportion of health service providers who were involved in providing FP services and who personally provided IUD removal service, APMARGIN 2024



On average, five (5) clients in the past month were personally provided with IUD removal services by 157 health service providers who were involved in providing FP services and personally provided IUD removal services (Table 10). The clients ranged from one (1) to 45.

The 134 health service providers with formal training in IUD insertion and removal had an average of five (5) clients in the past month which ranged from one (1) to 45 clients while the 23 health service providers with no formal training in IUD insertion and removal had an average of six (6) clients in the past month ranging from one (1) to 30 clients.

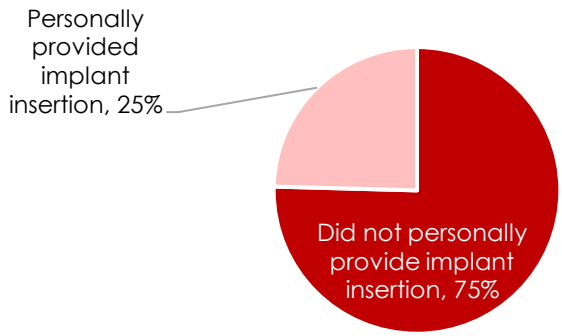
Table 10. Average, minimum and maximum number of clients provided with IUD removal services by health service providers providing FP services, APMARGIN 2024

	Mean	Min-Max	N
Involved in providing FP services and who personally provided IUD removal	5	1 to 45	157
No formal training in IUD insertion and removal	6	1 to 30	23
With formal training in IUD insertion and removal	5	1 to 45	134

Contraceptive Implant insertion. Of the health service providers who were involved in providing FP services, 25% (187 of 761) personally provided contraceptive Implant insertion services while 75% (574 of 761) did not personally provide contraceptive Implant insertion services (Figure 32).

Of the 187 who personally provided Implant insertion 84% (n=157) had formal training in Implant insertion; and 16% (n=30) had no formal training in Implant insertion.

Figure 32. Proportion of health service providers who were involved in providing FP services and who personally provided contraceptive Implant insertion service, APMARGIN 2024



On average, 12 clients in the past month were personally provided with contraceptive Implant insertion services by 187 health service providers who were involved in providing FP services and personally provided contraceptive Implant insertion (Table 11). The clients ranged from one (1) to 49.

The 157 health service providers with formal training in Implant insertion had an average of 14 clients in the past month which ranged from one (1) to 49 clients while the 30 health

service providers with no formal training in Implant insertion had an average of seven (7) clients in the past month ranging from one (1) to 30 clients.

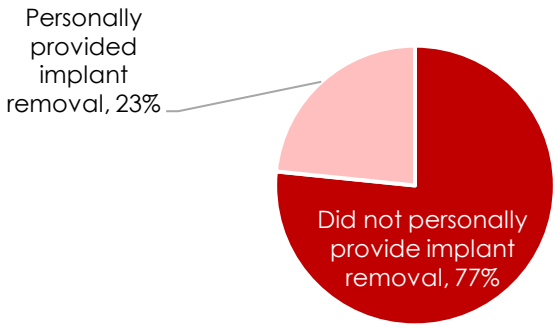
Table 11. Average, minimum and maximum number of clients provided with contraceptive Implant insertion by health service providers providing FP services, APMARGIN 2024

	Mean	Min-Max	N
Involved in providing FP services and who personally provided contraceptive Implant insertion	12	1 to 49	187
No formal training in contraceptive Implant insertion	7	1 to 30	30
With formal training in contraceptive Implant insertion	14	1 to 49	157

Contraceptive Implant removal. Of the health service providers who were involved in providing FP services, 23% (178 of 761) personally provided contraceptive Implant removal services while 77% (583 of 761) did not personally provide contraceptive Implant removal services (Figure 33).

Of the 178 health service providers who personally provided Implant removal, 83% (n=147) had formal training in Implant removal; and 17% (n=31) had no formal training in Implant removal.

Figure 33. Proportion of health service providers who were involved in providing FP services and who personally provided contraceptive Implant removal service, APMARGIN 2024



On average, seven (7) clients in the past month were personally provided with contraceptive Implant removal services by 178 health service providers who were involved in providing FP services and personally provided contraceptive Implant removal (Table 12). The clients ranged from one (1) to 49.

The 147 health service providers with formal training in Implant removal had an average of eight (8) clients in the past month which ranged from one (1) to 49 clients while the 31 health service providers with no formal training in Implant removal had an average of six (6) clients in the past month ranging from one (1) to 38 clients.

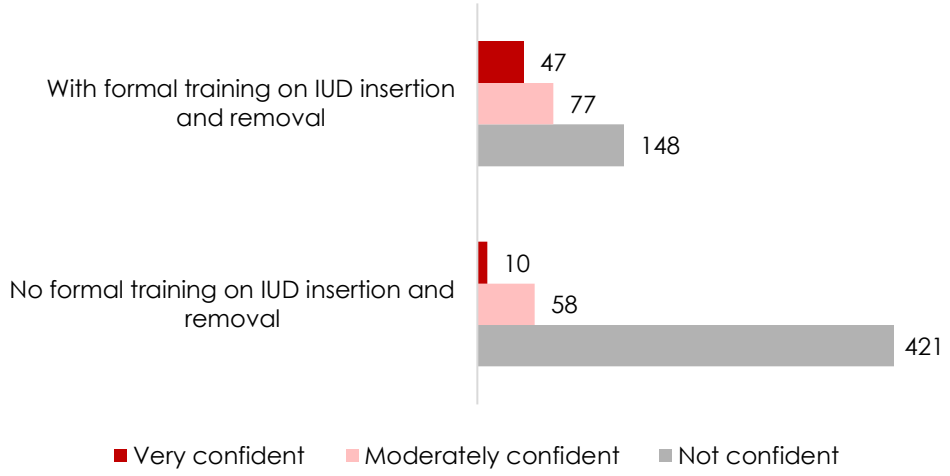
Table 12. Average, minimum and maximum number of clients provided contraceptive Implant removal by health service providers providing FP services, APMARGIN 2024

	Mean	Min-Max	N
Involved in providing FP services and who personally provided contraceptive Implant removal	7	1 to 49	178
No formal training in contraceptive Implant removal	6	1 to 38	31
With formal training in contraceptive Implant removal	8	1 to 49	147

Level of confidence in current level of skills for providing contraceptive Implant and IUD services

Level of confidence in current level of skills towards provision of postpartum IUD insertion services. Less than half of the health service providers with formal training in IUD had some level of confidence in providing PP IUD insertion services (124 of 272) (Figure 34).

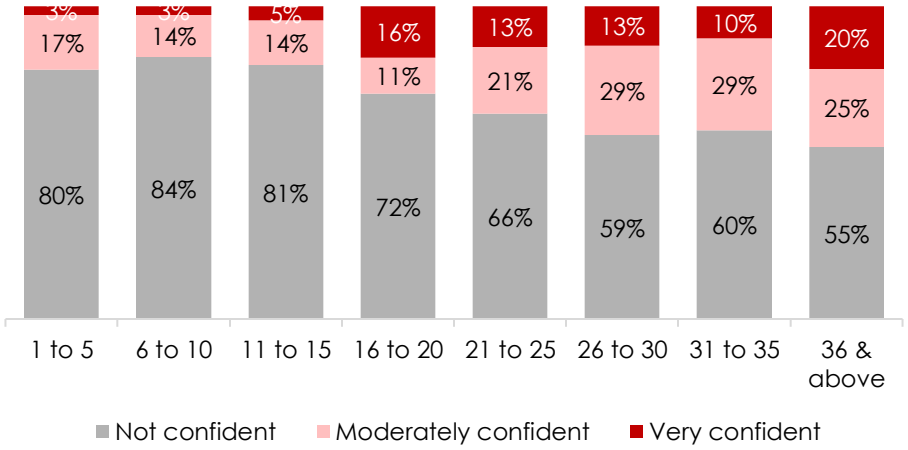
Figure 34. Level of confidence in current level of skills towards providing postpartum IUD insertion, by whether with or without formal training on IUD insertion and removal, APMARGIN 2024



Of the 272 health service providers with formal training in IUD insertion and removal, 238% (n=77) were moderately confident in providing PP IUD insertion; and 17% (n=47) were very confident in providing PP IUD insertion.

As shown in Figure 35, the percentage of those who felt moderately confident and those who felt very confident increases with the number of years in profession.

Figure 35. Level of confidence in current level of skills towards providing postpartum IUD insertion, by number of years in profession (5-year grouping), APMARGIN 2024



Level of confidence in current level of skills towards provision of interval IUD insertion services. About 70% of the health service providers with formal training in IUD have some level of confidence in providing interval IUD insertion services (190 of 272) (Figure 36).

Of the 272 health service providers with formal training in IUD insertion and removal, 33% (n=90) were moderately confident in providing IUD interval insertion; and 37% (n=100) were very confident in providing interval IUD insertion.

Figure 36. Level of confidence in current level of skills towards providing interval IUD insertion, by whether with or without formal training on IUD insertion and removal, APMARGIN 2024

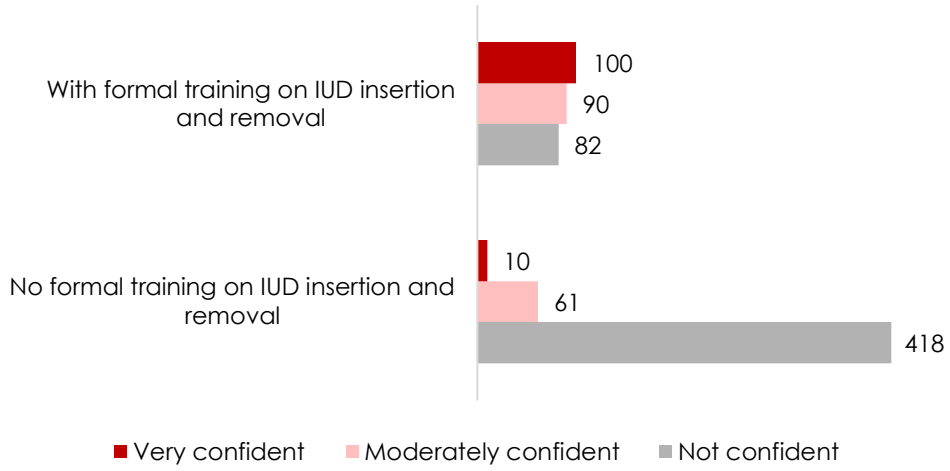
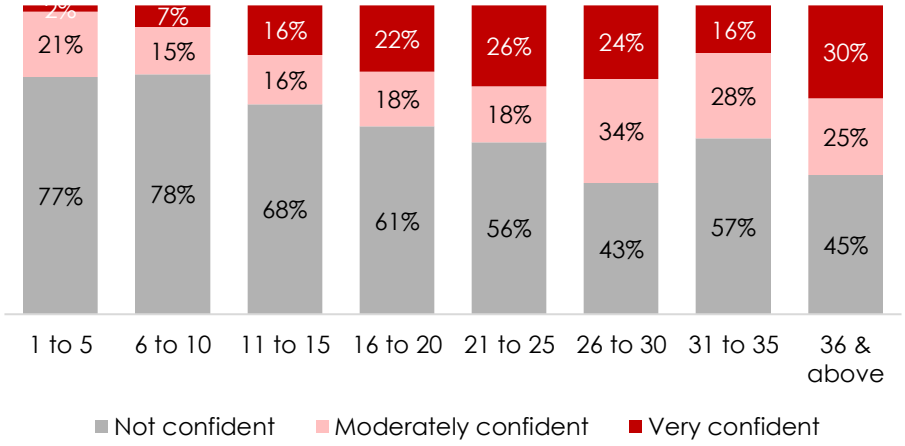


Figure 37 shows that the percentage of those who felt moderately confident and very confident towards provision of interval IUD insertion increases with the number of years in profession.

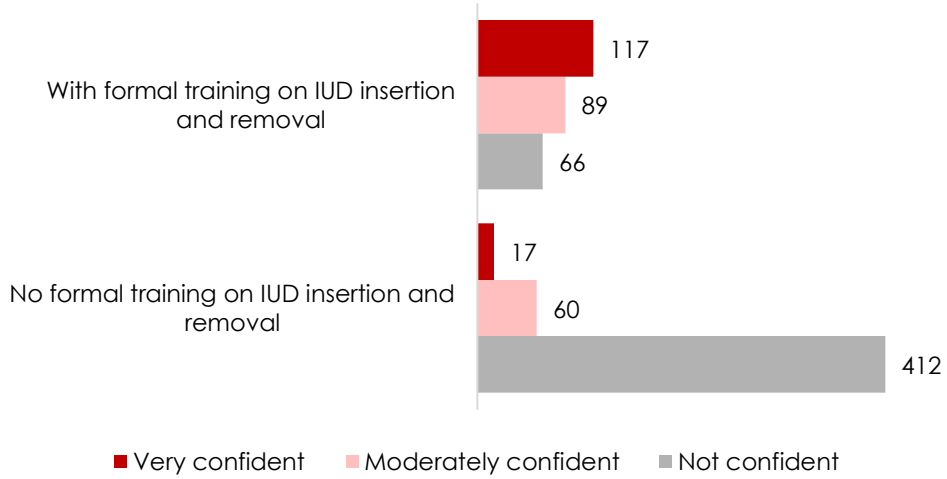
Figure 37. Level of confidence in current level of skills towards providing interval IUD insertion, by number of years in profession (5-year grouping), APMARGIN 2024



Level of confidence in current level of skills towards provision of IUD removal services. Of the health service providers with formal training in IUD, 76% have some level of confidence in providing IUD removal services (206 of 272) (Figure 38).

