‘A Healthy Me’: understanding and enhancing the impact of a health and wellbeing curriculum for Filipina adolescents

RESEARCH REPORT

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CONSUELO
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ABBREVIATIONS

AFY	Advocates for Youth
AHM	A Healthy Me
AIDS	Acquired immunodeficiency syndrome
ALS	Alternative Learning System
BCPC	Barangay Council for Protection of Children
BHW	Barangay health worker
CANE	Child abuse, neglect, and exploitation
CDC	Center for Disease Control and Prevention
CHO	City Health Office
CRPU	Child's Rights and Protection Unit
CSE	Comprehensive sexuality education
CSEC	Commercial sexual exploitation of children
CWC	Council for the Welfare of Children
DEPED	Department of Education
DHS	Demographic and Health Survey
DOH	Department of Health
DRDF	Demographic Research and Development Foundation
DSWD	Department of Social Welfare and Development
ECPAT	End Child Prostitution and Trafficking
FGD	Focus group discussions
GAD	Gender and development
HIV	Human immunodeficiency virus
ICF	International Classification of Functioning, Disability and Health
ICRW	International Center for Reasearch on Women
ILO	International Labor Organization
IPV	Intimate partner violence
KAP	Knowledge, attitudes, and practices
KII	Key informant interviews
LGU	Local government unit
MHO	Municipal health office
MSM	Men who have sex with men
NGO	Non-government organization
NSO	National Statistics Office
PCC	Parent-child communication
PCW	Philippine Commission on Women
PSA	Philippine Statistics Authority
PSL	Personal safety lesson
PYAP	Pag-asa Youth Association of Philippines
OSEC	Online sexual exploitation of children
OCSE	Online commercial sexual exploitation

RHIYA	Reproductive Health Initiative for Youth in Asia
RHU	Rural health unit
SK	Sangguniang Kabataan
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
STD	Sexually transmitted disease
TESDA	Technical Education and Skills Development Authority
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
YAFS	Young Adult Fertility and Sexuality

DEFINITIONS

Adolescence	a period of transition from childhood to adulthood where physical growth and psychological development occur
Adolescent participants	a term used in this research to refer to the adolescent girls who participated in 'A Healthy Me' program
Barangay	a native Filipino term for village or district referring to the smallest administrative division of Philippine local government
Commercial sexual exploitation	occurs when a person engages in any form of sex industry in exhange for anything of value including monetary and non-monetary benefits
Comprehensive SRH education	integral to ensuring that adolescents are equipped with the information they need to achieve healthy sexual and reproductive lives to avoid negative outcomes
Online sexual exploitation of children	refers to child sexual exploitation which is faciliated or takes place through the Internet and other related media including acts of grooming, live streaming, consuming child sexual abuse material, and coercing children for sexual purposes.
Pamayot	a Cebuano term referring to the act of a male prostituting oneself to a homosexual man
Program facilitators	a term used in this research to refer to the midwives, nurse, teachers, and purok volunteers who facilitated 'A Healthy Me' program
Purok	a political subdivision within a barangay composed of cluster of households and may be referred as zone or sitio in other areas of the Philippines
Unprotected / unsafe sex	engaging in sex without any form of contraception such as condom for protection against pregnancy and spread of STIs

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EXECUTIVE SUMMARY

PROBLEM DEFINITION

Adolescent girls face a range of threats to their overall health and wellbeing, and more specifically, to their sexual and reproductive health. Globally, they are considered a highly vulnerable and neglected population whose needs are only just being recognized as distinct from women and children in the Sustainable Development Goals (UNFPA, 2019, p. 8 & 12).

This is particularly true in the Philippines, which has a young population with an estimated 10 million females between the ages of 15 - 24 (PSA, 2019). There are currently many inter-related issues harming the health and wellbeing of Filipina adolescents. This includes high rates of teenage pregnancy, with 9% of teenagers aged 15 to 19 years having begun childbearing and 36% of teenagers pregnant by the age of 19 years (DRDF, 2014, p.14; PSA and ICF, 2018, p. 61). The Philippines also has the highest HIV growth rates in the Asia-Pacific. Newly diagnosed infections have been increasing exponentially over the past 10 years, with adolescents accounting for 30% of new cases (DOH, 2019). Although currently undocumented, the experience of specificalists suggest other sexually transmitted infections (STIs) such as herpes, gonorrhea, and chlamydia are also rising rapidly (Vista, 2018), with STI complications disproportionately affecting women of all ages (CDC, 2018). Recent research also reveals that 25% of children below the age of 18 have suffered sexual violence and that youth are increasingly experiencing potential harm online through exposure to sexually-explicit content, online pornography, cybersex, and sexting (CWC and UNICEF, 2016, p. 8; UNICEF 2017, p.10; DRDF, 2014, p. 9; UNICEF, 2016, p. 4). Furthermore, the Philippines has historically been a regional center for sex-tourism and is considered an epicenter for online sexual exploitation of children (OSEC), being one of the top ten countries for producing child pornographic material globally (UNICEF, 2016, p. 6).

Given the serious, life-long consequences of these issues, there is an urgent need for effective, affordable, and scalable programs which equip Filipina adolescents with the knowledge, attitudes, values, and skills to maximize their health and wellbeing and protect themselves against potential harm. Whilst various government and non-government organizations have implemented programs to address adolescent sexual and reproductive health (SRH) issues, there appears to be no published, peer-reviewed studies or rigorous program evaluation within the Philippines. However, a significant body of international research exists documenting the characteristics of effective SRH education. Effective programs contain scientifically accurate and comprehensive SRH information which imparts knowledge, attitudes, values, and skills to enable adolescent girls to take control of their health and lives. They use participatory methodology, employing a range of educational activities, are delivered

as they were intended to be, provide a safe learning environment, and are more intensive and of longer duration. However, despite this evidence, "ineffective interventions and ineffective ways of delivering them continue to be widespread, and interventions that have been shown to be effective are often delivered ineffectively" (Chandra-Mouli et al., 2015).

PROGRAM OVERVIEW

To address these needs, 'A Healthy Me' was developed, starting in 2014. 'A Healthy Me' (AHM) is a holistic health and wellbeing program providing comprehensive SRH education to Filipina adolescents as well as training to health educators and parents. The program uses participatory and progressive educational methodology employing a range of individual and group learning activities, with each session being guided by a unique 'learning journal'.

To date, the program has been implemented across eight cities and municipalities within the province of Cebu, involving 88 venues, with 340 trained facilitators and over 1000 adolescent girls graduating from the program. The program is implemented primarily within government national high schools and barangay (community) health centers, being facilitated by the teachers or health professionals within these venues. Program facilitators identify and invite up to 15 adolescent participants aged between 14 - 24 years per program, which includes nine small group sessions for adolescents and one session for parents to improve parent-child communication (PCC) about SRH and child protection topics.

RESEARCH METHODOLOGY

The researchers used a qualitative design through focus group discussions (FGDs) and key informant interviews (KIIs) to explore how 'A Healthy Me' was experienced by the adolescent participants and program facilitators, and its subsequent influence on their attitudes and behavior. Five focus groups involving 22 adolescent girls were undertaken and one adolescent KII, together with two focus groups involving 12 facilitators, and four facilitator KIIs. Data was collected between 2 - 6 months after program completion. Following transcription, thematic analysis and coding was undertaken over several phases as outlined by Braun and Clarke (2006) to identify recurring patterns in the data. Thematic maps and descriptions of the results were generated and the findings validated through follow up meetings with research participants and by external review.

RESEARCH FINDINGS

A total of five FGDs involving 22 adolescent participants were conducted involving participants from each of the program models and venues.

Two FGDs involving 12 health-professionals who were program facilitators were undertaken, together with four KIIs, which included three teachers and one health professional. Data was also collected during the subsequent validation groups which included eight adolescent girls, three teachers and 32 health professionals. Four adolescent girls, one teacher, and 21 health professionals had not participated in the original FGDs.

The findings are presented in three sections according to the research questions explored in the study. These are (1) Issues affecting adolescent girls in the community, (2) Experiences during and after 'A Healthy Me', and (3) Recommendations for 'A Healthy Me'.

FINDING: ISSUES AFFECTING ADOLESCENT GIRLS

In this study, the presence of a problematic community, the frequent risky behaviors of adolescents, and concerns about health and wellbeing of adolescents were the issues identified by adolescent participants and program facilitators. These issues were believed to have subsequent secondary effects in terms of social situation, and physical and psychological health problems.

THEME 1: ADOLESCENT GIRLS LIVE IN PROBLEMATIC COMMUNITIES

This theme was described by the research participants as the conditions within the social environment where the adolescent girls live that heightened their vulnerability to experience adolescent issues. Respondents characterized the problems in the community as unhealthy cultural norms, challenging household characteristics, and the presence or absence of supportive systems or services.