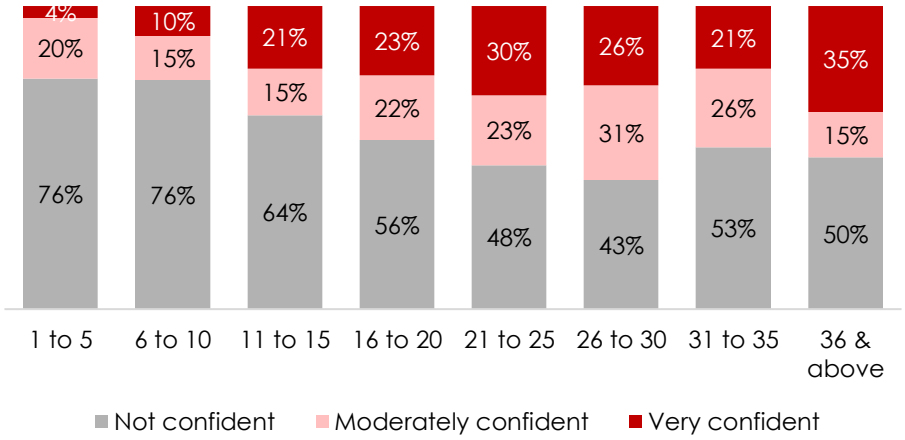
Of the 272 health service providers with formal training in IUD insertion and removal, 33% (n=89) were moderately confident in providing IUD removal services; and 43% (n=117) were very confident in providing IUD removal services. Of those with no formal training on IUD insertion and removal, about 16% have some level of confidence in providing IUD removal services indicative of health service providers performing said services even without formal training.

Figure 38. Level of confidence in current level of skills for providing IUD removal, by whether with or without formal training on IUD insertion and removal, APMARGIN 2024



As shown in Figure 39, the percentage of those who felt moderately confident and very confident towards provision of interval IUD insertion increases with the number of years in profession.

Figure 39. Level of confidence in current level of skills towards providing interval IUD insertion, by number of years in profession (5-year grouping), APMARGIN 2024

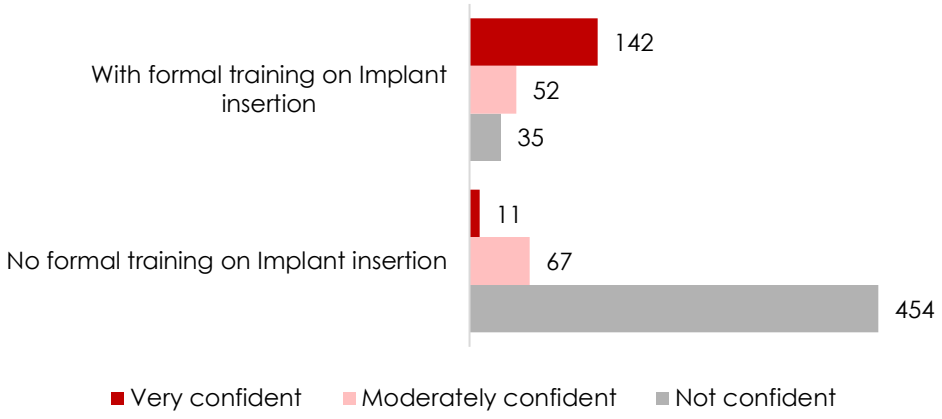


Level of confidence in current level of skills for providing contraceptive Implant insertion.

About 85% of the health service providers with formal training in contraceptive Implant insertion have some level of confidence in providing contraceptive Implant insertion services (194 of 229) (Figure 40).

Of the 229 health service providers with formal training in contraceptive Implant insertion, 23% (n=52) were moderately confident in providing contraceptive Implant insertion services; and 62% (n=142) were very confident in providing contraceptive Implant insertion services.

Figure 40. Level of confidence in current level of skills for providing contraceptive Implant insertion, by whether with or without formal training in contraceptive Implant insertion, APMARGIN 2024

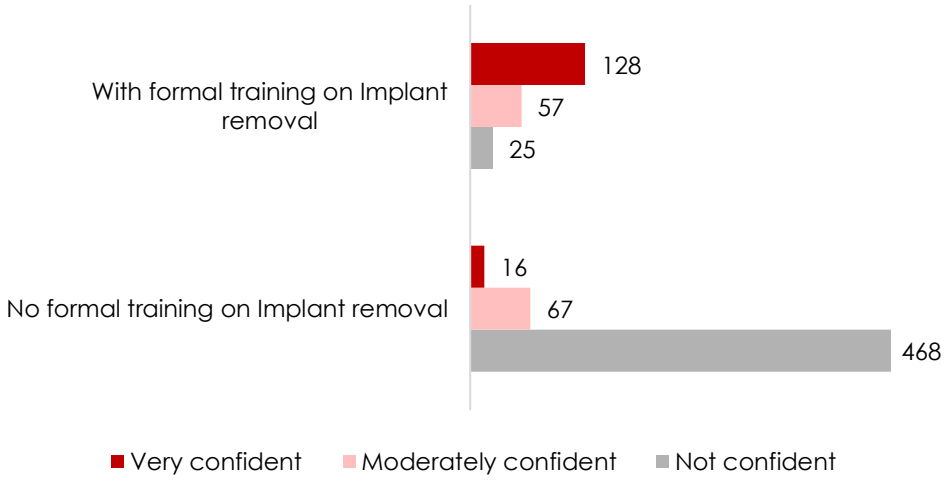


Level of confidence in current level of skills for providing contraceptive Implant removal.

About 88% of the health service providers with formal training in contraceptive Implant removal have some level of confidence in providing contraceptive Implant removal services (185 of 210) (Figure 41).

Of the 210 health service providers with formal training in contraceptive Implant removal: 27 (n=57) were moderately confident in providing contraceptive Implant removal services; and 61% (n=128) were very confident in providing contraceptive Implant removal services.

Figure 41. Level of confidence in current level of skills for providing contraceptive Implant removal, by whether with or without formal training on contraceptive Implant removal, APMARGIN 2024



Knowledge on IUD and contraceptive Implant

Knowledge on IUD. The average standard score on knowledge on IUD among 761 health service providers providing FP services is 36% ranging from 4% to 75%.

The average score on knowledge on IUD of health service providers with formal training in IUD insertion and removal is 36% ranging from 8% to 71% (Table 13). About 84% of the health service providers with formal training in IUD scored less than 50% (228 of 272). If the passing score is set at 80%, none of the health service providers passed the knowledge on IUD part of the TNA.

Table 13. Number and proportion of health service providers who were providing FP services by range of score on knowledge on IUD and selected descriptive (mean, min, max), and by whether with or without formal training in IUD insertion and removal, APMARGIN 2024

Score	No formal training in IUD insertion and removal		With formal training in IUD insertion and removal	
	No.	%	No.	%
<50%	421	86%	228	84%
51% to 59%	60	12%	37	14%
60% to 69%	4	1%	6	2%
70% to 79%	4	1%	1	0%
N	489		272	
Mean	35%		36%	
Min-max	4% to 75%		8% to 71%	

Knowledge on contraceptive Implant. The average standard score on knowledge on contraceptive Implant among 761 health service providers providing FP services is 49% ranging from 0% to 87%.

The average score on knowledge on contraceptive Implant of those with formal training in contraceptive Implant insertion is 51% ranging from 13% to 87% (Table 14). Less than

half (48%) of the health service providers with formal training in contraceptive Implant insertion scored less than 50% (111 of 229). If the passing score is set at 80%, only 5% of the health service providers passed the knowledge on contraceptive Implant part of the TNA.

Table 14. Number and proportion of health service providers who were providing FP services by range of score on knowledge on contraceptive Implant and selected descriptive (mean, min, max), and by whether with or without formal training in contraceptive Implant insertion, APMARGIN 2024

Score	No formal training in contraceptive Implant insertion		With formal training in contraceptive Implant insertion	
	No.	%	No.	%
<50%	290	55%	111	48%
50% to 59%	82	15%	35	15%
60% to 69%	113	21%	51	22%
70% to 79%	34	6%	24	10%
80% to 89%	13	2%	8	3%
N	532		229	
Mean	48%		51%	
Min-max	0% to 87%		13% to 87%	

The average score in knowledge on contraceptive Implant of those with formal training in contraceptive Implant removal is 50% ranging from 13% to 87 (Table 15). About 49% of the health service providers with formal training in contraceptive Implant removal scored less than 50% (102 of 210).

Table 15. Number and proportion of health service providers who were providing FP services by range of score on knowledge on contraceptive Implant, selected descriptive (mean, min, max), and by whether with or without formal training in contraceptive Implant removal, APMARGIN 2024

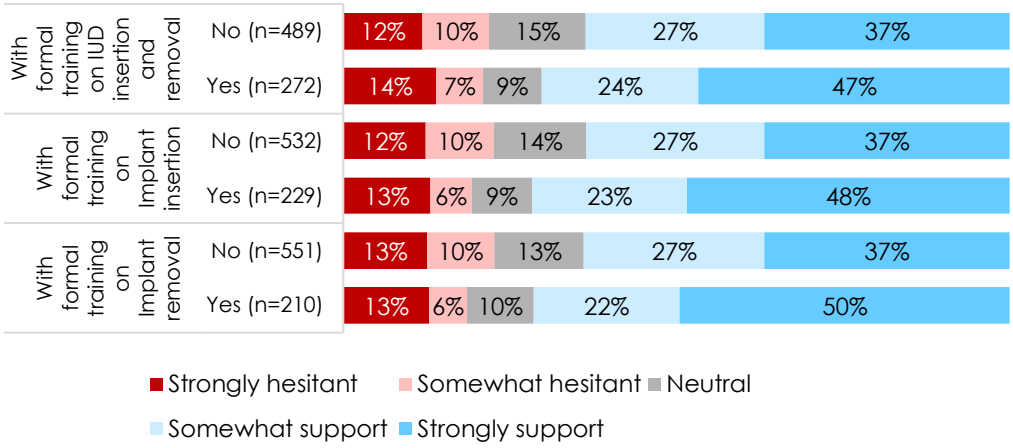
Score	No formal training in contraceptive Implant removal		With formal training in contraceptive Implant removal	
	No.	%	No.	%
<50%	299	54%	102	49%
50% to 59%	84	15%	33	16%
60% to 69%	118	21%	46	22%
70% to 79%	36	7%	22	10%
80% to 89%	14	3%	7	3%
N	551		210	
Mean	48%		50%	
Min-max	0% to 87%		13% to 87%	

Attitude on prescribing IUD or contraceptive Implants to nulliparous adolescents

Support to prescribing IUD/contraceptive Implant to nulliparous adolescents

More than 45% of those who had formal training in IUD/contraceptive Implant strongly supported prescribing IUDs or contraceptive Implants to nulliparous adolescents; 47% among those with formal training on IUD insertion and removal; 48% among those with formal training in contraceptive Implant insertion; and 50% among those with formal training in contraceptive Implant removal (Figure 42).

Figure 42. Attitude of health service providers on prescribing IUD or contraceptive Implants to nulliparous adolescents, by whether with or without formal training in IUD/contraceptive Implant insertion and removal, APMARGIN 2024

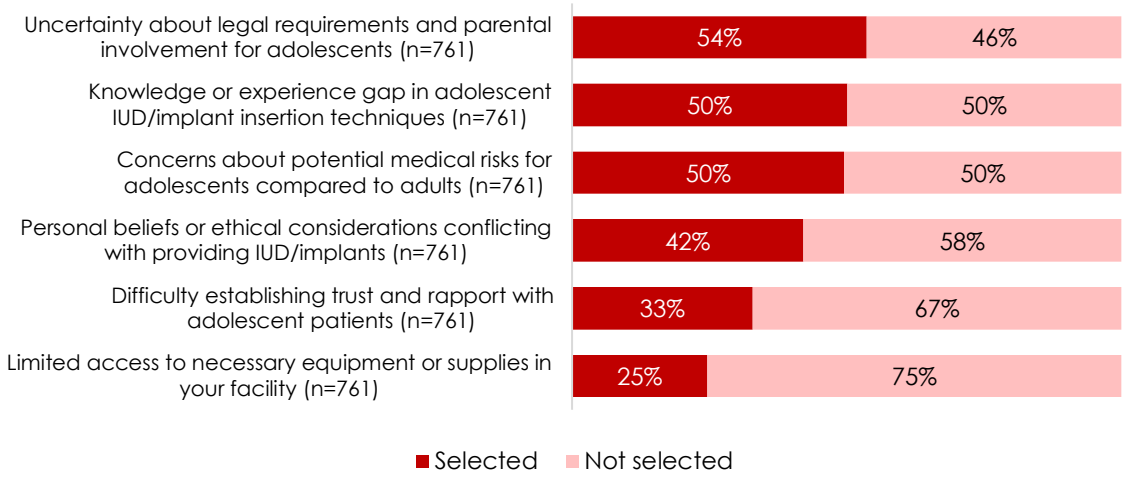


Biggest obstacle when managing requests from nulliparous adolescents for IUD or contraceptive Implant insertion

According to the health service providers, the biggest obstacles they faced when managing requests from nulliparous adolescents for IUD or contraceptive Implant insertion were: uncertainty about legal requirements and parental involvement for adolescents (54%); knowledge or experience gap in adolescent IUD/contraceptive Implant insertion techniques (50%); and concerns about potential medical risks for adolescents compared to adults (50%) (Figure 43).

Other obstacles include: personal beliefs or ethical considerations conflicting with providing IUD/contraceptive Implants (42%); difficulty establishing trust and rapport with adolescent patients (33%); and limited access to necessary equipment or supplies in the facility (25%).

Figure 43. Biggest obstacles health service providers providing FP service faced when managing request from nulliparous adolescents for IUD or contraceptive Implant insertion, APMARGIN 2024



The results show that although many providers support the use of IUD and Implant among adolescents, barriers such as: lack of awareness of the law as regards parental consent; inadequate knowledge and skills in the provision of the said methods; and conservative norms and belief may be indicative of poor uptake of LARC among adolescents. The information also suggests bias against provision of LARCs to nulliparous adolescent among those who were trained in LARCs. This reflects the prevailing conservative attitude in the community and ineffective or absence of behavioral change initiatives directed towards providers to influence their attitude and biases.

Table 16 reveals that at least 58% of the health service providers who identified the obstacles belonged to the 25 to 44 age groups.

Table 16. Biggest obstacles health service providers providing FP service faced when managing request from nulliparous adolescents for IUD or contraceptive Implant insertion by number of years involved in providing FP services, APMARGIN 2024, APMARGIN 2024

Obstacles	Age					Total
	18-24	25-34	35-44	45-54	55+	
Uncertainty about legal requirements and parental involvement for adolescents	1 *0%*	111 *27%*	120 *29%*	122 *30%*	54 *13%*	408 *100%*
Knowledge or experience gap in adolescent IUD/implant insertion techniques	2 *1%*	105 *28%*	117 *31%*	108 *28%*	49 *13%*	381 *100%*
Concerns about potential medical risks for adolescents compared to adults	0	101 *27%*	98 *26%*	121 *32%*	57 *15%*	377 *100%*
Personal beliefs or ethical considerations conflicting with providing IUD/implants.	1 *0%*	97 *30%*	99 *31%*	89 *28%*	34 *11%*	320 *100%*
	1	68	71	74	36	250

Obstacles	Age					Total
	18-24	25-34	35-44	45-54	55+	
Difficulty establishing trust and rapport with adolescent patients.	*0%*	*27%*	*28%*	*30%*	*14%*	*100%*
Limited access to necessary equipment or supplies in your facility.		53 28%	55 29%	56 30%	23 12%	187 100%

Table 17 presents the obstacles by the length of years the health service provider is involved in providing FP services. At least 53% of the health service providers who identified the obstacles have been providing FP services for less than 10 years.

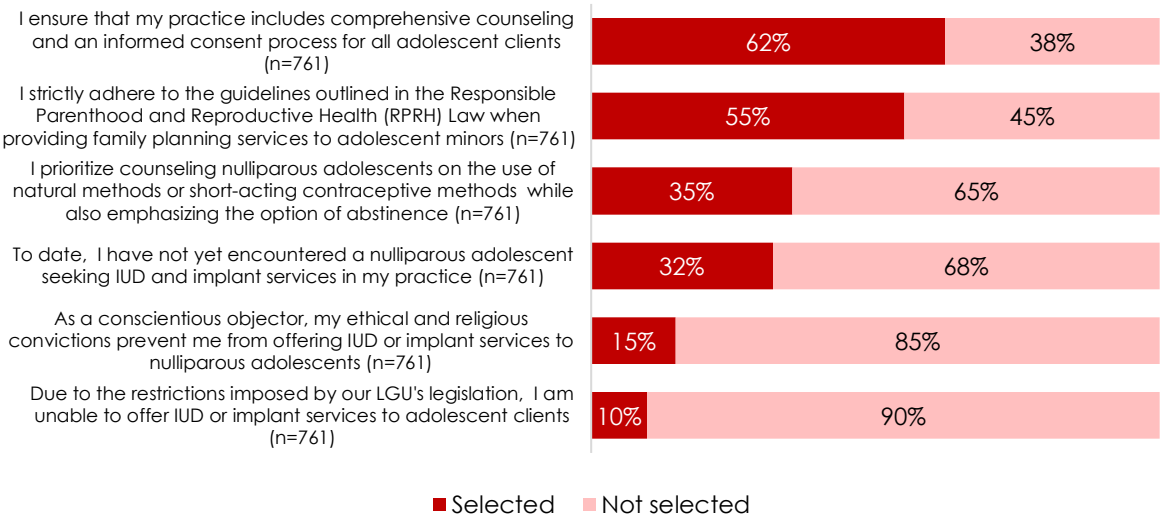
Table 17. Biggest obstacles health service providers providing FP service faced when managing request from nulliparous adolescents for IUD or contraceptive Implant insertion by number of years involved in providing FP services, APMARGIN 2024, APMARGIN 2024

Obstacles	Number of years involved in providing FP services									Total
	Less than 5	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 & up	
Uncertainty about legal requirements and parental involvement for adolescents	85 *21%*	131 *32%*	84 *21%*	37 *9%*	27 *7%*	15 *4%*	22 *5%*	5 *1%*	2 *0%*	408 *100%*
Knowledge or experience gap in adolescent IUD/implant insertion techniques	104 *27%*	124 *33%*	66 *17%*	30 *8%*	21 *6%*	15 *4%*	14 *4%*	3 *1%*	4 *1%*	381 *100%*
Concerns about potential medical risks for adolescents compared to adults	93 *25%*	117 *31%*	68 *18%*	22 *6%*	31 *8%*	12 *3%*	26 *7%*	5 *1%*	3 *1%*	377 *100%*
Personal beliefs or ethical considerations conflicting with providing IUD/implants.	86 *27%*	97 *30%*	64 *20%*	24 *8%*	14 *4%*	13 *4%*	18 *6%*	3 *1%*	1 *0%*	320 *100%*
Difficulty establishing trust and rapport with adolescent patients.	60 *24%*	88 *35%*	44 *18%*	16 *6%*	15 *6%*	9 *4%*	14 *6%*	2 *1%*	2 *1%*	250 *100%*
Limited access to necessary equipment or supplies in your facility.	52 *28%*	62 *33%*	28 *15%*	13 *7%*	8 *4%*	12 *6%*	9 *5%*	2 *1%*	1 *1%*	187 *100%*

Typical management of nulliparous adolescents who request an IUD or contraceptive Implant insertion

When asked how they typically managed nulliparous adolescents who requested an IUD or contraceptive Implant insertion: 62% said that they ensured that their practice included comprehensive counseling and an informed consent process for all adolescent clients; and 55% said that they strictly adhered to the guidelines outlined in the RPRH law when providing FP services to adolescent minors (Figure 44).

Figure 44. Typical management of nulliparous adolescents who request an IUD or contraceptive Implant insertion by health service providers providing FP services, APMARGIN 2024



About 35% typically managed nulliparous adolescents who requested an IUD or contraceptive Implant insertion by prioritizing counseling of nulliparous adolescents on the use of natural methods or short-acting contraceptive methods while also emphasizing the option of abstinence. This finding may suggest low respect for the right of choice of adolescents especially when health service providers focused on natural family planning and abstinence during counseling of adolescents on FP or when adolescents inquire about LARCs.

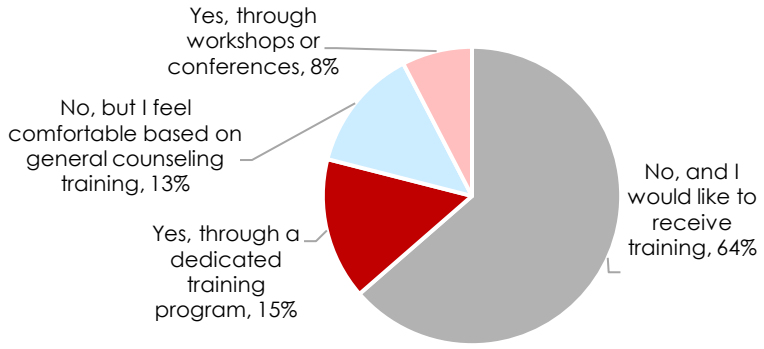
For other health service providers, as a conscientious objector, ethical and religious convictions prevent them from offering IUD or contraceptive Implant services to nulliparous adolescent (15%); while some were unable to offer IUD or contraceptive Implant services to adolescent clients due to the restrictions imposed by their LGU's legislation (10%). About 32% of health service providers have not yet encountered a nulliparous adolescent seeking IUD and contraceptive Implant services in practice.

Formal training on counseling adolescents about IUDs and contraceptive Implant (parous and nulliparous adolescents)

About 15% of those involved in providing FP services received formal training in counseling adolescents through a dedicated training program (117 of 761) (Figure 45). This finding suggests the urgent need to provide training to health service providers to mitigate the increasing teen pregnancy and encourage teens to access services from the health facilities.

Other trainings received were through workshops or conferences among 8% of health service providers (58 of 761). About 13% had no training but felt comfortable based on general counseling training (102 of 761) and 64% had no training and are willing to be trained (484 of 761).

Figure 45. Formal training in counseling adolescents, about IUDs and contraceptive Implant, APMARGIN 2024

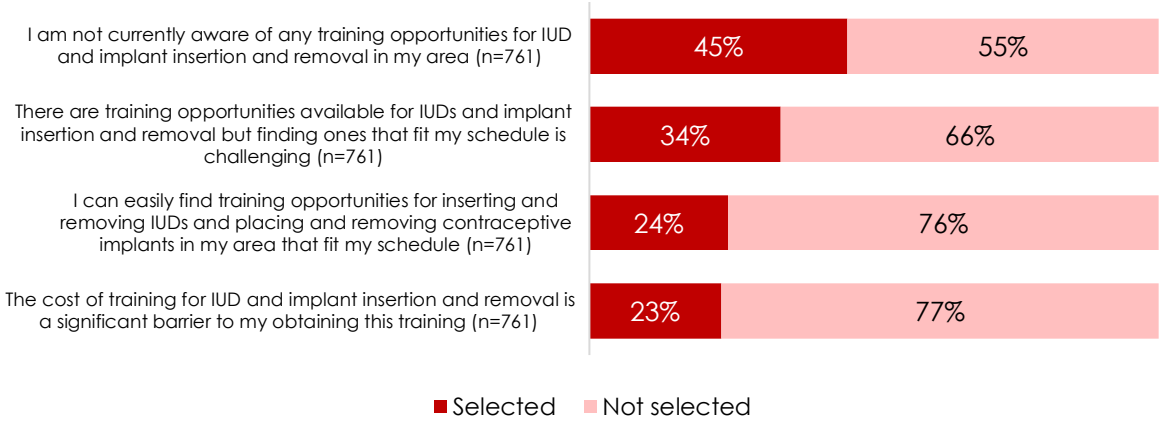


Current access to training on IUD or contraceptive Implant

Rating of current access to training opportunities for inserting and removing IUD and contraceptive Implant

Health service providers were asked to rate their current access to training opportunities for inserting and removing IUD and contraceptive Implants. Figure 46 shows that about 24% of those providing FP services can easily find in their area training opportunities for inserting and removing IUDs and placing and removing contraceptive Implants that could fit in their schedule (185 of 761); and 34% said that there are training opportunities available for IUDs and Implant insertion and removal but finding ones that fit their schedule is challenging (256 of 761). For the 23% (176 of 761), the cost of training for IUD and contraceptive Implant insertion and removal is a significant barrier to their obtaining the training. About 45% (345 of 761) were not currently aware of any training opportunities for IUD and contraceptive Implant insertion and removal in their area.

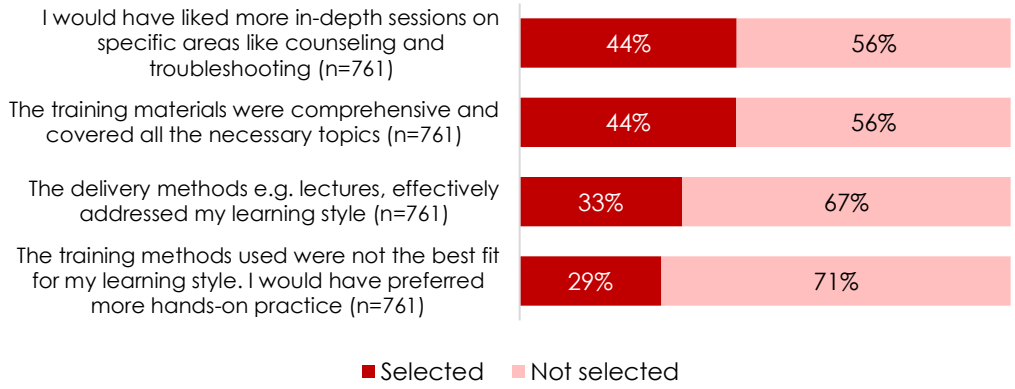
Figure 46. Rating of the current access to training opportunities for inserting and removing IUD and contraceptive Implant, APMARGIN 2024



Rating of IUD and contraceptive Implant insertion/removal training received

Of the 761 health service providers, 44% (n=336) would like more in-depth sessions on specific areas like counseling and troubleshooting; 44% (n=335) said that the training materials were comprehensive and covered all the necessary topics; 33% (n=251) said that the delivery methods such as lectures effectively addressed their learning style; and 29% (n=219) said that the training methods used were not the best fit for their learning style and that they would have preferred more hands-on practice (Figure 47). These responses seem to suggest for the need to look into the content and methodology of teaching.

Figure 47. Rating of the IUD and contraceptive Implant insertion/removal training received, APMARGIN 2024



Rating of hands-on training component of IUD and contraceptive Implant insertion/removal training

About 72% of health service providers providing FP services would have liked more opportunities to practice their skills in IUD/contraceptive Implant insertion and removal (548 of 761); 32% said that they have ample opportunities to practice IUD/contraceptive Implant insertion and removal skills (247 of 761); 21% said that the simulated scenarios used in the training felt realistic enough for them (158 of 761); and 11% said that the simulated scenarios used in the training did not feel realistic enough for them (84 of 761) (Figure 48).

Figure 48. Rating of the hands-on training component of IUD and contraceptive Implant insertion/removal training, APMARGIN 2024

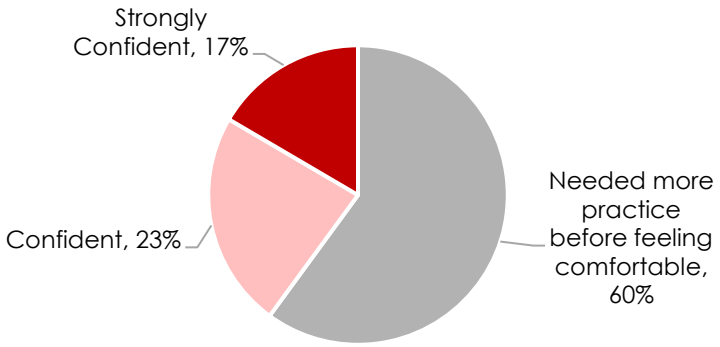
Based on these ratings on training received, health service providers have emphasized the importance of the practicum part of the training for them to achieve skills, knowledge and confidence. The skills learned from the training are further enhanced through the opportunities to practice provided in a face-to-face practicum and practice in their place of work. This will be facilitated by the presence of tools, logistics and commodities, as well as support such as mentoring. Likewise, the number of actual clients and, therefore, demand generation is an equally important strategy.

Level of confidence in their ability to perform IUD and contraceptive Implant insertion/removal procedures after the training

Of the 761 health service providers providing FP services, 40% (n=304) felt some level of confidence towards their ability to perform IUD and contraceptive Implant insertion/removal procedures after the training (Figure 49). This underscores the relationship between practice and the learner's confidence, i.e., the reality that confidence is not achieved right away. Practicing the skills learned is key to achieving confidence/competence. The health service providers who expressed their need to practice may require mentoring and supportive supervision to boost their confidence in performing such procedures.

About 17% were strongly confident (126 of 761) and 23% were confident (178 of 761) towards their ability to perform IUD and contraceptive Implant insertion/removal procedures after the training. Sixty percent needed more practice before feeling comfortable about performing IUD and contraceptive Implant insertion/removal procedures (457 of 761).