Much of the discussion focused on unhealthy cultural norms. These were presented as unwritten rules that were ongoing or emerging traditions, beliefs, lifestyle, and social expectations to which people subscribe or view as normal and which influence choices and behavior. Within the full findings from the study, the most varied respones between groups related to cultural norms. The norms which were consistent between all groups were use of illegal drugs, gambling, partner abandonment or infidelity, and gender norms and inequality. Heterosexual men engaging in sex with gay men to earn money was also described by both facilitator groups. However, many communities appeared to have unique values and practices, with one school-based community particularly struggling with parents not valuing education whilst encouraging engagement with foreign men. In this community, online sexual exploitation was also normalized. Health center-based facilitators shared that stigma and myths related to sexual and reproductive health education and use of modern contraception was common whilst teenage pregnancy was normalized and considered acceptable.

The characteristics and dynamics within the adolescents' households were also thought to be problematic. Poverty was seen as a significant issue which led to inadequate parental supervision because both parents needed to work. However, even outside the influence of poverty, poor parenting and family breakdown or dysfunction was viewed as a precursor to many adolescent issues. Society-level institutions, systems or services within the community to support adolescent girls were commonly described as being minimal and ineffective. This was particularly true of SRH programs for adolescent girls which were either completely absent or very limited in scope.

THEME 2: ADOLESCENT GIRLS ENGAGE IN RISKY BEHAVIORS

Research participants believed that the attitudes of adolescents and the activities they were involved with had the potential to cause negative outcomes. The risky behaviors were described as being related to the attitudes of adolescents, unsupervised peer activities, technology misuse, and substance misuse. The risky behavior most commonly mentioned by all groups was substance misuse, including alcohol, drugs, and cigarettes.

The attitudes of adolescents were described as a way of thinking and feeling which influenced the decision making and actions of adolescent girls. A common sentiment among research participants was that adolescents can be disrespectful and disobedient to authority figures, curious, easily influenced by peers and experience low self-esteem which make them vulnerable to behaving in a risky way.

Unsupervised peer activities were described as activities undertaken by adolescent girls with peers and without parental supervision. Activities repeatedly mentioned cutting class or absenteeism, going out, becoming involved in gangs or fraternities, and forming romantic relationships at an early age. Misuse of technology was thought to be increasing with excessive and problematic use of computers, cellphones, internet, and social media that had affected the values and choices of adolescent girls. Whilst the adolescent participants primarily focused on excessive use of cell phones or computers for social media and forming relationships quickly, program facilitators expressed far greater concern about more serious issues including sharing self-harming and sexualized images, non-consensual sharing of images, cybersex, and meeting strangers online, including foreign men.

THEME 3: THE HEALTH AND WELLBEING OF ADOLESCENT GIRLS IS NEGATIVELY AFFECTED

All groups of research participants expressed significant concern for the health and wellbeing of the adolescent girls in their communities. These concerns were described as being related to their sexual and reproductive health and the experience of abuse and exploitation.

Much of the concern regarding the sexual and reproductive health of adolescents centered on the issue of teenage pregnancy. Teenage pregnancies in the Philippines were observed to be increasing and happening at earlier ages, with most pregnancies thought to be unintended. Teenage pregnancies were believed to be caused by increasing sexual activity among adolescents, who are entering romantic relationships and sexually initiating at a younger age but lacked the knowledge and preparation to be able to protect themselves against pregnancy and sexually transmitted infections. Misinformation and myths about effective use of family planning and treatment of STIs were frequently mentioned.

Many stories regarding the abuse and exploitation of adolescent girls were shared, being described as any act of maltreatment perpetrated by adults to minors that violated their rights as children or under the law. All groups of program facilitators described adolescent girls experiencing commercial sexual exploitation of children (CSEC), sex trafficking, and physical and sexual abuse in their communities. Commercial sexual exploitation (CSE) was most commonly described by facilitators, where the adolescents, with or without a pimp, sold sexual services to men. Only one adolescent participant shared a story of abuse or exploitation during the FGDs. Although many of the adolescents shared stories with the facilitators during the course of 'A Healthy Me', they were largely silent about their experiences and those of other adolescent girls in their communities during the FGDs, despite many of them living in areas which are widely known to be hotspots for these issues.

THEME 4: THERE ARE SECONDARY EFFECTS OF ADOLESCENT ISSUES

The issues outlined in the first three themes were thought by the research participants to lead to other short and long-term negative effects. These were described as affecting the adolescents' social, physical, and psychological health. Whilst all groups of adolescent participants and program facilitators expressed being troubled by these secondary effects, the health center-based program facilitators felt a particular burden because they provided antenatal, obstetric, and infant healthcare to the teenage mothers.

The social conditions of the adolescent participants often worsened because of the issues affecting them, especially teenage pregnancy, with the most common secondary effect mentioned being a wasted education. Teenage mothers struggled not only with being unable to return to school but also to secure decent employment, leading to deeper poverty. It was also observed that early marriage and poor parenting were common consequences of teenage pregnancy, with grandparents and community health staff having to carry the additional burden of addressing the adolescent's lack of parenting skills.

Risky behavior and sexual and reproductive health issues were also described as impacting the physical health of adolescent girls. Whilst some of the teenagers focused on relatively minor issues such as lack of sleep, facilitators from the health centers described more serious complications resulting from illegal abortions and high-risk pregnancies such as post-partum complications and newborn deaths.

The psychological wellbeing of both the adolescent experiencing the issues, and those tackling them, was also negatively affected. The adolescent participants mentioned a loss of self-confidence because of the issues they faced. Meanwhile, program facilitators felt sad, blamed, and anxious because of the rise of sexual and reproductive health issues among teenagers, especially those providing healthcare to teenage mothers. However, all facilitator groups felt that they carried an emotional burden of acting in the role of 'second parents' for troubled adolescents.

FINDING: EXPERIENCES DURING AND AFTER 'A HEALTHY ME'

'A Healthy Me' was experienced as being beneficial with relationships strengthened because of program participation. Moreover, the program was reported to have salient educational methods which enhanced its effectiveness, whilst there still being some challenges experienced with program implementation.

THEME 5: 'A HEALTHY ME' WAS A BENEFICIAL EXPERIENCE

Both adolescent participants and program facilitators described how they benefited from participation in 'A Healthy Me'. The experience was perceived to prevent or mitigate many of the issues identified in earlier themes. The beneficial experience was described first in terms of the sessions involving a 'positive affect', with words such as fun, relevant, thankful, happy, and positive used by both the adolescents and facilitators to describe their overall experience.

Research participants also described that they experienced knowledge gains, changed attitudes, skills acquisition and behavior change as a result of program participation. It was noted that program facilitators presented not just their personal experiences, but also the experiences of adolescent participants and parents.

Common knowledge gains described by both adolescent participants and program facilitators related generally to sexual and reproductive health and, more specifically, to menstruation, feminine hygiene, modern contraception, and safer sex.

Research participants also described changes in their attitudes, values, and perceptions. Although varying attitudes were thought to have changed, all research groups observed an increase in adolescents' self-worth and self-confidence and their ability to make better choices because of the ability to distinguish 'right from wrong' and to anticipate the consequences of their actions. The attitude changes most commonly described by the adolescent groups were valuing 'what is right', valuing sex, being more self-accepting, and having higher self-worth or self-esteem. School-based facilitators highlighted that the adolescents started valuing their bodies more compared with the health-center based facilitators who described changing aspirations, particularly among out-of-school youth.

Both adolescent participants and program facilitators described that skills and healthy behaviors were acquired or strengthened because of participation in 'A Healthy Me'. Many of these were applied after the program ended. The ability to make better health choices was described as making decisions and choices that would benefit the overall health of the adolescents. This included actions such as choosing to eat healthier food, drinking alcoholic beverages in moderation, reducing cell phone or social media use, taking action to avoid risks, and practicing good self-care. Better SRH choices and behaviors included using contraceptives and improved menstrual and feminine hygiene.

The ability to refuse unhealthy invitations or activities and manage their emotions or mental health were also described as being acquired by the adolescent participants. Program facilitators, on the other hand, highlighted that the program developed or enhanced their education and facilitation skills especially related to managing and communicating with adolescent girls.

THEME 6: 'A HEALTHY ME' PARTICIPATION STRENGTHENS RELATIONSHIPS

Facilitator and adolescent groups described how 'A Healthy Me' enabled them to form stronger relationships including between the facilitators and adolescents, amongst the adolescents, and even with adolescents outside the program, including family members. The strengthened relationships were characterized by research participants as involving changed perceptions and stronger connections.

Changed perceptions described how personal perceptions, stereotypes, or initial impressions that the adolescents and facilitators held towards the other were challenged and changed because of program participation. As the sessions progressed, they became more understanding, accepting, and open toward each other. The adolescent participants described the changes on a more superficial level, experiencing the facilitators helpful, friendly, humorous, concerned for them, and competent. On the other hand, all program facilitators described how their existing stereotypes and prejudices about adolescents changed throughout the program. Because of their interactions during the sessions, they were able to see the adolescent through a different lens and gained a greater understanding of adolescent girls in terms of their experiences, behaviors, and outlook in life. As a result, they became more open and motivated their work with them, and for the health professions, more willing to provide SRH education and services.