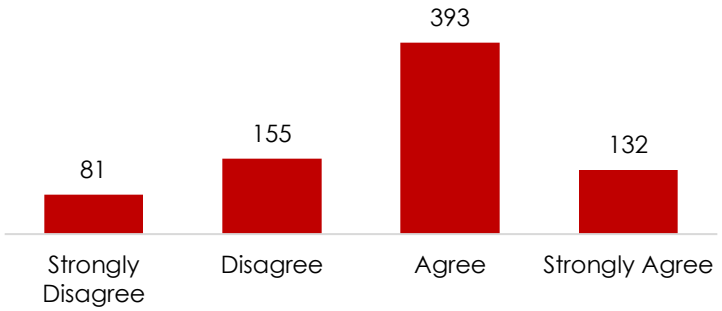
Figure 49. Confidence of health service providers in their ability to perform IUD and contraceptive Implant insertion/removal procedures after the training, APMARGIN 2024



Training adequately addressed common challenges and troubleshooting techniques for IUD and contraceptive Implant management

As shown in Figure 50, a little more than half (52%) of health service providers providing FP services agreed (393 of 761) and 7% strongly agreed (132 of 761) that their training adequately addressed common challenges and troubleshooting techniques for IUD and contraceptive Implant management.

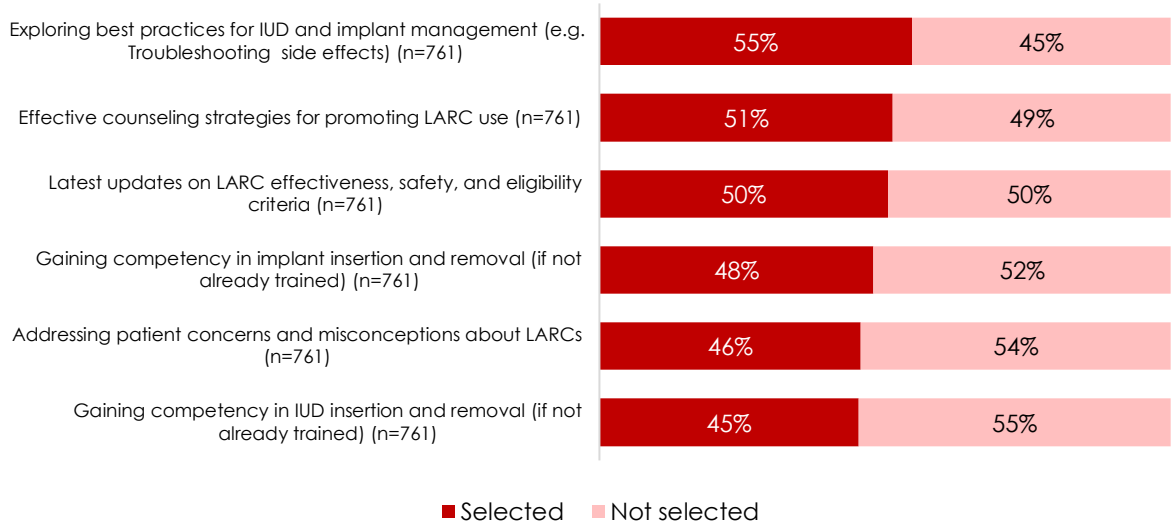
Figure 50. Level of agreement whether the training adequately addressed common challenges and troubleshooting techniques for IUD and contraceptive Implant management based on the health service providers' experience, APMARGIN 2024



Areas where health service providers would benefit from for their IUD and contraceptive Implant training

Of the 761 health service providers providing FP services, 55% (n=416) said that they would mostly benefit from contraceptive Implant management such as troubleshooting side effects; 51% (n=391) said that they would benefit from effective counseling strategies for promoting LARC; and 50% (n=348) said that they would mostly benefit from latest updates on LARC effectiveness, safety, and eligibility criteria (Figure 51). Less than 50% of the 761 health service providers would benefit from gaining competency in contraceptive Implant insertion and removal (n=365); 46% (n=348) from addressing patient concerns and misconceptions about LARCs; and 45% (n=345) from gaining competency in IUD insertion and removal.

Figure 51. Areas where health service providers providing FP services would benefit from for their IUD and contraceptive Implant Training, APMARGIN 2024

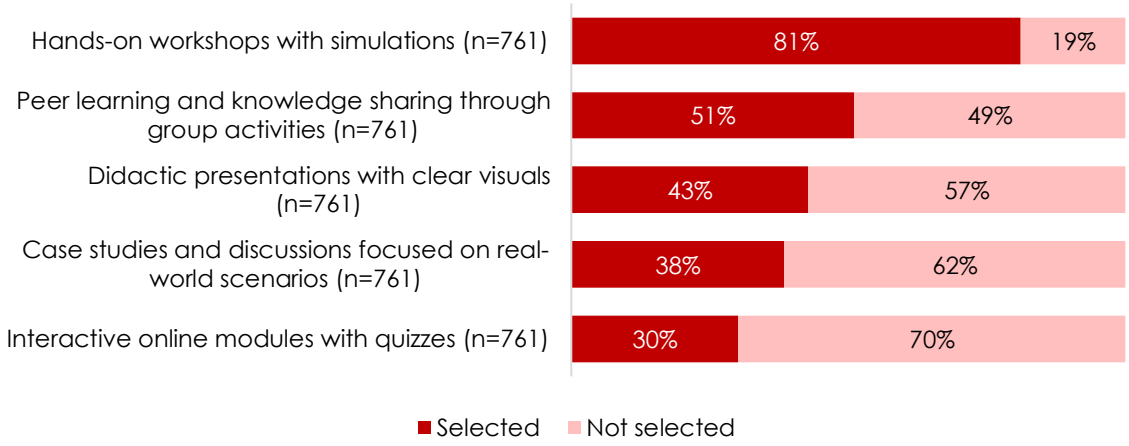


The results show that many of the participants were clear on what they can achieve with training, namely, best practices; management of adverse events; knowledge on contraceptive technology (IUD and Implant); counseling for FP; competency in insertion and removal; and dispelling myths and misconceptions.

Typical preferred learning experience

About 81% of health service providers providing FP services preferred hands-on workshops with simulation (617 of 761); 51% preferred peer learning and knowledge sharing through group activities (388 of 761); 43% favored didactic presentations with clear visuals (325 of 761); 38% chose case studies and discussions focused on real-world scenarios (292 of 761); and 30% preferred interactive online modules with quizzes (229 of 761) (Figure 52). The results show participants' preference to teaching methodologies that need manual skills i.e., hands-on practice, case-based simulations, peer interactions such as in group discussions which are teaching methodologies utilized in FPCBT 2. The findings also underscore the importance of interactive sessions in any learning format.

Figure 52. Typical preferred learning experience of health service providers providing FP services, APMARGIN 2024

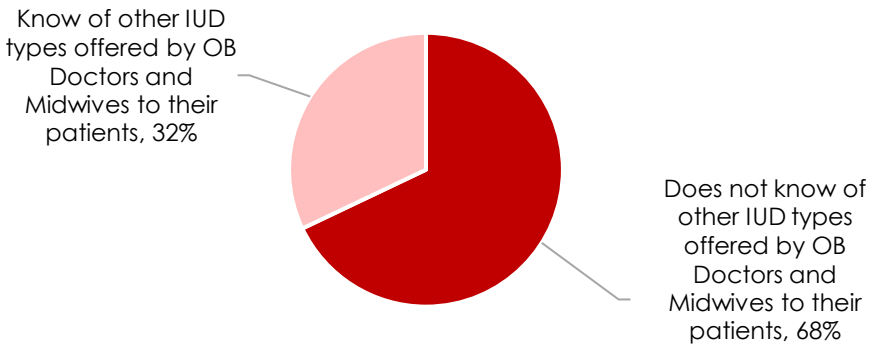


Other types of IUD offered

Knowledge of other types of IUD offered

About 32% knew of other IUD types offered by Obstetrics (OB) doctors and midwives to their patients (251 of 797) (Figure 53).

Figure 53. Knowledge of health service providers providing FP services about other types of IUD offered, APMARGIN 2024



Offering a new IUD variant designed for smaller uterus

As shown in Figure 54, almost half (49%) agreed that offering a new IUD variant designed for smaller uteruses would be beneficial in expanding IUD access for their patients (387 of 797).

Figure 54. Level of agreement of health service providers providing FP services on the statement that offering a new IUD variant designed for small uteruses would be beneficial in expanding IUD access for their patients, APMARGIN 2024

Among the 374 health service providers who agreed that offering a new IUD variant designed for smaller uteruses would be beneficial in expanding IUD access for the patient, 46% (n=171) said that they strongly supported prescribing IUD or Implants to nulliparous adolescents (Table 18). They believed that IUDs/Implants are a valuable option for adolescents and they are happy to provide them. A quarter (n=92) somewhat supported or recognized the benefits of IUDs/implants for adolescents but may have some concerns. About 11% (n=42) and 9% (n=34) are strongly hesitant and somewhat hesitant, respectively about prescribing IUD or Implant to nulliparous adolescents.

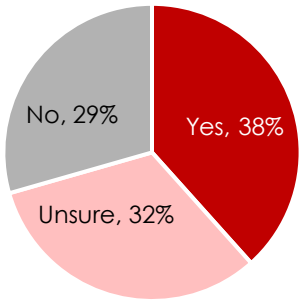
Table 18. Feelings about prescribing IUD or Implant to nulliparous adolescents and belief that offering a new IUD variant designed for smaller uteruses would be beneficial in expanding IUD access for patient, APMARGIN 2024

Feelings about prescribing IUDs or Implants to nulliparous adolescents	Believed that offering a new IUD variant designed for smaller uteruses would be beneficial in expanding IUD access for the patient		
	Disagree	Neutral	Agree
Strongly hesitant (not comfortable prescribing IUDs/implants to adolescents)	9	45	42
	17%	13%	11%
Somewhat hesitant	3	31	34
	6%	9%	9%
Neutral (no strong feelings either way about prescribing IUDs/implants to adolescents)	4	56	35
	8%	17%	9%
Somewhat support (recognize the benefits of IUDs/implants for adolescents but may have some concerns)	11	92	92
	21%	27%	25%
	25	111	171

Feelings about prescribing IUDs or Implants to nulliparous adolescents	Believed that offering a new IUD variant designed for smaller uteruses would be beneficial in expanding IUD access for the patient		
	Disagree	Neutral	Agree
Strongly support (believe IUDs/implants are a valuable option for adolescents and I'm happy to provide them)	48%	33%	46%
Total	52 100%	335 100%	374 100%

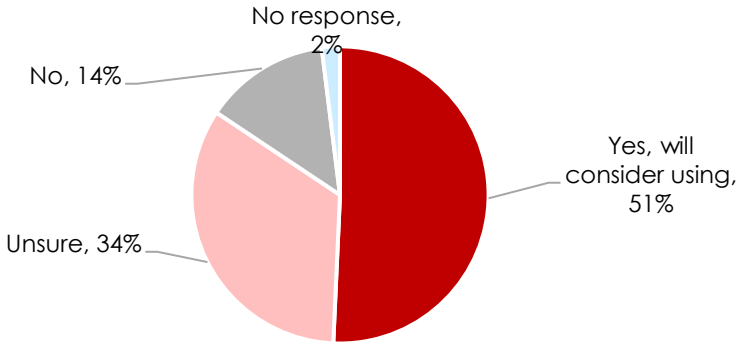
About 38% of health service providers would consider recommending new IUD type for younger women or women who have not given birth (304 of 797) (Figure 55).

Figure 55. Percent of health service providers providing FP services who will consider recommending new type of IUD for younger women or women who have not given birth, APMARGIN 2024



A little more than half (51%) of health service providers would consider using this new type of IUD (403 of 797) (Figure 56). Conversely, 14% would not consider such action which may be reflective of bias against providing IUD to nulliparous women.

Figure 56. Percent of health service providers providing FP services who will consider recommending new type of IUD for younger women or women who have not given birth, APMARGIN 2024



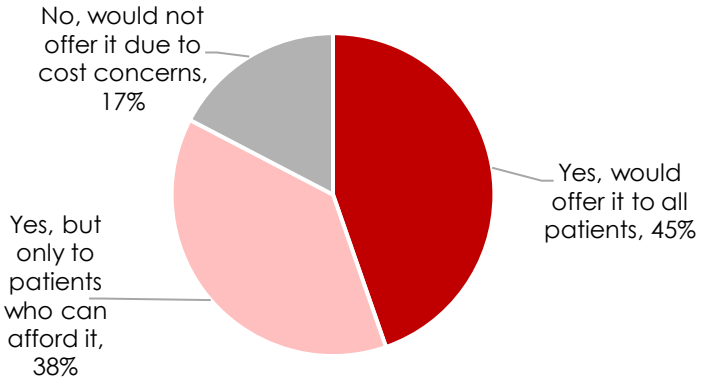
Offering Silverline Cu IUD

As shown in Figure 57, about 38% of health service providers agreed that higher cost, which is usually equated with better quality or effectiveness in medical products, would influence women's preference for potentially more expensive Silverline Cu IUD compared to a regular copper IUD (300 of 797).

Figure 57. Level of agreement of health service providers providing FP services on the statement that higher cost which is usually equated with better quality or effectiveness in medical products would influence women's preference for potentially more expensive Silver Cu IUD compared to a regular copper IUD, APMARGIN 2024

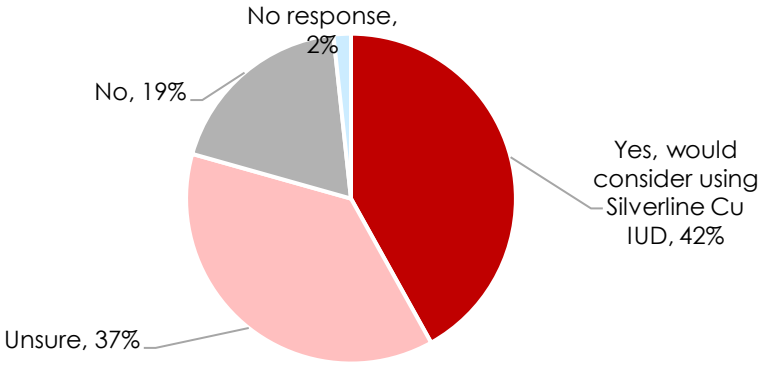
About 45% of health service providers would present the Silverline Cu IUD as an option to widen the range of IUDs offered to their patients, taking into account that this brand might be more expensive (358 of 797) (Figure 58).