The adolescent participants and program facilitators also described forming stronger connections during the program which were often sustained after the program. It was evident that adolescent participants and program facilitators were able to build relationships between each other. Likewise, adolescent participants had created bonds with their fellow participants. The connections that flourished during sessions enabled adolescent participants to feel more comfortable and open toward their program facilitators and continued to approach them for both health care and personal advice after the program. Likewise, the program facilitators felt better able to relate with adolescents in general and continued to apply these skills, both to their students or patients and to their own children.

THEME 7: THE IMPLEMENTATION METHODS USED WERE SALIENT

It was highlighted by the adolescent participants and program facilitators that 'A Healthy Me' possessed salient or important methods that were remarkable to them. The salient methods highlighted were related to the educational tools used and dynamics created during both the adolescent and parenting sessions.

The educational tools used in 'A Healthy Me' were reported by the majority of the adolescent participants and program facilitators to be relevant and effective. Group discussions and sharing were viewed as being important to reinforce knowledge and create two-way learning, where adolescents not only learnt from each other but facilitators also learnt from the adolescents' experiences. Role plays were important for skill development. It was also reported that they broke down barriers to participation and learning. Other activities which were viewed as both fun and educational were the group composition and performance of songs or poems.

Dynamics were described as the interactions and engagement created between participants, including both adolescent girls and their parents, and the program facilitators during the sessions. Apart from two-way learning, the research participants, in particular the program faciliators, viewed the program as an opportunity to address the issues. In addition, 'A Healthy Me's' educational methodology was described as an innovative platform to better guide their participants towards healthier behaviors by correcting the misconceptions, misinformation, or their unhealthy practices, and imparting some values.

THEME 8: IMPLEMENTATION CHALLENGES WERE EXPERIENCED

Although 'A Healthy Me' was considered to be a positive and beneficial experience, the program facilitators experienced challenges with some elements of implementation. These challenges were related to the attitudes of adolescent participants and program facilitators, and because of program logistics. Most challenges were shared by facilitators rather than by the adolescent participants.

The attitudes of some adolescent participants and program facilitators toward the program were often challenging at the start of the program. However, these issues are typically resolved throughout the program. Some adolescents and facilitators initially felt shy or anxious participating in group discussions and were uncomfortable with some of the more sensitive sexual and reproductive health-related content. Facilitators also expressed initial concern about how they would juggle the additional workload related to 'A Healthy Me' and whether their facilitation skills would be adequate.

The logistic challenges related to identifying appropriate adolescents to invite and ensuring good attendance and punctuality of the adolescents. The facilitators also struggled to manage their time and workload because of the additional responsibilities related to implementing 'A Healthy Me'. Interpersonal conflict and differences between older midwives and younger nurses within the health center-setting were also experienced as challenges.

FINDING: RECOMMENDATIONS FOR 'A HEALTHY ME'

Following the identification of challenges with program implementation, recommendations were provided to address these and to enhance the impact and reach of the program.

THEME 9: THERE ARE OPPORTUNITIES FOR PROGRAM ENHANCEMENT

Ongoing program improvements are integral to strengthing the methodology and further enhancing program effectiveness. To address the implementation challenges, adolescent participants and program facilitators discussed changes to the content or materials and the implementation process. In comparison with the latter topic, relatively few suggestions were made regarding the content and materials, with the majority of research participants agreeing that the topics covered were appropriate and 'complete', and that the educational methodology employed was effective.

Suggestions regarding the implementation process included widening the promotion of 'A Healthy Me' and strengthening the means of inviting adolescents, whilst ensuring that those who were selected to participate were both eager to learn and had available time. It was thought that facilitator selection could also be improved. The ideal facilitator was described as being motivated, passionate about the wellbeing of adolescents, able to view the program as an important opportunity rather than as a burden, with adequate facilitation skills, and believing in the effectiveness of the program.

Recommendations were made about ensuring the timing of the program was the most suitable for both facilitators and participants. This was to ensure minimal conflict with regular programs or activities. However, it was also felt there was benefit in extending the actual sessions from 1 ½ to 2 hours if needed.

Both the adolescents and facilitators acknowledged the importance of maximizing the attendance of parents at the parenting session due to their critical role in the lives of their children. Facilitators suggested including material incentives for parents who joined to encourage attendance.

THEME 10: SCALING UP 'A HEALTHY ME' IS RECOMMENDED

The adolescent participants and program facilitators strongly recommended scaling up 'A Healthy Me' to reach more adolescent girls through both widening program coverage and sustaining implementation of the program.

Widening the program coverage involved broadening of the target population to include younger participants aged 12 to 13 years to better prepare them for the changes and challenges of adolescence. It was also recommended that adolescent boys be involved to address their perceptions and values toward women and to improve the health choices they make. Focusing more on implementing through schools was also identified as a key strategy to help widen program

coverage, including in elementary schools and private schools. However, the importance of ongoing implementation within the community, particularly through the purok-based model (household clusters) was also recognized in order to continue to reach higher risk out-of-school youth.

Research participants suggested many specific strategies to help sustain 'A Healthy Me' within their schools and communities. This included providing ongoing follow up and support to former 'A Healthy Me' graduates and including them in future programs. Strengthening local government partnerships to obtain assistance with program funding and implementation was also frequently suggested. Finally, institutionalizing the program through various government agencies was also strongly recommended, which suggested involving local, municipal, and national-level institutionalization, including through agencies such as through the Department of Health or Department of Social Welfare and Development.

DISCUSSION

'A Healthy Me' was developed to provide Filipina adolescents with greater access to comprehensive SRH health education to help protect them against the serious SRH issues affecting them. This research was undertaken to demonstrate program effectiveness, understand the elements of the program which were important in achieving this effect, and identify further opportunities for program enhancement. Overall, the findings reinforce much of the existing research about the nature of the issues affecting adolescent girls globally and in the Philippines, and the elements of effective programs. The research adds a richer understanding of the importance of the facilitator-adolescent relationship and breaking down barriers that impair access to comprehensive SRH education and government health services for adolescent girls.

PROBLEM DESCRIPTION

The research findings are consistent with existing data about the common issues affecting adolescent girls in the Philippines. Given the long-standing, widespread, and highly visible nature of teenage pregnancies, it is not surprising that much of the concern focused on this. The problems of commercial sexual exploitation, including online sexual exploitation, were also recognized as being significant as reflected in the relevant literature (NSO & ILO, 2011, p. vxii; Terres de Hommes, 2013, p. 5; UNICEF, 2016, p. 6). However, an emerging concern was the increasing commercial sexual exploitation of adolescent boys, particularly with the MSM population amongst whom HIV/AIDS has been rapidly escalating in the Philippines (DOH HIV/AIDS & Art Registry Philippines, 2019). In east and southeast Asian regions, data show that prostitution of boys is occurring but it is largely undocumented due to the stigma about homosexuality (Melgar et al., 2018; ECPAT, 2016). However, it is known that young males involved transactional same-sex relationships are at higher risk of experiencing violence (Tan, 2001; Hernandez & Imperial, 2009; Holmes, 2015).

The complex social determinants from which these problems arose were recognized in the findings, similar to that described by Chandra-Mouli et al. (2015) as a "complex web of interrelated factors that operate at different levels". These are also consistent with literature from the Philippines (Melgar et al., 2018; UNICEF, 2016, p12) and this research where conservative beliefs and myths about SRH, poverty, family breakdown and dysfunction, lack of access to comprehensive SRH services and education have been identified as determinants together with the normal adolescent behaviors of curiosity, risk taking, and peer influence. A further influence strongly expressed in one research location was the cultural norm of adolescent girls being encouraged to seek relationships with foreign men. Local research confirms that a desire to improve their economic situation is common reason behind this behavior (Sassler & Joyner, 2011) along with a 'colonial mentality' that people with white ancestry have more favorable physical characteristics (Nadal 2004; Gaston, 2003; Revilla, 1997; Root, 1997b). These longstanding influences appear to be converging with more recent societal

factors such as the increasing sexual activity of young people and access to cheap devices and technology, to drive the issues of commercial sexual exploitation and the online sexual exploitation of children (OSEC).

EVALUATION OF PROGRAM EXPERIENCES

The research documented the experiences of program facilitators and adolescent participants during and after 'A Healthy Me'. These findings are useful in evaluating whether the program has been successful in achieving the program's goals. 'A Healthy Me' has four program goals which are to:

1. Provide comprehensive health education, including SRH education
2. Develop supportive relationships between the adolescent participants and key adults, including parents, teachers, and community health staff
3. Create greater access to youth-friendly government health services
4. Enhance parent-child communication about SRH issues to support their children to make healthier choices and to protect them against abuse and sexual exploitation

PROVIDING COMPREHENSIVE HEALTH EDUCATION

The effect of 'A Healthy Me' in providing comprehensive SRH education is consistent with international research about the benefits of comprehensive SRH and characteristics of effective programs. These characteristics included the participatory, activity and discussion-based learning orchestrated through a unique 'learning journal which international research demonstrates lead to better learning outcomes (UNESCOa 2018, p. 12; Pound et al., 2016; Lopez et al. in UNESCOb, 2018, p. 19; UNESCOb, 2018, p. 95).

The learning environment which was greater was reported to have led to significant knowledge gains, positive attitude and identity formation, and skill acquisition. Knowledge gains included not only those related to SRH but also to broader issues such as emotions, social media, and body image. However, knowledge alone is considered to be a relatively weak determinant of health choices (Kirby et al., 2011), and thus effective programs must strengthen protective factors such as relevant attitudes, self-confidence, agency, strong communication skills, and personal aspirations (Chandra-Mouli et al., 2015; Pound et al., 2016). These changes were also observed among 'A Healthy Me' participants, in particular improvements in their self-worth and self-confidence, how they appreciate their bodies and sex, their values about what is 'right and wrong' and, among out-of-school youth, their aspirations. Health-related skills which were observed to have been strengthened included moderating alcohol and social media use, risk avoidance, refusal skills, emotional regulation, and the ability to manage contraceptive use.

CREATING SUPPORTIVE RELATIONSHIPS WITH KEY ADULTS

It was well established in the findings that meaningful connections were created by those participating in the program, both between the adolescent participants and between the facilitators and adolescents. The interactive, discussion-based educational methodology enabled the facilitators and adolescents to share their ideas and experiences which led to a greater understanding, acceptance, and openness towards each other. The development of these safe, supportive adult relationships appeared to be a key factor in whether the adolescents chose to disclose their experiences of abuse and exploitation.

The need for facilitators to be competent and motivated (Kontula, 2010) and to create an environment where adolescents feel safe and comfortable participating (Pound et al., 2017; Pound et al., 2016, p. 4) in comprehensive SRH programs has been recognized. However, the importance of creating strong, meaningful connections between facilitators and adolescents from vulnerable households where the parents or guardians may be neglectful or disengaged, as described in the findings, has not been strongly emphasized as influencing the effect of the program. The depth of these relationships appears to go well beyond what is described under the term "youth-friendly" by the World Health Organization (2012, p. 7) where services should be are accessible, acceptable, equitable, appropriate, and effective for young people. It instead recognizes that children and young people need at least one supportive, nurturing adult relationship to be successful (Cohen, 2017; Singer et al., 2013; Scales & Leffert, 1999) and our findings suggest that these relationships can be formed through 'A Healthy Me'.

This finding supports the need to move beyond the one-off or limited training models for adults working with adolescents and potentially engaging with them about their SRH, to including more experiential and two-way learning methodologies. This will inevitably involve more time, effort, and challenges with schedules, but will produce a greater impact in the capacity of the facilitators and hence the lives of both the adolescents they work with.

IMPROVING ACCESS TO YOUTH-FRIENDLY HEALTH SERVICES

The barriers experienced by Filipino adolescents in accessing comprehensive SRH education and health services were described in findings as including community and parental values and stigma, the attitudes of health service providers, and the perceptions of adolescents held about the health staff and services. Overcoming these barriers thus requires more than ensuring services are affordable, friendly and welcoming, and that adolescents are knowledgeable of the services and how to use them suggested in relevant guidelines and research (ICRW, 2014, p. 8a; Chandra-Mouli et al., 2015).

Both the quantitative and qualitative research investigating 'A Healthy Me' confirms that the program helps reduce the barriers experienced by adolescents and program facilitators. The research confirms that this result was not merely achieved by providing comprehensive health education, but by providing a context where the facilitators' and adolescents' negative perceptions and stereotypes about not only SRH education and services but also about each other could be challenged and changed. The connections that were thus formed and, in many cases, sustained after the end of the program were a key in helping the adolescent continue to access health advice and care.

ENHANCING PARENT-CHILD COMMUNICATION ABOUT SRH

Parent-child communication (PCC) has a significant long-term impact on the health and wellbeing of their children (Haberland, 2015; Kirby et al., 2011). Research confirms PCC influences a range of health and life outcomes among children, including SRH outcomes such as unintended pregnancy and STIs. (Lezin et al., 2004). Research suggests that the impact of PCC depends greatly on factors such as the characteristics of parents, the quality of the relationship with their children, and their communication style (Kirby et al., 2011). Within the Philippines, poor knowledge about SRH, feelings of discomfort and anxiety about SRH topics, the family's conservatism, and a lack of closeness in the parent-child relationship were drivers of poor PCC (Arguilla and Habitan, 2014).

The experiences and responses of the parents are described indirectly by the program facilitators and supported through observational data collected by the research assistants and the results of a small pilot conducted during development of the parents' session (see Appendix E). These findings suggest that parents gain awareness, knowledge, confidence, and skills which may help improve the quality and content of their communication with their children about SRH. Research involving multiple programs aimed at enhancing PCC about SRH have demonstrated a positive effect on at least one short-term outcome, including those which were also limited to a one-off, short session (Gavin et al., 2015).

However, despite the possible benefits of the session, the facilitators described difficulties in encouraging parents to attend, with only 36% being parents of the adolescent 'A Healthy Me' participants joining the session. The challenges were similar to those described in related research such as a lack of availability of the parents due to work or household responsibilities and the parents' skepticism about the benefits of the program (Jejeebhoy et al., 2014), including the misconception that SRH education promotes sexual activity (RHIYA, 2006).

RECOMMENDATIONS

The recommendations are aimed at addressing the gaps in the program implementation to strengthen the program's impact and ensure sustainability. Many of the recommendations from adolescent and facilitator research participants were consistent with relevant best-practice guidelines and research are explored below.

BROADEN THE PROFILE OF PARTICIPANTS INVITED

This recommendation involves broadening the participants involved the program to include adolescent girls aged 11 – 13 years, creating a program specifically for adolescent boys, and ensuring higher levels of attendance of parents in the existing parenting session. The research participants strongly believed that broadening attendance in this manner would have significant benefits for the adolescent girls. This is largely consistent with international research, save for the lack of research related to the issues affecting adolescent boys and effective programs for them.

SCALE 'A HEALTHY ME' & EXPAND THE PROGRAM'S REACH

It was strongly recommended to extend the reach and duration of the program. Specific suggestions included involving more schools, health centers, and community venues, together with maintaining programs with existing partners. This would also require sufficent attention is paid to facilicator training and program monitoring and evaluation to ensure that adequate quality and fidelity of implementation is maintained (Chandra-Mouli et al., 2015). Given some of the challenges of implementing fully within a health-center, it appears most feasible to scale predominately within government high schools with the purok-based model could be used predominately during summer vacation and the health-center only model used to reach out-of-school youth.

Expanding the duration of the program is consistent with high quality research confirming the 'dosage' is important in maximizing the impact of the program, including both intensity and duration (Chandra-Mouli et al., 2015). Strategies to address this recommendation could include growing 'A Healthy Me's' online community, progressive curriculums over several school years, and after school peer-led support groups.

IMPROVE TRAINING FOR FACILITATORS

It is well established in existing research that facilitator attitudes and skills affect program outcomes (Kontula, 2010, Denno et al., 2015). This research also found that establishment of strong relationships was critical in achieving the program goals. Thus, ensuring that the facilitators are highly engaged and equipped is even more important. As facilitators are typically selected by the partnering organizations, more guidance could be provided to them about whom to select based on characteristics described in other research which includes the confidence, competence, and attitude of the facilitators (Pound et al., 2016). However, for the health-center model, it is often necessary for most nurses and midwives within a city or municipality to be involved, and even within the high schools, few of the teachers are available to take on additional responsibilities. Thus, it is unlikely that facilicators can be selected according to very specific criteria.

The effectiveness of the pre-program training in empowering and equipping facilitators is therefore very critical. Currently faciliators participate in a half-day training activity prior to the program and receive site visitations and follow up calls with structured feedback during implementation. Although the training is limited and some facilicators express an initial lack of confidence in implementing 'A Healthy Me', most were able to achieve adequate implementation and fidelity to the educational methodology, acquiring the interpersonal and communication skills needed to make meaningful connections with the adolescent participants. This reflects a 'learning by doing' or experiential learning approach and, interestingly, the most powerful 'teachers' for the facilitators appear to be the adolescents themselves. More training would be helpful in improving the facilicators' initial confidence and enthusiasm toward the program. It could also better equip them with basic debriefing skills to manage adolescent participants who disclose abuse, and to help resolve scheduling issues and conflict with co-facilitators. Because there is limited time to conduct training, a solution is to make further, optional online training modules available where facilicators can select short electives which addresss their self-identified training needs.

ADDRESS ONGOING KNOWLEDGE GAPS

Many knowledge gaps remain regarding effective adolescent SRH programs, particularly in the Philippines. This includes the SRH-related attitudes and behaviors of adolescent boys and programs designed to improve these, effective parent-child communication training, and the long-term effects of 'A Healthy Me', ideally including biological outcomes such as unintended pregnancy.