Figure 58. Proportion of health service providers providing FP services who would still present Silverline Cu IUD as an option to widen the range of IUDs offered to patient, considering it might be more expensive, APMARGIN 2024



Of the 797 health service providers, 43% said that, as a woman, they would consider the use of the new and more expensive Silverline Cu IUD (337 of 797) (Figure 59).

Figure 59. Proportion of health service providers providing FP services who would consider using the new and more expensive Silverline Cu IUD, APMARGIN 2024



4. Service availability, capacity building, promotion and challenges on LARC

This chapter provides the results of the interviews conducted among Provincial/City/ Municipal Health Officers to understand the current state of IUD and contraceptive Implant services in the area and to identify areas for improvement and potential gaps. A total of 22 Key Informants (KIs) from the 10 study sites consisting of City/Municipal Officers, Rural Health Physician, FP Coordinators, Public Health Nurse and Provincial Population Officer were interviewed from April to May 2024. Thirteen of them were from areas which performed high in LARC and nine from areas which performed low in LARC. The results from these interviews were clustered into four sections: service availability, training and capacity building, promotion and awareness and challenges and opportunities.

Service availability

- Demand for IUD and contraceptive Implant

High performing in LARC. According to the KIs, they have observed increase in demand for contraceptive Implant for more than half of the sites as compared with demand for IUD. This finding suggest that health service providers prefer the Implant because it is less invasive than IUD, is more convenient and requires less preparation for health service providers.

Low performing in LARC. Of the nine KIs, six shared that they observed an increase in demand for contraceptive Implant compared to IUD mainly because it was easier to provide.

- Availability of IUD and contraceptive Implant stocks

High performing in LARC. Less than a quarter of the KIs said that they experienced stock-outs on either IUD or contraceptive Implant in the current year. One KI said that their facility experienced stock-out on both IUD and contraceptive Implant in 2023.

Low performing in LARC. About a third of the KIs said that they experienced stock-out on either IUD or contraceptive Implant in the current year. They said that they referred clients to nearby health facility with available stock of either IUD or contraceptive Implant.

These findings suggest that stock-out on both IUD and Implant remains to be a problem in both the high- and low-performing areas which may have an effect on the uptake of LARCs in both areas. Note, however, that some KIs shared that they experienced lack of supplies of FP commodities in the current year. This was not perceived as stock-out since they can readily access these FP commodities within the referral network (e.g., from the province or CHD).

- Referral system for IUD and contraceptive Implant services

High performing in LARC. All KIs shared that there is an established referral system in-place for women seeking IUD or contraceptive Implant. Two KIs shared that they do not have a "formal" arrangement with the members of the referral system such as memorandum of agreement.

Low performing in LARC. Of the nine KIs, only one said that they have no established referral system in-place in their area. Among most KIs, their facilities usually referred clients to another health facility within the network.

These findings suggest that the high-performing areas have referral system in-place which could be one of the reasons for their good performance. The opposite may be true among the low-performing areas for which most do not have an established referral system.

Training and capacity building

- Integration of training in plans

High performing in LARC. Of the 13 KIs, 12 shared that LARC training is included in the 2024 Annual Investment Plan (AIP) or Annual Operational Plan (AOP). Five of them said that the budget allocated was for transportation only while one said that although there is budget allocated for training, it is not easily accessible for such training because FP is least prioritized by the LGU.

Low performing in LARC. Five of the nine KIs shared that LARC training is included in the 2024 AIP/AOP. Two of the KIs shared that the allocation was for per diem or transportation expenses and one shared that in their LGU, they cannot decide where to use the budget.

- Availability of training opportunities

High performing in LARC. Five of the 13 KIs said that training opportunities were not sufficient for health service providers for them to become qualified IUD and contraceptive Implant providers. Some of them shared that only a few in their health service providers were trained due to limited slots for training offered.

Low performing in LARC. Seven of the KIs shared that the training opportunities on IUD and contraceptive Implant for health service providers like them were not enough because of the limited slots offered. A few of them said that after 2019, there were no follow-up training activities conducted and this led to more health service providers who were not trained on IUD and contraceptive Implant.

Based on the sharing from the KIs, there were barriers in training that have been identified in the past that remain up to this day. Although the budget for the training were included in the annual plans, it may not be sufficient to meet the training needs of health service providers. The availability of such fund will also depend on the existence of competing priorities that will require funding.

- Training institutions within the region

High performing in LARC. For a little more than half of the KIs, they mentioned the DOH regional offices (CHDs) as the training institution within the region that offered LARC training programs for health service providers. Some of them also mentioned the province, City Health Office, Medical Center, POPCOM and ReachHealth.

Low performing in LARC. Of the nine KIs, eight mentioned CHD as the training institution within the region that offered LARC training programs for health service providers.

Other training institutions offering LARC training programs in the region were DKT, Medical Center, POPCOM and other NGOs.

- Challenges in accessing LARC training

High performing in LARC. The KIs mentioned the following challenges they encountered when accessing training on LARC: synchronizing their schedule with the training schedule; non-availability of health service providers on the scheduled training; limited slots offered; not enough training opportunities to ensure more health service providers were trained; lack of budget; and giving less priority to FP (by the LGU).

Low performing in LARC. For the nine KIs, the challenges in accessing LARC training were: lack of budget or funding for the training of the health service providers; non-availability of health service providers on the scheduled training; limited slots; and lack of hands-on exercise to boost confidence of staff in the provision of IUD and contraceptive Implant services.

- Effectiveness of current LARC training programs

High performing in LARC. Ten of the 13 KIs shared that the LARC training programs were effective in equipping health service providers with the necessary skills and knowledge so that they can confidently offer IUD and contraceptive Implant services. Specifically, these LARC training programs were effective when providing actual service provision and in increasing the number of acceptors.

Low performing in LARC. Eight of the nine KIs shared that the LARC training programs were effective in honing their skills and in giving them confidence to perform contraceptive Implant and/or IUD services. One of them shared that it is only going

to be effective if the learning from the training were actually applied by health service providers.

Note that these findings show that the participants believed that the trainings they attended were effective in providing them with the skills and confidence to offer FP services.

Promotion and awareness

- Educational materials

High performing in LARC. Only three of the 13 KIs shared that they have budget for educational materials e.g., pamphlets, posters, etc. and have developed their own materials to promote IUD and contraceptive Implant as FP options. For the rest, they distributed the educational materials developed and shared by DOH.

Low performing in LARC. Most of the KIs shared that they do not develop their own educational materials to promote IUD and contraceptive Implant as FP options. They only distributed materials developed by other agencies and provided to them such as those from DOH, POPCOM and USAID.

- Ongoing community outreach programs or initiatives

High performing in LARC. According to all KIs, there were existing outreach programs where awareness raising on IUD and contraceptive Implant is a part of such as medical mission, health education activity, caravan and Usapan serye.

Low performing in LARC. Similarly, eight of the nine KIs shared that there were existing outreach programs where awareness raising on IUD and contraceptive Implant is a part of such as: monthly activities in the health facility/center; during provision of services for prenatal check-up; conduct of specialized Usapan sessions for adolescents; and conduct of activities on health in partnership with the region and province.

Generally, both high- and low-performing areas had outreach programs and utilized the USAPAN series for health awareness. Only the low-performing areas mentioned

integration of FP to other health programs such as prenatal which means that there is a need to strengthen integration of FP to the various health programs implemented in the community.

- Collaboration with local media outlets

High performing in LARC. Only three of the 13 KIs shared that they have collaborated with local media outlets to disseminate information about IUDs and contraceptive Implants and dispel common misconceptions. According to the five KIs, they have Facebook account and other social media outlets for interacting with their clients.

Low performing in LARC. Six of the nine KIs shared that they had no media engagement for IUD and contraceptive Implant. Three said that they use their Facebook account as platform for posting their health programs. One KI said that they have a television unit in the waiting area of their health facility where they have videos showing common misconceptions about FP.

In both the high- and low-performing areas, there was an impression that media platforms, specifically social media, were underutilized for health promotion purposes.

- Ensuring effective counseling of clients

High performing in LARC. Five of the 13 KIs mentioned the following to ensure effective counseling of health service providers on the benefits, risk and suitability of IUD and contraceptive Implant before service provision: continuous quality improvement; monitoring and supervision; observation; mentoring and coaching; feedbacking mechanisms; reporting; and preparation of supervisory logbook of findings and recommendations.

Low performing in LARC. Three KIs shared that they conducted random checks to find out if health service providers were actually doing FP counseling. One KI said that the strategy they used was to ask the health service providers to share the questions that were raised during pre-marriage orientation/counseling and how they responded to these queries. Some of them conducted random monitoring, monthly meetings and reporting.

Based on the sharing, it seems that there is no standard in monitoring the quality of FP counseling as less than half of the KIs in the high-performing areas mentioned established practice or methods of monitoring for quality. In the low-performing areas, randomness of monitoring seemed to be the norm.

- Most common concerns of clients

High performing in LARC. The most common concerns that women expressed regarding IUD and contraceptive Implant were: pain (head, chest, abdomen); weight concerns (weight gain/weight loss); menstruation concerns (no period/heavy period); and preference for herbal (by IPs). For IUD, the most common concerns expressed were: pain during sex; IUD ejected when carrying heavy things (especially among farm workers); and fear of speculum. For contraceptive Implant, the most comment concerns expressed were: high blood pressure; fear of needle; and "dislocated" needle.

Low performing in LARC. The most common concerns that women expressed regarding IUD and contraceptive Implant were: menstruation concerns (no period/heavy period); weight concerns (weight gain/weight loss); high blood pressure; irritability; not compatible; and lack of sleep. For IUD, the most comment concerns expressed by women were: thread of IUD gets entangled with penis; loss of interest in sex; and IUD is messy when inserted. For contraceptive Implant, women were concerned about the needle moving within the body or transferring from the arm to other parts of the body.

Findings show that most of the concerns of the clients about LARCs were legitimate ones because they are the observed side effects and complications of the method. However, some of these concerns were myths or misconceptions i.e., entanglement of the penis in the IUD thread, that should be addressed during FP counseling or during follow up.

In addition, it is interesting to note that in the high-performing areas, lack of providers was not mentioned; whereas, in the low-performing areas this appeared to be an important issue to take into consideration.

Challenges and opportunities

- Major obstacles hindering wider provision of IUD and contraceptive Implant services

High performing in LARC. These are the major obstacles in the wider provision of IUD and contraceptive Implant services in the area mentioned by the KIs: misconception; social stigma; religion; disagreement by husband/ partner about the FP method; weak support from provincial government; and lack of supplies for IUD (hence the MOA entered into by the health facility with private clinics).

Low performing in LARC. The following were the major obstacles in the wider provision of IUD and contraceptive Implant services mentioned: no available IUD provider; refusal of some health service providers to undergo training because of old age or near retirement; budget constraints; and complaint of husband (especially about discomfort during sexual intercourse which they said is because of the IUD).

Based on the sharing of KIs, the barriers to the provision of LARCs remain the same over the years from the demand side (misconceptions, societal norms, subservience to the partner) and supply side (inadequate support from the government, lack of logistics). Other barriers mentioned were: lack of providers; lack of training; lack of confidence even if they were trained because of inadequate/ineffective/non-standardized training: lack of practice after training; inadequate funding for the training; and lack of interest of the health service provider to undergo training.

- Financial resources

High performing in LARC. All of the KIs shared that they received adequate funding to support the promotion and provision of IUD and contraceptive Implant services from DOH/CHD, and C/PHO either in the form of funds or technical assistance.

Low performing in LARC. Three of the nine KIs received adequate funding for the promotion and provision of IUD and contraceptive Implant while the rest said that though there is fund for this purpose, this is not adequate.

Based on the interviews, the high-performing areas seemed to have no issues about funding which is in contrast with the low -performing areas where funding remains to be an issue.

- Collaboration of government agencies and NGOs

High performing in LARC. Of the 13 KIs, 10 shared that the collaboration of government agencies and NGOs to improve access to IUDs and contraceptive Implants is effective. They mentioned collaboration with government agencies such as with DOH, DSWD and POPCOM/CPD; with international agencies such as United States Agency for International Development (USAID), United Nations Population Fund (UNFPA), DKT International; as well as NGOs such as Likhaan Center for Women's Health, Family Planning Organization of the Philippines (FPOP) and Integrated Midwives Association of the Philippines (IMAP).

Low performing in LARC. Three KIs shared that the collaboration between government (DOH, LGU) and NGOs (FPOP) to improve access to IUDs and contraceptive Implants was effective. Four of the KIs said that there was no collaboration on FP per se though there were such collaboration in other health services such as for immunization (Rotary) and TB (Philippine Business for Social Progress).

Based on the interviews, the high-performing areas received assistance and have collaborated with various stakeholders from both government and NGOs while the low-performing areas have less of this assistance.

- Innovative approaches to increase uptake of IUD and contraceptive Implant

High performing in LARC. The following innovative approaches or pilot program implemented in their respective areas to increase uptake of IUD and contraceptive Implants were mentioned: conduct of pre-marriage orientation/counseling; conduct of events such as Buntis Congress, Parent's Class, summit and FP caravan; integration of FP in other services (e.g., immunization); conduct of Usapan; conduct of modified 3-day FPCBT for HRH to avoid missed opportunities; and conduct of home visits. The 3-day modified FPCBT for HRH is the initiative of one of the KIs who is a PHO. The PHO trained its nurses (Job Order) on FP counseling and on FP methods so that they can help in the provision of FP services in their facility.

Low performing in LARC. The innovative approaches or pilot program mentioned were: conduct of Buntis Congress, Usapan Serye, conduct of Mother's Class; and integration of FP in postpartum care.

Among all the innovations mentioned by the KIs, only the 3-day FPCBT for HRH is a real innovation.

- Crucial steps to improve access to and utilization of IUD and contraceptive Implant services

  High performing in LARC. The most crucial steps needed to improve access to and utilization of IUD and contraceptive Implant services in the region were: capacity development/training for health service providers; conduct of quarterly updates on performance of health providers providing IUD and contraceptive Implant services; ensuring adequate and available supplies; increasing awareness among the clients and the community; integration of FP in other services; strengthening referral mechanism; and securing and strengthening LGU support.

  Low performing in LARC. The following were mentioned as the most crucial steps needed to improve access to and utilization of IUD and contraceptive Implant services in the region: conduct of health promotion activities/strengthening of social media; securing fund support for training and logistics/FP commodities; increasing services for IUD and contraceptive Implant; and having a one-stop-shop for FP services.