CONCLUSION

This qualitative study involving facilitators and adolescents participating in 'A Healthy Me' adds to both local and international research regarding effective approaches. It supports the significant body of research which demonstrates that effective SRH programs are comprehensive, participatory and activity-based, learner-centered education and are implemented in a safe, supportive environment by competent facilitators. However, the research also adds insights about the importance of experiential, two-way learning involving both program facilitators and adolescent participants to break down unhelpful stereotypes and relationional barriers between these groups. Removing these barriers enables mutual trust, openness, greater learning, and improved access to both health care services and safe, nurturing adults for the adolescents, the latter being particularly important given adolescents were often described as lacking these relationships with the caregivers at home.

Whilst implementation challenges were experienced, particularly with the increased workload and scheduling around regular activities, much of this is unavoidable as effective programs must be comprehensive and of higher dose and duration for adolescents to gain the holistic knowledge, attitudes, and skills for a sustained impact. Given that most adolescent SRH programs experienced by program partners prior to 'A Healthy Me' have been of limited scope and duration, embracing an alternative approach will take a change in mindset. However, the findings reveal that experiencing a different approach like 'A Healthy Me' can help program partners and facilitators make this transition.

The research also adds to the understanding of the significant threats to the health and wellbeing of both adolescent girls and boys in the Philippines and the complex determinants of these. This points not only to be need to reach more girls and boys with comprehensive SRH education and to capacitate the various adults in their lives to provide the support this need, but to also to the importance of multi-faceted and multi-sectoral approaches which penetrate deep into communities and households.

Adolescence is a time of rapid socio-emotional development and brain neuroplasticity, and thus represents a critical window where effective, evidence-based interventions can significantly alter long-term health and life outcomes. This will require significant effort, allocation of resources, and reorganization of existing responsibilities and responses in the Philippines. When compared against the significant vulnerabilities experienced by adolescent girls and the current adverse outcomes they suffer in increasing numbers, that these efforts would not be made is unthinkable.

1. INTRODUCTION

1.1 BACKGROUND AND RATIONALE

There is growing recognition of the importance of adolescent health and wellbeing. In response to this growing concern, the Philippine government has introduced several legislative measures since 2016 to address the lack of SRH knowledge and access to SRH services among adolescents including House Bill No. 4231 or "An Act incorporating lessons on teenage pregnancy prevention and population education in the curriculum of basic education in the Philippines", and "Sangguniang Kabataan (SK) Reform Act of 2015" which pushed for the committee building and budget allocation on programs and projects for adolescent SRH (DOH & Commission on Population, 2017, pp. 48-49).

The Philippine Department of Health (DOH) also had responded to these emerging issues and had ensured access to quality health care and services in an adolescent-friendly environment through directives such as the Republic Act 354 (also known as the Responsible Parenthood and Reproductive Health Act of 2012), the DOH Administrative Order 2013-0013 on the National Policy and Strategic Framework on Adolescent Health and Development, and other policies. Thus, in April 2000, the Adolescent and Youth Health Sub-program under the Children's Health Cluster of the Family Health Office was created by DOH (DOH, 2017, p. 2).

However, despite these advances in reproductive health law and other legislative efforts, there has been no meaningful improvement in related outcomes among adolescents and, in some areas, a worsening situation. Whilst existing research highlights the underlying determinants of many of these issues in the Philippines, there is currently a lack of published research evaluating programs designed to address them.

'A Healthy Me' is a holistic health and wellbeing educational program which is culturally sensitive and contextualized to the full range of health needs of adolescent girls in the Philippines. Since its initial pilot programs were completed in 2016, pre and post surveys have demonstrated significant knowledge gains related to SRH among the adolescent participants. More recent program research via a pre and post program survey was conducted to evaluate the effect of 'A Healthy Me'. Matched data was collected from 326 adolescent participants and 31 program facilitators across five program cities and municipalities in the province of Cebu, Philippines, including from schools, health centers, and other community locations. The results demonstrated statistically significant SRH-related knowledge gains of 56% by the adolescent participants. Small, but statistically significant, improvement in the two attitude scales for adolescents was also demonstrated. The first scale

showed improvements in how the adolescents perceived community health professionals and the second demonstrated a greater awareness of their rights to SRH education and services and confidence in accessing these. The facilitator scales for nurses and midwives demonstrated a greater openness towards adolescents and engaging with them. A second scale regarding their willingness to provide SRH education and services showed a small, non-significant improvement, although specific questions were significant including "I am okay with providing contraceptives to young people" ($z = 2.104$, $p = 0.035$) and "Adolescents should be given contraceptive counselling before they even become sexually active" ($z = 2.119$, $p = 0.034$). A detailed description of quantitative research is available in Appendix A.

Whilst these results demonstrate a positive effect from AHM participation, they provide only a limited understanding of AHM's influence on attitudes and behavior. It was further recognized that there is a lack of research regarding adolescent SRH education in the Philippines and the characteristics of effective programs.

1.2 RESERCH GOALS & OBJECTIVES

To address these knowledge gaps, a team from Renewsiya Foundation Inc., Consuelo Zobel Alger Foundation, and several academic institutions conducted qualitative research via focus group discussions and key informant interviews. The research explores the following questions:

1. How do the adolescent participants and program facilitators understand the issues affecting adolescent girls in their communities? What is their perspective on how the community addresses these issues? How are adolescent girls affected by these issues?
2. How do the adolescent participants and program facilitators make sense of their experience in the 'A Healthy Me' program?
3. What enhancements do the adolescent participants and program facilitators suggest? How do they see the program being further used in the community?

It is through exploring the experiences of program facilitators and adolescent participants that the program's subsequent influence on attitudes and behavior will be better understood and opportunities for program enhancement also identified.

2. PROBLEM DEFINITION

2.1 PREVALENCE

Adolescent girls around the world face a range of threats to both their overall health and wellbeing and, more specifically, to their sexual and reproductive health, being disproportionately affected by unintended pregnancies and sexually transmitted infections (Haberland, 2015). They are considered a highly vulnerable and neglected population whose needs have only recently been recognized as distinct from women and children in the Sustainable Development Goals (UNFPA, 2019, pp. 8 & 12). The Philippines has a young population with an estimated 10 million females between the ages of 15 - 24 (PSA, 2019). There are currently many inter-related issues which are harming the health and wellbeing of Filipina adolescents, including teenage pregnancy, sexually transmitted infections such as HIV, and commercial sexual exploitation, including the emerging threat of online sexual exploitation.

The Philippines has high rates of teenage pregnancy, with 9% of teenagers aged 15-19 years having begun childbearing and 36% of teenagers pregnant by the age of 19 (DRDF, 2014, p.14; PSA & ICF, 2018, p. 61). This is significantly higher than most other countries in the region, with no meaningful improvement over the past 25 years (Maravilla et al., 2018). Of particular concern is the rising rates of teenage pregnancy among 10 to 14 year old girls, which increased by 63% between 2011 and 2018 (POPCOM, 2020).

New HIV/AIDs infections have been increasing exponentially over the past 10 years, with the Philippines having the highest HIV growth rates in the Asia-Pacific (UNAIDS, 2018, p. 2). The proportion of new infections among adolescents is also increasing with young people aged between 15-24 years now accounting for approximately 30% of new cases (DOH, 2019). Although most infections are occurring among men-who-have sex-with-men (MSM), infections among young women continue to rise, with male-female sex the most common mode of HIV transmission in this population (DOH, 2019). There is limited data about the prevalence of other STIs in the Philippines, including herpes, gonorrhea, and chlamydia, due to a lack of awareness and access to affordable diagnostic tests. However, the experience of specialists suggests that infections are increasing (Vista, 2018).

Recent national data reveals that approximately 80% of children and youth have experienced a form of violence in their lifetime, with 25% of children below the age of 18 having experienced sexual violence, often by a household member (UNICEF 2017, p.10; CWC & UNICEF, 2016, p. 5). Many young women also experience intimate partner violence (IPV). Between the ages of 20-24 years, 20% have experienced physical IPV and 6% have experienced sexual IPV since the age of 15 (PSA & ICF, 2014, pp.190-1). Filipino youth are also increasingly exposed to forms of cyber-violence or

other potential harm including sexually-explicit content, online pornography, cybersex, and sexting (UNICEF Philippines, 2016; DRDF, 2014, p. 9; UNICEF, 2016, p. 4).