  The high-performing areas recognized the crucial initiatives to improve access to LARCs. Training and subsequent monitoring seemed to be important to them even though lack of training was not mentioned previously as a barrier. This is different from what the low-performing areas identify as crucial which is promotion and funding while training was not perceived as a crucial step to improve access to LARCs. It seemed that some of the steps the high-performing areas took are not done by the low-performing areas. It is interesting to note, however, that the one-stop-shop for FP was mentioned by KIs in the low-performing areas.

5. Knowledge, attitudes and practices of women current users on LARC

This chapter provides the results of the focus group discussions among women current users as regards their knowledge, attitudes and practices on copper IUD and contraceptive Implant. A total of 56 women current users from 10 study sites participated in the group discussions conducted from April to May 2024. The results from FGDs were clustered into three sections: Knowledge, Attitude and Practices.

Knowledge of women current users on IUD

IUD is described by most women current users as a "T"-shaped object with a thread at the end inserted inside the vagina/uterus.

According to most women current users, IUD functions as a barrier to prevent sperm from entering the uterus (*"pagkontrol sa pagpasok ng sperm sa matris"; "may harang para di makapasok ang sperm"*) so that the egg and sperm will not meet. Some believed that IUD kills the sperm while some said that IUD "ejects" the sperm.

Majority of the women current users said that IUD as an FP method is very effective and long-acting and lasts from 5 to 12 years. For most of them, with IUD, they are primarily less worried about getting pregnant. It also means having a space/gap in-between child.

IUD insertion service is provided free at the public health facility according to most women current users. Some of them mentioned that IUD insertion in public health facility costs about PhP200, while in private facility the cost ranged from PhP1,200 to PhP1,500. For most of the women current users, IUD is for women who already have children; who are sexually active and those; and those who gets pregnant easily.

When asked about the side effects of IUD, the following were mentioned: weight gain, heavy period, pain/discomfort felt by husband during sex (one of the mothers said that this leads to quarrel between husband and wife); and not allowed to carry heavy objects because IUD might come out.

Most said that a woman can get pregnant again after removal of IUD. When asked if they know women using IUD who became pregnant, about two said that they know of

women who got pregnant while on IUD. Most mothers do not know of specific maintenance required after IUD is inserted.

Based on findings, in general, women current users have fair knowledge on what the IUD is, its mechanism of action (mostly inaccurate although some said the correct one which is, it kills sperm); side effects; and duration of action (long term). Most of them are confident about the effectiveness of the method, however, myths and misconceptions still persist such as it is a method used by those who already have children. From the sharing, it seemed that not all of the respondents were aware that IUD services are free in government facilities. It appears that post insertion instructions were not given to these women or were not emphasized because they were not aware of what to look out for.

Attitudes of women current users on IUD

Most women current users recognized the benefit of using IUD for contraception particularly in having more quality time raising their family. However, they are also concerned with the side effects that they know of or heard about from others.

For most women current users, using an IUD means not getting pregnant or having space before the next pregnancy. This means less worry and less burdensome in their lives as they are able to have quality time with their family.

In addition to the side effects already mentioned, the following were also shared by most of the women current users: IUD causes infection/cancer; causes corrosion and once removed will produce pus; is painful when inserted; and experience of heavy bleeding when IUD is inserted.

Most of the women current users said that they felt comfortable talking to the health service providers concerning IUD as most of them are approachable and good listeners. Discussing matters about FP use is beneficial according to most of them because the health service providers will provide them guidance specifically in addressing/coping with side effects.

All women current users would recommend IUD to other mothers as well as to their relatives as a potential family planning option because of its benefits. Some also said that they will tell the mothers about the possible side effects that they will experience when they use IUD.

From the sharing of the women current users, it seems that they have the self-efficacy to discuss the IUD with the health service provider. They also perceived the health service provider as someone they can get helpful health information from such as in coping with side effects. A few of them also expressed their possible role in spreading information about IUD; both its benefits as well as side effects. They also value their family and if it means spacing pregnancy to show this, they will do it.

Practices of women current users on IUD

Most of the women current users were satisfied with IUD because they do not have to worry about getting pregnant. They also manage side effects well and most have supportive husband/partner about their FP option.

Most of the women current users who participated in the FGD were satisfied with IUD. One of them said that she will have it (IUD) until she reached menopause stage.

In terms of managing side effects, three of four women current users did not do anything about the side effects and just endured what they experienced. Some, however, were able to visit their health service provider for check-up and advice.

A few did not do anything to properly care or maintain their IUD. Some of the mothers, however, went to the health facility for their regular check-up and Pap smear.

According to most women current users, their husband/partner were very supportive of their FP choice (*"supportive si husband kasi alam niya mabilis akong mabuntis"*). Some mothers shared that their husband/partner even encouraged them to avail FP services. As for the three mothers, their husbands/partners did not approve of IUD and convinced them to have it removed because of the pain/discomfort the husband/partner felt during intercourse.

In order to stay informed about updates or development related to IUDs, most women current users relied on information from the health center via their healthcare providers or during house-to-house visit of health worker. Some of them attended seminars or received flyers about FP from the barangay. About a quarter of them made inquiries via the FB page of the CHO and did some research about IUD via the internet (i.e., Google, YouTube).

Based on the sharing, most of the women current users were satisfied with the IUD primarily because they are confident about its effectiveness in preventing pregnancy. With IUD, they were also assured of the assistance from the health service providers as regards their concerns and have the support of their husbands. Some demonstrated

empowerment in seeking information and managing side effects on their own with the assistance of health service providers.

Knowledge of women current users on contraceptive Implant

Most women current users described contraceptive Implant as a match-like object or stick inserted in the skin of the arm and is effective for three (3) years. It helps with spacing or putting a gap in-between child and preventing pregnancy.

According to most women current users, contraceptive Implant is "inserted" in the body (*"inject sa katawan para magsimulang maglabas ng pangkontra para di mabuo ang sperm na papasok sa pwerta"*). Some mothers said that the "object" inserted is made of elastic material while some said it is made of rubber. More than half of the mothers said that contraceptive Implant has a "liquid" or "medicine" or hormone (progesterone) inside which prevents ovulation to avoid fertilization and therefore pregnancy. Most women current users said that the duration of action of contraceptive Implant is three (3) years while a few said contraceptive Implant lasts a few months to more than three (3) years.

Most women current users said that contraceptive Implant should be used by women who already have children; those who are at least 15 years old; and those who easily gets pregnant.

Half of the women current users said that contraceptive Implant insertion is free while a few said that it will cost PhP200 to PhP4,000.

All women current users said that contraceptive Implant is at least 95% effective. Some said that contraceptive Implant is 100% effective in preventing pregnancy. With contraceptive Implant, most mothers believed that they have less stress (*"maganda, iwas pagbubuntis, mahirap ang panahon, sino mag-aalaga (sa mga anak)"*). To maintain contraceptive Implant, most mothers said to avoid carrying heavy objects and to make regular checks of the arm where the contraceptive Implant is inserted as it might get deeper in the fat layer.

As for the side effects, most women current users mentioned the following: weight gain, no period/menses and irregular period. More than half shared that when contraceptive Implant is removed, the chances of getting pregnant is high.

Based on the sharing, the knowledge of women current users on Implant seems to be more accurate compared with their knowledge on IUD. This may be because the Implant has been implemented more recently than the IUD and thus recall of correct information is better. As shared by the health service providers who were trained on the Implant, they

seem to be more confident compared with those who were not trained. They, however, have the misconception that Implant should be used only by women who already have children. It is surprising that the users were not against the use of Implant by 15-year-old teens.

Attitudes of women current users on contraceptive Implant

Most women current users said that using contraceptive Implant means not getting pregnant or having space in-between pregnancies; this means more quality time with the children; most, however, were concerned of the side effects of this FP method.

Most women current users shared that using contraceptive Implant meant not getting or having space in-between pregnancies which means less expenses and more quality time for taking care of their children.

Some women current users, however, were concerned about contraceptive Implant. A few said that contraceptive Implant will stick on the baby (*"Huwag magpalagay ng contraceptive Implant kasi baka madikit (ang) bata kapag nagbuntis"*). Some were concerned about its removal because the cut (incision) might be large because the stick may be already embedded in the fat layer (*"nakabaon"*) apart from what some said that removal of contraceptive Implant is expensive. Others were concerned about having headache while on Implant. Some feared that contraceptive Implant will break apart when inserted. Almost a third of the women current users said that contraceptive Implant does not stay on the arm but moves around the body.

When asked if they would feel comfortable discussing contraceptive Implants with their health service provider, most women current users said that they felt comfortable talking to their health service provider and that they do not feel embarrassed because these encounters helped them cope or address the side effects they experienced.

Almost all women current users would recommend contraceptive Implant to other mothers. Some of them, however, would tell these mothers about possible side effects of contraceptive Implant especially those that they themselves experienced.

Based on the group discussion, current users of Implant value their family which they show by using effective method despite experiencing side effects. They did this so that they

can prevent pregnancy that will drain their finances and affect the women's attention to the family. The current users expressed no hesitation in consulting with health service providers for their concerns about the Implant.

Practices of women current users on contraceptive Implant

More than half of the mothers were satisfied with contraceptive Implant as they do not worry anymore about getting pregnant; a few however would like to have their contraceptive Implant removed.

More than half of the women current users were satisfied with contraceptive Implant. Some of them said that they plan to get re-insertion after three years.

As for side effects experienced, most of the women current users did not do anything about it and just endured or managed them on their own while other mothers went to their health provider for check-up and advice.

To ensure proper maintenance and care of contraceptive Implant, most of them had no specific actions done except to touch their arms to feel if the contraceptive Implant is still in its original place during insertion.

The husband/partner of most women current users were very supportive with their use of contraceptive Implant especially if the woman gets pregnant easily. Most mothers stayed informed about updates or development related to contraceptive Implant via information from the health center and their healthcare providers or during house-to-house visit of health worker. Some of the mothers participated in the activities in the barangay such as seminar and were given IEC materials. Some made personal inquiries from CHO via the official FB page while others did research about contraceptive Implant from Google and/or YouTube.

From the sharing, women current users were generally happy with the Implant not only because they need not worry about pregnancy but because their husbands were supportive of the Implant which cannot be said about the IUD. Similar with the IUD, most who have Implant get their information about this method from health service providers as well as from the internet.

6. Knowledge, attitudes and practices of nulliparous women on LARC

This chapter provides the results of the focus group discussions among sexually active nulliparous women (women who have not given birth) on their knowledge, attitudes and practices on IUD and contraceptive Implant. A total of 48 nulliparous women participated in the discussions conducted from March to May 2024. The results from FGDs were clustered into three sections: Knowledge, Attitude and Practices.

Knowledge of nulliparous women on IUD

Some nulliparous women mentioned IUD as LARC though some also mentioned other methods such as condom, pills and injectable as LARC. Some women have heard IUD for the first time during the group discussion. Those who knew about IUD also knew well about the side effects.

Some women mentioned IUD as a LARC. According to them IUD is a "T"-shaped object inserted into the vagina/uterus and blocks ovulation. It is a device which prevents the meeting of sperm and egg (*"may bumabara sa pagkita (ng egg at sperm)"*) and can prevent pregnancy for up to 10 years or more. More than half of the women said that the duration of IUD before replacement is at least five years and at most 12 years. Some of the women also mentioned condoms, pills and injectable as LARC methods.

When asked if they ever come across any brand names associated with IUDs, all women who participated in the FGD have no idea about IUD brands.

Most women sought information about IUD from health service providers, some from their relatives and a few from online sources. Also, most women who knew about IUD said that IUD prevents pregnancy which means more quality time for the children, better health of the mother and children, less burden to the family's income and therefore better life for the family.

Most women knew about the potential side of IUD which include: weight concerns (weight gain/weight loss); not allowed to carry heavy objects; cramps; headaches; menstruation concerns (no period/heavy period); can cause cancer; painful for the man during intercourse; can cause abrasion in the uterus *("gasgas sa matris")*; can cause infection after many years of using; and will produce pus that will accumulate in the uterus.

For some women, IUD is effective and long-lasting than other contraceptives. They shared that users of IUD will also not forget it unlike with pills or condoms which can easily be forgotten *("hindi na basta-basta nalilimutan, nasa pwerta na")*.

When asked if IUD can be used by women who plan to have children in the future, some women said that this would depend on the decision of the woman and her husband/partner. Some also said that newly-weds may not take this as an option because they want to have children or are achieving. Some of them said that FP is for those who already have a child/children.

Most women can distinguish between IUD and contraceptive Implant in terms on how they are inserted. According to them, contraceptive Implant is inserted through the arm (after incision, disinfection and anesthesia) while IUD is inserted through the vagina. As for its removal; contraceptive Implant is pulled out after incision on the arm according to one woman while the rest did not know how contraceptive Implant is removed. IUD is removed from the vagina (reverse of how it was inserted) and usually done during menstruation according to few of the women.

Based on findings, it seems that most women have knowledge of the various methods but these are less than accurate. Since most get their information from health facilities/health service providers, it may be possible that the health service providers themselves have provided less accurate information, at least where the group discussion were conducted i.e., those who have had children should use the IUD, a bias that is culturally entrenched; and the inability of the user to get pregnant after removal which continue to prevail as a misconception. One thing is clear, though, and that is they equate FP to quality family life.

Attitudes of nulliparous women on IUD

Between contraceptive Implant and IUD, the former is more preferred because of the manner on how it is inserted; most women were worried about the side effects and difficulty of removing IUD.

According to most women, since IUD is inserted in the vagina, they will feel uncomfortable having it inserted on them *("…kasi kapag sa pwerta ilagay, nakakatakot")*. The IUD, however, is more discrete and private compared to pills. When using IUD, other people will not know unless the user told a person.

Most women were worried about the side effects that they heard about IUD such as: IUD getting misplaced or tendency for it to come out when lifting heavy object; weight concerns (weight loss/weight gain); IUD causes cancer; and copper in IUD will corrode and cause abrasion in the uterus. The younger women were worried about not getting pregnant in the future if they use FP at a young age. Some of the women were concerned about the removal of IUD.

Despite the concerns on IUD, most of the nulliparous women said that IUD is important because this will help the family plan for its future, provide quality care for the children and ensure financial stability for the family.