Finally, the Philippines has historically been a regional center for sex-tourism. There is an estimated 500,000 to 800,000 men, women, and children working in the sex industry at any time, of which 100,000 are estimated to be children (PCW, 2013). One pilot study estimated that 2% of children aged between 5–17 years were victims of child sexual exploitation in Cebu City, which is a 'hot spot' for child prostitution and sex tourism (NSO & ILO, 2011, p. vxii; Terres de Hommes, 2013, p. 5). The Philippines is also considered an epicenter for OSEC and is one of the top ten countries for producing child pornographic material globally (UNICEF, 2016, p. 6). In 2017 alone, the Philippines received a total of 45,645 referrals or tips of possible OCSE with a growing number of live-streaming criminal cases (Recuenco, 2019; Homes, 2016). Two in 10 Filipino children are considered vulnerable to becoming victims of child online sexual exploitation and abuse (Philippine Kids Online Survey, 2018).

2.2 DETERMINANTS

Adolescent SRH outcomes are recognized as being influenced by a "complex web of interrelated factors that operate at different levels" (Chandra-Mouli et al., 2015). This holds true in the Philippine context with rapidly changing patterns of sexual activity, existing sociocultural norms, and a lack of evidence-based programs identified as the key determinants of the poor SRH outcomes among adolescent girls.

2.2.1 CHANGING PATTERNS OF SEXUAL ACTIVITY AMONG YOUNG PEOPLE

Profound changes in the sexual behavior of Filipino adolescents are being observed, including earlier sexual initiation and increasing pre-marital sexual experiences, with much of these increases being among young females especially from lower socioeconomic backgrounds (DRDF, 2014, p. 12; PSA & ICF, 2014, p.152). The majority of adolescents' first sexual encounters are unprotected, with only 12.9% using condoms (DRDF, 2014, p.12). Among sexually active young women aged 15-24 years, condom usage is low with only 0.7% and only 22% using any form of modern contraception (PSA & ICP, 2018, p. 90). Furthermore, there is a high unmet need for family planning among sexually active, unmarried women of 49% (PSA & ICP, 2018, p. 86).

2.2.2 SOCIOCULTURAL NORMS

Sociocultural and religious beliefs in the Philippines significantly influence attitudes toward sexuality and reproductive health, SRH education, access to health services, and the use of modern contraception (Marquez et al., 2017; UNICEF, 2016, p. 19; Terres de Hommes, 2013 p. 18). These norms can also influence the attitudes and behavior of health service providers and how SRH services

are perceived by adolescents. Although there is a lack of research from the Philippines, a systematic review of healthcare providers in developing countries found that unprofessional attitudes and lack of youth friendly reproductive health services were barriers for adolescents in accessing SRH services. (Chilinda et al., 2014).

Family breakdown and poor parenting are also considered key drivers of violence against children, including children involved in online exploitation (Terres de Hommes, 2013, p. 37). The Philippines is a leading exporter of labor which often results in the absence of the mother. This is identified as a key factor in violence against children, including sexual violence (UNICEF, 2016, p. 35). Parent-child communication about SRH also plays a significant role in promoting healthy behaviors among adolescents (AFY, 2009). However Filipino parents, whether present or absent, generally do not talk with their children about SRH. This is influenced by poor parental knowledge, discomfort or embarrassment about discussing SRH, cultural and religious beliefs, myths and fears about negative reactions or encouraging sexual activity, and generally poor or distant parent-child relationships (Arguilla & Habitan, 2014; Gumban et al., 2016).

Finally, the Philippines also has one of the lowest "age of consent" laws for sexual acts globally at 12 years of age (Cullen, 2015). This means that sex with a child over the age of 12 years may impose lower penalties (Fifteenth Congress of the Republic of the Philippines, 2010 p. 1).

2.2.3 LACK OF EVIDENCE-BASED PROGRAMS

There are many academic papers describing SRH-related knowledge, attitudes, practices, and needs of Filipino youth (de Irala et al., 2009; Gipson et al., 2014; Tanaka et al., 2017). Whilst program evaluations of limited scope exist (IntraHealth, 2005), there is a lack of rigorous, peer-reviewed research from the Philippines demonstrating positive outcomes from adolescent SRH educational programs. Research pertaining to SRH outcomes is largely focused on preventative programs for HIV/AIDS, usually in populations such as sex workers or higher-risk men (Restar et al., 2018).

Although there is a lack of local research, there is a significant body of international research across multiple contexts confirming the characteristics of effective programs. This research confirms that, to be effective, programs must provide comprehensive SRH education (see Section 5: Effective programs). Although Philippine government law and related policies generally support the SRH rights of adolescents and provide a strong mandate for comprehensive reproductive health education, in practice those that exist are typically limited in scope. Anecdotally, current community-based programs also use lecture-style, facilitator-directed educational methodologies which are also unlikely to be effective. High public profile events intended to raise awareness of emerging SRH issues, such as sex trafficking and online sexual exploitation, are also frequently conducted. However, research suggests these approaches have limited benefit (Chandra-Mouli et al., 2015; Kiss and Zimmerman, 2019).

It is therefore not surprising that limited access to comprehensive SRH education and services is identified as a major cause of teenage pregnancies in the Philippines (Salvador et al, 2016). In a recent national survey, only 27.4% of young respondents reported that they have adequate knowledge about sex, with females scoring lower (24%) than males (31%) (DRDF, 2014, p. 16). Furthermore, only 17% of Filipino youth reported having comprehensive knowledge about HIV and AIDS (DRDF, 2014, p. 16).

3. PROGRAM BACKGROUND

3.1 PROGRAM GOALS

To address the urgent need for evidence-based, comprehensive SRH programs for adolescent girls in the Philippines, Renewsiya Foundation Inc. began developing 'A Healthy Me' in 2014. To date, the program has been implemented across eight cities or municipalities within the province of Cebu, involving 88 venues, with 340 trained facilitators and over 1000 adolescent girls graduating from the program.

'A Healthy Me' was developed, evaluated, and updated over multiple iterations, incorporating the perspectives and feedback of both Filipina adolescents and the professionals or guardians engaged with them. Hence the program is culturally sensitive, being specifically tailored to the needs of Filipina adolescents aged between 14 – 24 years, particularly from lower socio-economic backgrounds.

'A Healthy Me' is a holistic health and wellbeing curriculum to support the development of knowledge, attitudes, values, life skills, and health behavior which will empower and equip Filipina adolescents to make positive health choices and avoid negative outcomes. Within the program, health is defined according to the Alma Ata declaration as 'complete physical, mental, and social wellbeing' and not merely 'the absence of disease and infirmity' and discussed as a basic human right (WHO, 1978). Within this framework, multiple elements of health are explored from simpler to complex elements, such as personal hygiene, nutrition, body image and gender norms, online safety, mental and emotional wellbeing, puberty and menstruation, healthy relationships, abuse and exploitation, contraception and family planning, safer sex, and risky behavior. Throughout the curriculum, integrated learning activities build the underlying core skills required to support healthy choices, such as self-awareness and critical reflection, self-confidence and self-esteem, strengthening of personal identity, values, and aspirations, and assertiveness and communication skills, including refusal skills. The program also aims to build a safe space and strengthen relationships with key adults (such as teachers and health professionals) to enable the adolescents to confidently share their experiences and perspectives and reach out for additional help if needed.

'A Healthy Me' has the following four program goals, which are to:

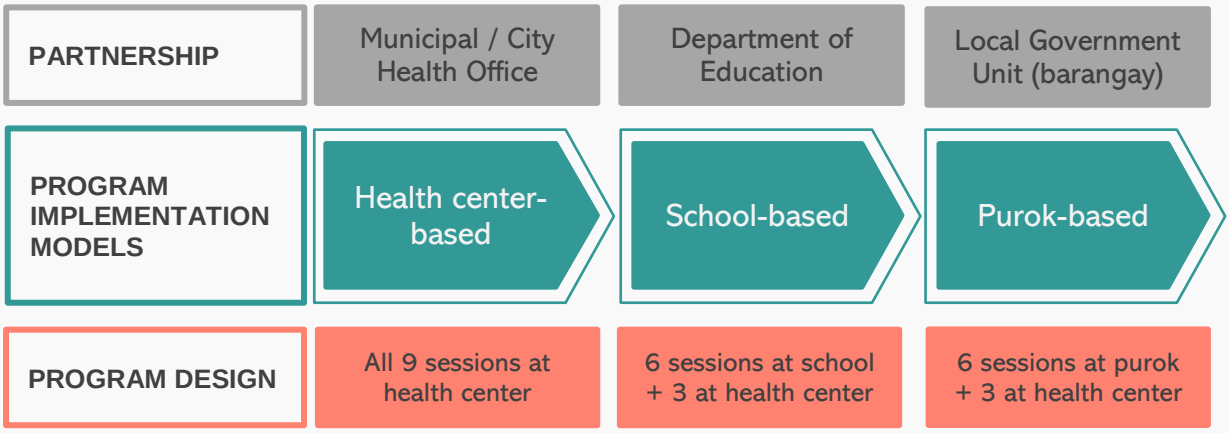
1. Provide comprehensive health education, including SRH education
2. Develop supportive relationships between the adolescent participants and key adults, including parents, teachers, and community health staff
3. Create greater access to youth-friendly government health services
4. Enhance parent-child communication about SRH issues to support their children to make healthier choices and to protect them against abuse and sexual exploitation

3.2 PROGRAM IMPLEMENTATION

'A Healthy Me' includes nine small group sessions for adolescents and a single session for parents to improve parent-child communication about SRH and child protection topics. It is facilitated by government stakeholders within their respective facilities under the guidance and supervision of Renewsiya Foundation's program officers. Most materials are provided by Renewsiya, with the government partners given the option of counterparting. Because it was designed for use within the government sector with government employees acting as facilitators, it is user-friendly and time-sparing compared with more traditional approaches. Program facilitators identify and invite up to 15 adolescent participants aged between 14 - 24 years per program based on guidelines given to them by Renewsiya (e.g. are willing and able to participate and have no conflicting responsibilities).

There are currently three implementation models as demonstrated in Figure 1. The first model (Model 1) is when all educational sessions are undertaken within the government community health center (called barangay health center) in partnership with their governing municipal health office (MHO). The further two models involve just three sessions being undertaken in the barangay health center with the remaining sessions being conducted with a national high school in partnership with the Department of Education (Model 2) or in household/purok clusters (Model 3) in partnership with Local Government Units (LGUs).

FIGURE 1. THE THREE PROGRAM MODELS OF 'A HEALTHY ME'



3.3 EDUCATIONAL METHODOLOGY

'A Healthy Me' uses participatory and progressive educational methodology employing a range of individual and group learning activities, such as journaling and self-reflection, values surveys, quizzes, group discussions, games, roles plays, and demonstrations. Each session is guided by a unique 'learning journal' given to each adolescent participant and facilitator. The journal enables what is termed 'flipped learning', which is a pedagogical approach where participants or students are given the learning material prior to the group session, with group time then used to review the content, share perspectives and experiences, adjust or deepen understanding of the content, and undertake skill development activities, such as role plays and demonstrations. Research shows that 'flipped learning' can improve general educational outcomes (Advance HE, 2018).

Using the 'learning journal' also helps to reduce the 'top-down', facilitator-focused dynamic of traditional educational approaches and create a more collaborative and shared-learning experience. It also aims to ensure adequate fidelity to the curriculum's content and methodology, given that each group member (participant and facilitator) has the same material which is reviewed step by step during each session. Furthermore, it helps reduce the possibility of sensitive or controversial content being avoided or re-messaged by facilitators.

4. LITERATURE REVIEW

4.1 OVERVIEW OF EFFECTIVE ADOLESCENT SRH PROGRAMS

The benefits of well-implemented, comprehensive SRH education are well established across a range of global settings. Alternatively known as comprehensive sexuality education (CSE), it is described as providing a full range of scientifically-accurate information together with skills and values in an age-appropriate, culturally relevant, realistic, and non-judgmental manner (UNESCOa, 2018, p. 6). The goal of comprehensive SRH is to ensure that "young people are receiving comprehensive, life skills-based sexuality education to gain the knowledge and skills to make conscious, healthy and respectful choices about relationships and sexuality" (UNESCO 2015, p. 7). High-quality evidence confirms that comprehensive SRH education is effective in achieving this goal and can improve outcomes such as the age of sexual initiation and safer sexual practices, as well as reduce rates of unintended pregnancies and sexually transmitted infections (UNESCO 2015, p. 14; UNESCOb 2018, p. 12.). Emerging evidence suggests the impact of comprehensive SRH education can also extend to broader issues such as gender-based violence and gender norms (UNESCOb, 2018, p. 29).

Unfortunately, not all SRH educational programs are effective despite an increasing body of evidence documenting the characteristics of effective SRH education. These characteristics relate to the content, delivery, and duration and dose of the programs.

4.2 CONTENT

It is well established that SRH education must be comprehensive to be effective. Programs which are comprehensive include scientifically-accurate content which addresses not only early or unintended pregnancy and sexually transmitted infections, but related topics such as healthy relationships, gender-based violence, and increasingly more recently emerging issues such as the internet and social media, and mental and emotional wellbeing (UNESCOb, 2018, pp. 12 & 14). Programs which are rights-based and address social and cultural gender norms and power relations are also known to be more effective (UNESCOb, 2018, p. 29; Haberland and Rogow, 2015). Comprehensive programs not only provide factual information about these SRH-related topics, but also build relevant attitudes and skills; strengthening protective factors, self-confidence, agency, communication skills, and personal aspirations (Chandra-Mouli et al., 2015; Pound, 2016).

Programs which address multiple risk-taking behaviors simultaneously are considered to be best practice and more efficient, given the common causative pathways and protective factors of many

SRH issues (Catalano et al., 2012; UNESCOb, 2018, p. 35). Thus, not surprisingly, emerging research suggests that these approaches can improve wider outcomes beyond those which are immediately health-related, such as gender-based violence, gender equity norms, and self-efficacy, and lead to stronger and healthier relationships (UNESCOb, 2018, p. 29; UNESCO, 2015, p. 14). In comparison, limited SRH programs, such as 'abstinence-only programs', have been shown to have little or no effect on SRH outcomes (Santelli et al., 2017).

When the opinion of youth is sought, they express wanting comprehensive SRH education which discusses more than human biology and the mechanics of sex, but also addresses the emotional and relational aspects of sex (Pound et al., 2016; UNESCO, 2015, p. 44). These global findings are consistent with research involving Filipino teenagers which found they were "requesting help to achieve a healthier lifestyle, and they are in fact more interested in character education encompassing affective aspects of sexuality rather than biological information" (de Irala et al., 2009).

4.3 DELIVERY

It is increasingly recognized that the delivery of comprehensive SRH education is just as important as the content. Several high-quality reviews have confirmed that participatory, activity-based, learner-centered methodologies enable a more holistic acquisition of knowledge, attitudes, values, and skills and are more effective than traditional, facilitator-directed approaches (UNESCOa 2018, p. 12; Lopez et al. in UNESCOb, 2018, p. 19; UNESCOb, 2018, p. 95). Furthermore, youth themselves report preferring group discussions and activity-based learning compared with more traditional approaches (Pound et al., 2016).

Programs must also occur in a context where adolescents feel safe and have their feelings acknowledged. Safety means that they feel comfortable participating in discussions, their confidentiality and privacy is protected, and the implementing site supports the overall intention of the program (Pound et al., 2017; Pound et al., 2016, p. 4). Safety is also created when it is acknowledged that sex is a sensitive and 'special' topic which can lead to feelings of discomfort and anxiety, together with an acceptance that many young people are already sexually active (Pound et al., 2016). The need for safety and confidentiality may explain why girls consistently report preferring girls-only educational programs, often feeling harassed or attacked by male students, which may pass unaddressed by teachers (Pound et al., 2016).

To overcome the significant barriers adolescents often experience in accessing affordable health care, evidence suggests they must be knowledgeable of the SRH services and how to use them (ICRW, 2014, p. 8a). Therefore, programs which are most impactful in increasing access to health services have at least a component which is delivered within a 'youth-friendly' health center (Chandra-Mouli et al., 2015; UNESCOb, 2018, p. 28). Implementing programs within the community, including the health center, is also important in being able to reach more marginalized, higher-risk youth, including

out-of-school youth (UNESCOa, 2018, p. 34; UNESCOb, 2018, p. 19). However, multiple studies show that, to improve access, it is also important to ensure the health staff within the facilities are friendly and nonjudgmental, and that the facilities are welcoming and appealing (Chandra-Mouli et al., 2015).

Finally, comprehensive programs need to be delivered as they were intended to be, with sufficient quality and fidelity. Ensuring that programs are implemented in a manner which maintains the original content and methodology increases the likelihood that the desired outcomes will be achieved (UNESCOa, 2018, p. 27; Chandra-Mouli et al., 2015). In school settings, ensuring teachers are motivated, comfortable, and competent enough with the content and do not avoid or minimize sensitive topics helps to achieve sufficient quality and fidelity to ensure a positive impact from the program (Kontula, 2010; UNESCOb, 2018, p. 18).

4.4 DURATION AND DOSE

Programs demonstrate greater impact when they are more intensive and are sustained over a longer period of time, preferably adapted to the development stage of the child or adolescent over multiple years (UNESCOa, 2015, p. 18; UNESCOb, 2018, p. 94). Given the complexity of behavior change, programs need to be longer term and at the community level, although the optimal duration and intensity has not yet been established (Chandra-Mouli et al., 2015). Single-event programs and awareness campaigns may be popular, but in both general SRH education and trafficking and exploitation campaigns, research suggests limited or no impact (Kiss & Zimmerman, 2019; Chandra-Mouli et al., 2015).

Because of the complex determinants of adolescent SRH, programs which are multi-faceted and multi-sectoral are also likely to be more effective. This includes employing programs and policies across schools, families, and communities (Chandra-Mouli et al., 2015; UNESCO, 2015, p. 20). Finally, programs must achieve adequate reach, scale, and sustainability across communities and countries so that, despite the proven benefits of comprehensive SRH education, more than only few children and young people actually receive it (UNESCOb, 2018, p12; Catalano et al., 2012; UNESCO, 2015, p. 15).