From the sharing, it seemed that the participants prefer to have the Implant over the IUD because of ease of use. This may be a reflection of the providers' attitude as shared by the one of the KIs in the interview. Also, nulliparous women have a lot of myths and misconceptions surrounding IUD which may be indicative of inaccurate information they get from the community. Despite the inaccurate information, nulliparous women believed that IUD has a role to play in planning a family and recognized that the method allows for privacy.

Practices of nulliparous women on IUD

For most women, use of FP when they do not have children yet is not an option; they said that having children is the priority.

Most women will consider using IUD because of the following reasons: when they already have children; if the method is effective; easier to remove compared to contraceptive Implant; and lasts longer. A few of them said that they will not use IUD because they do not like where it is inserted.

For most women, the health center is the place to go if one wants to avail of IUD insertion service. More than half of the women have not discussed about the use of IUD with their health service providers as their priority is to get pregnant or have a child.

As for the potential barriers for women with no children in using IUD, most women said that the lack of complete and correct information about IUD and lack of access to a health facility offering IUD insertion service were potential barriers.

The information most useful for women about IUD so that they can make informed decision for its use were: details about its use and effectivity that should be delivered by people in authority e.g., doctors/healthcare providers; and dispelling of rumors and misconceptions through information education, campaign and IEC.

Based on the sharing, nulliparous women generally do not consider the IUD because their primary concern is to have children first. They, however, believed that nulliparous women wanting to use IUD face barriers such as lack of correct information on the IUD and lack of access to facilities that offer IUD. Also, the misconceptions about IUD have implication on their decision to use the method.

Knowledge of nulliparous women on contraceptive Implant

Some women mentioned contraceptive Implant as LARC though some also mentioned other methods such as condom, pills and injectable as LARC.

Contraceptive Implant was mentioned as a LARC by some women though they also mentioned condom, pills and injectable as LARC.

According to most women, contraceptive Implant is an object inserted in the skin on the arm *("kinokonek sa ugat")* to prevent a woman from having more children. Inside the needle is a hormone which will make the lining of the uterus thick and will not make the woman menstruate. One woman described contraceptive Implant as a method which stops ovulation for three years and therefore prevents pregnancy.

Most women perceived contraceptive Implant as a family planning method which provides longer protection and is not easily forgotten, unlike pills. This means less worry about having children, ability to plan for the spacing of children, financial benefit for the family and better health of mother and children.

The potential side effects of contraceptive Implant mentioned by most women were: no menstruation; dry skin; irritability; and weight concerns (weight gain/weight loss).

Most of the women who knew about contraceptive Implant said that it will be replaced after three years. A few of them said that it will be replaced after six months or after a year.

Of the women who participated in the FGD, only two mentioned Implanon as a brand for contraceptive Implant. The main source of information about different contraceptive methods by most women is the health center through the seminars conducted and flyers distributed in their barangay. Other women relied on their relatives' knowledge. Others did their research about contraceptive methods via online e.g., Facebook, Google.

For most of the women, contraceptive Implant should be used if the woman already has children. For some women, contraceptive Implant can be used by those who are already sexually active.

Most women can distinguish between IUD and contraceptive Implant in terms on how they are inserted. According to them, contraceptive Implant is inserted through the arm (after incision, disinfection and anesthesia) while IUD is inserted through the vagina. The contraceptive Implant is removed by pulling it out after incision on the arm according to one woman. As for the rest, they did not know how contraceptive Implant is removed.

Based on the sharing of nulliparous women, their knowledge on the Implant seems to be more accurate compared with their knowledge on IUD. They have awareness of the benefit of the implant that goes beyond the method itself but also the benefit of preventing unplanned pregnancy to the family. Most of them get their information about the Implant from the health service providers. Similar to other groups of women, there is misconception that the Implant should only be used by those who already have children and those who are sexually active.

Attitudes of nulliparous women on contraceptive Implant

Contraceptive Implant is the preference of most women because it is only inserted in the arm; most women, however, have some qualms about using contraceptive Implant because of the side effect that they read or heard about it.

Most women who are interested in using LARC chose contraceptive Implant because it is more "comfortable" for them during insertion as compared to IUD *("hindi na bubukaka"; "mas hindi hassle kasi pag sa pwerta ilagay, nakakatakot")*. The contraceptive Implant is also more discrete and private compared to pills or condom according to most women.

Most women were worried about the side effects that they heard about contraceptive Implant such as: blood clot/buildup of blood which results in thickening of the lining (in the uterus) and dirt accumulation; weight loss; dry skin; irritability; no menstruation; and severe headache. The younger women were worried about not getting pregnant in the future if they use FP at a young age. Some of the women were concerned about the insertion and removal of contraceptive Implant and said that it might feel painful when inserted or difficult to remove.

Based on the sharing, nulliparous women may be interested in the Implant as a method despite the side effects because of the ease of the procedure and because it is not an indignity (IUD is an affront to the modesty of Filipinas). Although most of the side effects that the nulliparous women knew about the Implant are accurate, some myths and misconceptions are held.

Practices of nulliparous women on contraceptive Implant

For most women, use of FP when they do not have children yet is not an option; they said that having children is the priority.

Most women will consider using contraceptive Implant when they already have children; or based on its effectivity. For most women, the health center is the place to go if one wants to avail of services for contraceptive Implant.

More than half of the women have not discussed about contraceptive Implant with their health service providers as their priority/goal is to have a child or to get pregnant. A few said that they have already discussed contraceptive Implant with their health service providers and relatives for future use.

Most women said that having a child is a must prior to using contraceptive Implant. According to them, nulliparous women should be provided with complete and correct information about contraceptive Implant and should have readily access to a health facility offering services for contraceptive Implant to help them decide on the use of FP method.

The information most useful for women about contraceptive Implant so that they can make informed decision for its use were: details about its use and effectivity that should be delivered by people in authority e.g., doctors/healthcare providers; and dispelling of rumors and misconceptions through information education, campaign and IEC.

Findings show that nulliparous women seem to have bias against the use of Implant among those who do not have children yet. Although nulliparous women are aware of the benefits of the method, their priority before using it would be to have children first. The factors that women need to have to convince them to use Implant include access to the method and seemingly comprehensive counseling. The counseling part will help them to have full understanding about the method and this information should be given by people in authority whom they recognize as the health service providers.

7. Knowledge, attitudes and practices of 15-19 adolescent girls on LARC

This chapter provides the results of the focus group discussions among sexually active and non-sexually active adolescent girls aged 15 to 19 years old, including both nulliparous (who have not given birth) and parous (who have given birth) girls, as well as users and non-users of IUD and contraceptive Implants on their knowledge, attitudes and practices regarding IUD and contraceptive Implant. A total of 50 adolescent girls from the 10 study sites participated in the group discussions conducted from April to May 2024. The results from FGDs were clustered into three sections: Knowledge, Attitude and Practices.

Knowledge of adolescent girls on IUD

Most adolescents know about the different FP method including IUD and contraceptive Implant; pills, injectable (or Depo) and condom; few mentioned withdrawal as an FP method; they can easily describe IUD and contraceptive Implant including the side effects for themselves, one deciding factor is to prevent unplanned pregnancies.

Adolescent girls were asked about the different FP methods that they know of. Most of the adolescents were able to identity pills, contraceptive Implant, Injectable or Depo, IUD and condoms; a few mentioned withdrawal as an FP method. Some of the adolescents who were not able to name the FP method shared what they knew about FP methods in general i.e., for protection and not to get pregnant; for determining how many children to have; and for planning before getting into a relationship (*"bago pumasok sa relasyon, paghandaan ang sarili"*).

A few of the adolescents described the IUD as a "T"-shaped object inserted inside the vagina. One said that the IUD also has an "S"-shaped part which is longer. According to most of the adolescent girls, IUD is used as family planning method and to block sperm. From what most of them heard, IUD lasts from 10 to 12 years. More than half of them said that if the IUD is removed, the likelihood of getting pregnant is high.

When asked if they came across rumors or hearsay about IUD, these were the responses: dangerous; may result in not

getting pregnant in the future; can damage uterus and cause cancer; can make one sick; and might get displaced or come out when carrying heavy objects.

In terms of advantages, for some adolescents, using IUD meant not having to worry about having unplanned pregnancies which means avoiding expenses as cost of living is becoming higher *("mahal na (ang) bigas at gatas")*.

Some of the potential side effects that they heard of were the following: IUD is painful during cold weather (this is from a neighbor of one of the adolescent girls; neighbor is using IUD); damages the uterus; weight concerns (weight lose/weight gain); irritability; and abdominal cramps.

As for the duration of IUD, less than half of the adolescents responded and said that it will be replaced after 8 to 12 years. According to most of them, a woman may not be able to use IUD if she is sick or with health issues (diabetic, high blood pressure, asthma) or have fear of side effects.

When asked of the steps involved in getting an IUD, collectively, the adolescents who were currently using IUD said that there will be a counseling/two-hour lecture followed by a check-up and then the actual insertion of IUD. Most of the adolescents said that IUD can be accessed from the district hospital, City Health Office, health center and birthing home/lying-in.

A few of the adolescents who had IUD said they did not pay for the IUD insertion service though some of them heard that the cost ranged from PhP500 to PhP1,000.

Based on findings, adolescents have awareness of the various methods and have fair amount of correct information on IUD. Fears of side effects and misconceptions, primarily about ensuing infertility with its use, pose as one of the barriers for them to consider the method. As for the benefits of the method, particularly in preventing or spacing pregnancy, they would consider the method and would even recommend it to their peers. As for the source of information, it is worth noting that the adolescents still get their information on FP methods mainly from the health facilities. This is in contrast to the expectation that they will most likely get information from social media. The adolescent also knew where to access the IUD; a finding which underscores the importance of providing adolescent-friendly training for health service providers, specifically FP services for adolescents.

Attitudes of adolescent girls on IUD

A few of adolescents would recommend IUD to their friends primarily because of its longer effectivity.

Some adolescents will advise their friend to use LARC while a few of them would recommend IUD to their friends because of its longer effectivity. They would also strongly advice their friend to seek advice from CHO so that she will be given advice and guidance towards her decision to accept IUD. One adolescent girl would even accompany her friend to the health center.

As for the factors that they will consider when deciding whether to use or not to use IUD, most adolescents mentioned ability to manage their fertility (i.e., not ready to have another child soon) so that they will not have unplanned pregnancies and that they will be able to go back to school and finish their studies, save money and reach their dreams. Other factors were: longer effectivity of the method; popularity of the method (whether being used by many); if decided together with husband/partner; and reversibility of the method.

Half of the adolescents were comfortable discussing IUD with healthcare providers as such interactions were beneficial for them. A few were not comfortable because they feel embarrassed discussing these matters.

In terms of the main concerns or fears that they have regarding the use of IUD, the response was more of the IUD falling off or causing damage to the uterus.

More than half said that they have enough information on IUD from the health center, health workers and internet/social media. Less than half wanted more information about this method while a few said that those who have not gotten pregnant will have no way of learning about it.

Based on findings, adolescent girls would consider using IUD and recommend it to their friends. There are several factors that would influence the use of IUD in adolescents especially those who have children already. These include their desire to go back to school and pursue their dreams and the recognition that this is possible only if they plan/manage their fertility with the use of effective and long-acting method, the support of their husband and the assurance of reversibility. Half of the adolescent girls have the self-efficacy to discuss their FP concerns with the health service provider who is the source of their information on IUD, in addition to what they get from social media/internet.

Practices of adolescent girls on IUD

Almost half of the adolescents considered using an IUD; for current users of IUD, their experience was good with the method; however, the lack of information about these methods my pose as challenge in accessing IUD.

Almost half of the adolescent considered using IUD to prevent pregnancy, to have time to go back to school and to reach a stage of financial readiness. A few who were already mothers were contemplating on using IUD though they feared that they might not get pregnant in the future if they use IUD at an early age.

Most of the IUD users said that their experience with the method was good (*"maganda, di mabubuntis")* and that they would recommend it to others. One adolescent girl said that she will not recommend it to those who have no partner or have not experienced pregnancy.

The use of IUD can be promoted among adolescent girls through seminars, campaigns (IEC materials or tarpaulins) and advocacy activities within the barangay or in school setting. Other means to promote IUD which they suggested was via online platforms such as YouTube and social media. A few of them said to include teenage pregnancy prevention as one of the initiatives so that adolescents will understand its impact to their lives and their future.

When asked if there were any barriers or challenges that they have encountered or foresee in accessing and using IUD, they mentioned the following: people gossiping about adolescents using FP; disapproval of partner/husband about the use of FP; lack of complete and correct information about FP methods; parents not allowing their child to use FP; requirement of having a partner to use FP method; and requirement of having children first before using FP.

Most of the adolescents said that information about FP should be complete and correct and should be delivered by a person of authority (health service provider). The health service providers should ensure that FP methods are safe and free. The barangay should also do house-to-house visits to ensure that all adolescents will be informed about health services offered in the barangay. A few of the adolescents said that parents should be involved in these initiatives.

Based on the sharing, although the adolescent girls seem to get their information mainly from the health service providers, they also recognized that the internet can be a source of information and can be utilized to promote the uptake of IUD. The adolescent girls consider gossiping about their use of FP, lack of partner's/parental consent/approval and lack of accurate and complete information on IUD as barriers to their use of the method. This puts emphasis on the role of the health service providers as source of information about FP and the fact that they are considered as persons of authority as regards FP.

Knowledge of adolescent girls on contraceptive Implant

Most adolescents know about the different FP method including IUD and contraceptive Implant; pills, injectable (or Depo) and condom; few mentioned withdrawal as an FP method; they can easily describe IUD and contraceptive Implant including the side effects.

Contraceptive Implant was described by most adolescents as an object made of plastic similar to matchstick or plastic straw that is inserted inside the arm. It prevents pregnancy and is used as an FP method which lasts for about three years. Few adolescents said that it will last for a few months.

According to most adolescent girls, the rumors they heard about contraceptive Implant were: contraceptive Implant will make one feel dry and make the bones brittle; dangerous and may result in not getting pregnant in the future; needle will go deeper into the skin and will be difficult to remove ("*bumabaon sa laman, mahirap tanggalin*"); contraceptive Implant transfers to other parts of the body and can cause cancer ("*lumalakad daw ang contraceptive Implant; nakaka-cancer*"); bad for health; painful in the arm; and causes dry skin.

A few of the adolescents said that contraceptive Implant is more economical than pills because it is long-acting and can stay in the body for three years without incurring cost. As for potential side effects; the adolescent girls shared what they heard of: menstruation concerns (no period/heavy period); loss of appetite; headache; contraceptive Implant is moving around the body; and increased bust size.

Non-use of contraceptive Implant according to most adolescent girls may be brought about by certain factors such as person is sick or have health issues; heavy/fat (as the needle might go deeper into the fat tissue); and fear of side effects.

Current users of contraceptive Implant shared how contraceptive Implant insertion is provided based on their experience. For those who were not pregnant or had no recent birth delivery: client had to queue; interviewed and checked for vital signs; administered with anesthesia then inserted with contraceptive Implant. For those who had birth delivery: attend a 2-hour lecture and take pills for three weeks prior to the process of contraceptive Implant insertion.

In terms of cost, most said that contraceptive Implant insertion is free while a few said that the cost ranged from PhP250 to PhP3,000 for this service in private facility. Services for contraceptive Implant can be easily obtained from the district hospital, birthing home/lying-in, CHO and health center.

From the sharing, adolescent girls seem to have awareness of the various FP methods and have a fair amount of correct information on Implant including its effectiveness in preventing pregnancy, duration of action, among others. However, these adolescent girls also have misconceptions that revolved around side effects, movement of the Implant within the body as well as difficulty in its removal. It is also worth noting that what is striking in this portion of the FGD is the experience of the adolescent girls in accessing Implant services which suggests that there are some standards that are not followed during Implant service provision e.g., 2-hour lecture substituted to a one-on-one FP counseling.

Attitudes of adolescent girls on contraceptive Implant

Most adolescents would recommend contraceptive Implant to their friends because it has shorter duration; for themselves, the deciding factors are to prevent unplanned pregnancies and to go back to school.

Most adolescent girls will encourage their friend to use contraceptive Implant for the following reasons: good for those who are forgetful; is long-acting; and will enable spacing of children.

As for the factors that they will consider when deciding whether to use or not to use Implants, most adolescents mentioned ability to manage their fertility (not ready to have another child soon) so that they will not have unplanned pregnancies and that they will be able to go back to school and finish their studies, save money and reach their dreams. Other factors were: longer effectivity of the method; popularity of the method (whether being used by many); if decided together with husband/partner; and reversibility of the method.

Half of the adolescents were comfortable discussing contraceptive Implant with healthcare providers as such interaction is beneficial for them. A few of them said that they were not comfortable discussing contraceptive Implant with healthcare providers because they feel embarrassed discussing these matters.

Some of the fears mentioned by most adolescents regarding the use of contraceptive Implant were: not menstruating; needle getting deeper into fat tissues; needle moving around the body; and dry skin.

More than half said that they have enough information on Implants from the health center, health workers and internet/social media. Less than half wanted more information about this method while a few said that those who have not gotten pregnant will have no way of learning about it.

Based on the sharing, the overarching factor that influence the use of Implant among the adolescent girls is aspirational, i.e., achieving their dreams by continuing to go to school which they realize will not be possible if they get pregnant. These sharing from the adolescents may inform the behavioral change initiatives for teens to prevent teen pregnancy. Also, generally, the source of the adolescents for information about Implant include the health service provider who they are able to engage with and the various social media platform. Interestingly, none of the adolescent girls mentioned peers as their source of information.

Practices of adolescent girls on contraceptive Implant

Most adolescents would consider use of contraceptive Implant; they said that their experience with the method is generally good and will recommend it to others.

Most adolescent girls wanted to use LARC. For some of them, contraceptive Implant is much preferred because of its shorter duration compared with IUD which has a longer duration. A few were contemplating on using contraceptive Implant though they fear that they might not get pregnant in the future if they use contraceptive Implant at an early age.

Most of the contraceptive Implant users said that their experience with the method was good (*"maganda, di mabubuntis")* and they would recommend it to others. One adolescent said that she will not recommend it to those who have no partner or have not experienced pregnancy.

The use of contraceptive Implant can be promoted among adolescent girls through seminars, campaigns (IEC materials or tarpaulins) and advocacy activities within the barangay or in school setting. Other means to promote contraceptive Implant which they suggested was via online platforms such as YouTube and social media. A few of them said to include teenage pregnancy prevention as one of the initiatives so that adolescents will understand its impact to their lives and their future.

When asked if there were any barriers or challenges that they have encountered or foresee in accessing and using Implants, they mentioned the following: people gossiping about adolescents using FP; partner/husband does not approve of FP; lack of complete and correct information about FP methods; parents not allowing their child to use FP; requirement of having a partner to use FP method; and requirement of having children first before using FP.

Most of the adolescents said that information about FP should be complete and correct and should be delivered by a person of authority (health service provider). The health service providers should ensure that FP methods are safe and free. The barangay should also conduct house-to-house visits to ensure that all adolescents will be informed about health services offered in the barangay. A few of the adolescent girls said that parents should be involved in these initiatives.

Based on the results, adolescent girls would consider the use of Implant because they are aware of its shorter duration compared with IUD. However, they fear that it would affect future fertility if they use it at a young age, a misconception that may influence their decision to use FP method. The barriers that adolescent girls may encounter in accessing Implant services may be imposed by the family/partner, community bias and provider bias as well as the lack of enough information that may influence their decision.

8. Summary of Findings and Recommendations

This chapter provides the summary of findings for each of the study objectives and the corresponding recommendations.

1. Training needs of health providers and community motivators regarding LARC (Objective 1) and targeted strategies and plans for LARC education and training (Objective 4)

   Few health service providers with training in LARC. Based on findings from the TNA, of the 761 health service providers providing FP services, less than 50% had formal training on IUD insertion and removal (34%); 30% had formal training in contraceptive Implant insertion; and 28% had formal training in contraceptive Implant removal.

   The findings reflect lack of training which remain as major issue in the provision of FP services. This is because of the barriers that health service providers encounter to meet their training needs such as limited number of trainings, workload that prevents scheduling oneself for training and cost of training.

   There is also no separate dedicated training for counseling specifically for Implant and IUD. The concepts and skills in FP counseling are learned from the FPCBT 1 training which is a requirement before the health service provider is accepted to the implant or IUD training.

   Recommendations:

   a. Conduct an assessment of health service providers to examine the barriers and hindrances in the delivery of services.

   b. Strengthen Post Training Monitoring and Evaluation to determine extent of delivery of services for IUD and contraceptive Implant and assess performance of health service providers vis-a-vis training.

   c. For the training design, there should be more focus on in-depth sessions on specific areas like counseling and troubleshooting; more practice of skills in IUD/contraceptive Implant insertion and removal; and hands-on workshop with simulation and peer learning and knowledge sharing through group activities.

   d. Future studies should look into whether the implementation of blended learning can address the main barriers in training identified from this study which were: scheduling of the training and cost of training.

Less than 20% with formal training on counseling adolescents about IUD and contraceptive Implant. Only 15% and 8% have received formal training through a dedicated training program and through workshops or conferences, respectively, on counseling adolescent about IUDs and contraceptive Implants specifically for both nulliparous and parous patients. This is despite the existing training and program on adolescent-friendly health facilities which include provision of FP services.

Among those currently providing services to nulliparous adolescents, the obstacles in managing requests from nulliparous adolescents for IUD or contraceptive Implant insertion are: uncertainty about legal requirement and parental involvement for adolescents; gap in knowledge or experience in adolescent IUD/contraceptive Implant insertion techniques and concerns about potential medical risks for adolescents compared to adults.

Recommendations:

a. More health service providers should be provided formal training to address the growing demand from nulliparous and parous adolescents and ensure no missed opportunities in the provision of FP services across age groups. Worth noting is the opportunity for about 64% health providers who had no training but are willing to be trained for this based on the current study's finding.

b. Strengthen training in adolescent-friendly approach among health service providers to ensure that there are no missed opportunities in the provision of services to this sub-population group. The topic of adolescent FP is tackled in the module on special populations. The module on FP in courses on adolescent-friendly approach to FP service provision should be integrated and expanded to cover all the issues identified by the adolescents themselves in this study including behavioral change directed towards health service providers.

c. The obstacles should be taken into account when finalizing the training design and methodology for the training on counseling adolescent about IUDs and contraceptive Implants specifically on emphasizing on the discussion.

2. KAP on LARC (Objective 2) and targeted strategies and plans for LARC education and training (Objective 4)

Low level of knowledge of health service providers on IUD and contraceptive Implant. In terms of knowledge on both IUD and contraceptive Implant, the average score is

low at 36% and 49%, respectively. About 84% of the health service providers with formal training in IUD scored less than 50% while less than half (48%) of the health service providers with formal training in contraceptive Implant insertion scored less than 50%. Half of the KIs said that the training opportunities for healthcare providers to become qualified IUD and contraceptive Implant providers is not sufficient; this is because the slots are limited; and some training activities were conducted during pre-pandemic and were not followed-up.

The low level of knowledge of the provider can also be attributed to the quality of training conducted and to the incompleteness of the training cycle which includes post training monitoring and evaluation or supportive supervision with mentoring.

Recommendations:

a. Low level of knowledge is indicative of the need to look into whether this is partly because of the lack of actual application after training or the perceived inadequacy in the training activities related to LARC.

b. There is a need to assess the effectiveness of the current methodology of teaching and perhaps reconfigure the training to devote more time in practice. Practice is key in FPCBT 2 training to achieve competence and confidence in the skill that has been learned.

Incomplete information on FP provided to the clients. For most of the women who knew about the LARC method, the information that they shared were not complete in terms of how they understood LARC and the mechanism of action (i.e., do not recall the term used, they do not look at the IUD/contraceptive Implant inserted to them, they do not have ready response on how IUD/contraceptive Implant was inserted to them, etc.). Most of the sharing during the group discussion were focused on the side effects that they felt and/or heard of. In most groups of women and adolescents, while some of them have already discussed these side effects with their respective health service provider/s, they still asked the same questions during the group discussions as if confirming/validating what they know or the response to their queries.

The following table is a summary of the biases, fears and benefits of LARC or as regards LARC based on the discussions:

Barriers and Biases	Fears	Benefits
More than half said that training opportunities were not sufficient for HSPs Not all HSPs were very confident in providing IUD/contraceptive Implant services; only 40% have some level of confidence towards performing IUD and contraceptive Implant services after training Lack of funds for LARC training and PTME in most sites Less than 25%: with budget for educational materials for IUD and contraceptive Implant; with media engagement to dispel common misconceptions; lack of complete and correction information about LARC FP is least prioritized by LGU Client: LARC are for women with children or women with many children Adolescent clients: embarrassed to talk about FP wit HSP Adolescent clients: using FP at a young age will mean not having children in the future	Body pain (head, chest, abdomen); weight concerns (loss/gain); menstruation concerns (none/heavy); irritability, lack of sleep IUD: Pain/discomfort during sex; ejected when carrying heavy things; fear of speculum; entangled with penis; loss of interest/appetite for sex; corrosion which will lead to infection/cancer; more invasive when inserted contraceptive Implant: high BP, fear of needle, moves within the body; needle will stick on the baby; tendency for needle to embed deep into the fat layer, dry skin	Provider: Implants are less invasive; more convenient Clients: effective in preventing pregnancies; effective for child spacing, long-acting/not easily overlooked; more quality time with children and family, financial stability Adolescent: managing their fertility means finishing their studies and preventing unplanned/multiple pregnancies; use of LARC motivates the adolescent to realize their dreams

Recommendations:

a. In the training, health service providers should be provided with techniques on how to validate whether the FP client actually understood what was discussed with her (and her husband/partner) during counseling and follow-up check-

ups. This will ensure that they have complete and correct information that will leave no doubts and prevent the clients from resorting to online information about the method or dwelling on misconceptions which they pass around to other women.

b. Consolidate all the stakeholder's websites/social media to have accurate and standardized information and increase the awareness of clients of these websites for them to be able to access them.

c. Future studies should look into which among the age groups of health service providers were set on their attitude towards FP that may influence how messages are perceived by clients and therefore their acceptance of FP method particularly LARC.

d. Strengthen the module on dispelling myths and misconceptions. The future initiatives on behavioral change directed towards the health service providers and their biases should also be looked into.

3. Status of current initiatives on LARC promotion and services (Objective 3) and targeted strategies and plans for LARC education and training (Objective 4)

Incomplete understanding of clients about LARC. Most of the women, especially those who have only heard about IUD and contraceptive Implant during the group discussions, perceived the duration of the method prior to replacement as a "lock-in" period, i.e., poor understanding of the concept of "reversibility" at any time that they intend to have children; a few adolescents wanted to use contraceptive Implant instead of IUD because of its "shorter" duration. For nulliparous women and adolescents, they felt that three (3) or more years duration of effectivity is "too long."

Most of the women, especially those who have only heard about IUD and contraceptive Implant during the group discussions, perceived the duration of the method prior to replacement as a "lock-in" period, i.e., poor understanding of the concept of "reversibility" at any time that they intend to have children; a few adolescents wanted to use contraceptive Implant instead of IUD because of its "shorter" duration. For nulliparous women and adolescents, they felt that three or more years duration of effectivity is "too long."

Although users of IUD and implant demonstrated self-efficacy to bring their concerns to their providers, there still work to be done to further improve self-efficacy especially those who are non-users and who have not sought consult with a FP provider.

Behavioral change initiative addressing those who are embarrassed to seek consult for FP or who are afraid of censure from the community should be looked into.

Recommendations:

a. In the training, all the myths and misconceptions and how these will be dispelled should be discussed thoroughly with sessions for doing mock-discussion of such.

b. In the health facility, health service providers should use existing official materials shared with all the facilities within the service delivery network to ensure consistency of information provided to clients.

Clamor for more information about IUD and contraceptive Implant for adolescents. Although there are adolescents who said that there is enough information on IUD and contraceptive Implant which they can get from the health center and internet, this is only possible for adolescent girls who have experienced pregnancy already. Some adolescents recognized the importance of getting information from reliable sources as compared to information that they got from internet for which they are not sure if correct or complete.

Recommendations:

a. In the plan of action prepared during the training, health service providers should include a clear strategy on how to disseminate information to all adolescents while ensuring collaboration with other stakeholders, including the family and community to ensure that messages or information are consistent and reinforced.

b. There is no assurance that the information the adolescents get from various sources are accurate. There should be initiatives to increase awareness of legitimate sources of information such as DOH websites, academic websites, and stakeholders' websites. It is reassuring that many adolescents look up to health service providers as authorities who could address their reproductive concerns, and this trust should be cultivated and used as motivation for the adolescents to establish a relationship with health providers for their health needs.

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