5. METHODOLOGY

The research is designed to address the following three questions:

1. How do the adolescent participants and program facilitators understand the issues affecting adolescent girls in their communities? What is their perspective on how the community addresses these issues? How are adolescent girls affected by these issues?
2. How do the adolescent participants and program facilitators make sense of their experience in the "A Healthy Me" program?
3. What enhancements do the adolescent participants and program facilitators suggest? How do they see the program being further used in the community?

5.1 METHODOLOGICAL APPROACH

The researchers used a qualitative design to explore how the 'A Healthy Me' program was experienced by the participants and facilitators. It is believed that through a qualitative approach, a holistic account of the participants' subjective experiences during and post program will be understood. It is through their experiences that any outcome related to the program will be identified. Given the program's focus on SRH issues, including abuse and exploitation, the ways in which the program may help the participants protect themselves against these negative outcomes will be specifically explored. Furthermore, in addition to the implementation models described above, the program is also implemented in settings where adolescent girls who have experienced abuse and exploitation are recovering (e.g. in residential aftercare facilities and workplaces). Thus, the research also explored whether program participation is perceived to enhance post-traumatic recovery and growth.

5.2 RESEARCH LOCATION

The research was undertaken in the Province of Cebu, across three cities and two municipalities. The locations included three municipal or city health offices and two school partners, and were selected to include both highly urbanized settings and more rural communities.

5.3 RESEARCH PARTICIPANTS

The research participants included both the adolescent participants and program facilitators. The adolescent participants were aged between 14 to 24 years and identified by their prior participation in the program (having attended a minimum of six of the nine sessions). Adolescents who were pregnant at the time of the research were excluded from the study. Purposive sampling was used to ensure adolescent research participants represented the range of program implementation strategies, including school, health center, and purok-based models. For the health center-based model, groups were further selected to include young, in-school participants and older, out-of-school youth. Homogeneity within groups ensured that the experiences of divergent populations were explored and also that there was strong group cohesion to improve participant engagement in the FGDs. Locations were selected to represent both highly urbanized and more rural settings as well as municipalities which are known to be 'hot spots' for commercial sexual exploitation, including online child sexual exploitation.

Purposive sampling was also utilized in selecting the program facilitators. The groups were formed based on community classification (rural or urban) and included both barangay health staff (nurses and midwives) and national high school teachers.

5.4 RECRUITMENT OF PARTICIPANTS

After identifying possible research locations which reflected the selection criteria, researchers approached the senior officials at each location to seek written approval to conduct the research. Following approval, the community-level staff were then approached to assist with disseminating information about the research. Potential participants who were 18 years or more were provided with information sheets and consent forms, and parents of participants below 18 years provided with information sheets with assent/consent forms prior to the FGD (see Appendix B).

With the approval of senior officials, the researchers also liaised with program facilitators in the selected locations to invite them to participate in the research. Formal written invitations were provided to those who expressed interest. Written consent was obtained immediately before the start of the FGD or KII.

The initial target was for five FGDs for adolescents with 6 - 8 participants per group, or a total of 30 - 40 participants. However, the research assistants experienced challenges recruiting for the FGDs. One challenge was the lack of availability of the previous program participants given many were in-school youth and busy during the school term, as compared with the program implementation which took place during the summer break. Others were difficult to contact without the full co-operation of barangay volunteers. Finally, the research assistants were hesitant to appear to be pressuring the adolescents to join, given the ethical standards employed in the research. The availability of nurse and midwife facilitators was also limited in some municipalities due to the end-of-year reporting commitments. With greater time and community presence (e.g. house-to-house visitations in the evening or weekends), it is likely that higher participation could be achieved. However, despite the lower numbers of adolescents participating, data saturation was reached with the themes and sub-themes shared being highly consistent between groups.

5.5 RESEARCH TEAM

The research assistants assigned to undertake data collection and analysis were two of Renewsiya's program officers. They were female with degrees in Psychology, one being a licensed psychometrician and the other a licensed teacher and master in Clinical Psychology student. Both were previously involved in facilitator training and supervision throughout program implementation but did not act as facilitators. Although this may introduce bias, the researchers' role did not involve facilitating or directly engaging with the adolescent participants during program implementation. Program monitoring typically only occurred once per program venue. Thus, the investigators believe that bias was minimized. However, prior engagement was also important because it enabled the researchers to observe the participants in their respective communities and to build rapport prior to conducting the research interviews. Prolonged engagement allowed the researchers to be immersed in the research context to be able to understand and interpret the meaning of the responses.

To ensure rigor throughout each step of the research process and to minimize potential bias from the research assistants, the research was actively supervised by the lead researcher, Mr. Khael Quinain, who is an Assistant Professor and Chairperson at the Department of Psychology, University of San Carlos. Mr. Quinain and a research assistant from Renewsiya received training on ethics in research through Consuelo Foundation. Consuelo Foundation's independent research consultant also reviewed and had input into the research design and methodology. A site visit during FGD implementation was also conducted by an associate from Consuelo Foundation.

5.6 TIMING OF DATA COLLECTION

Data was collected between two to six months after the programs were concluded. This enabled a more valid assessment of the program's sustained impact rather than immediate recall of program content (e.g. to reduce recall bias).

5.7 DATA COLLECTION

Aside from basic demographic information, qualitative data was collected to address the research questions. This was predominantly collected via focus group discussions (FGD) with several key information interviews as well as supplemental data collected during observational field visits during program implementation and during the FGDs.

6.7.1 FOCUS GROUP DISCUSSIONS AND KEY INFORMANT INTERVIEWS

Data was collected via focus group discussions with some key informant interviews. Key informant interviews (KII) were undertaken when program facilitators were unable to coordinate their schedules to meet as a group. Furthermore, when an adolescent participant disclosed an abuse experience during the FGD, the research assistant approached the participant after the FGD to discuss the possibility of a KII to understand how 'A Healthy Me' intersected with this experience and to ensure appropriate support was provided to the victim. If significant signs of discomfort or distress were noted at any time through the FGD or KII by any participant, the research assistant was trained to pause the interview, isolate the participant, and activate the distress/emergency response. The distress/emergency response protocol is described in Appendix C.

The group and individual interviews utilized a semi-structured format, with the primary questions asked and potential follow up questions prepared for use if required for deeper subject exploration. The format of the FGD and KIIs were as follows:

i. Introduction of research assistants
ii. Review of the research objectives and processes
iii. Review of consent, including voluntary participation, privacy, and confidentiality
iv. Discussion on the ground rules for the FGD or KII
v. Ice-breaker activities which will be undertaken prior to the start of the FGD.
vi. Commencement of video and audio recording
vii. Facilitation of the group discussion or interview led by the research questions
viii. Conclusion of the group discussion or interview
ix. Provision of a meal and tokens of gratitude (giveaways)

Two pilot FGDs and one KII were undertaken prior to the actual conduct of research to evaluate the feasibility, duration, adverse events, and to improve the process. Revisions had been made to the list of interview questions after the three pilot tests.

6.7.2 OBSERVATIONAL DATA

The research assistants also collected data during site visits during program implementation. The data included observations on program delivery, group dynamics, participant engagement, non-verbal cues, and the issues and topics which were raised during the sessions.

During the FGDs, one research assistant was tasked with documenting observations about the group dynamic, engagement of the research participants, patterns of verbal and non-verbal communication, the possible impact on the research assistant on the FGD session, and other responses which might be missed in the analysis of the data transcript alone.

5.8 DATA MANAGEMENT, PRIVACY, AND CONDIFIDENTIALITY

In accordance with Republic Act No. 10173, otherwise known as the Data Privacy Act, the researchers ensured that the privacy of participants was protected, whether personal or related to individual feedback about the program. The FGDs were undertaken in a private room where only participants and researchers could hear responses. The researchers were prepared to terminate the FGDs if a significant threat to the confidentiality or safety of the participants was identified.

Both audio and video devices were used to record the interviews, which were undertaken in the local dialect of Bisaya. To ensure confidentiality of information, written consent forms were immediately placed in an envelope and later stored in a locked cabinet accessible only to the researchers and program officers. Before being transcribed and thereafter deleted, video cameras were also stored in the locked cabinet. The full interviews were transcribed verbatim by the research assistants with participants assigned with non-identifiable numerical ID's which were used throughout the transcribed document. The document identifying each participant's ID, together with all other research data, were stored on a password-protected computer and accessible only to the researchers. All documents, whether soft or hard copies, will be destroyed and deleted five years after the research.

5.9 DATA ANALYSIS

Interview data from the focus group discussions was analyzed using an inductive approach, meaning that the data analysis was 'data-driven'. Themes were identified based on recurring patterns in the data and not on a predetermined set as prescribed by a theory. Steps outlined by Braun and Clarke (2006) were utilized as follows:

1. Generating initial codes,
2. Searching for themes,

3. Reviewing themes, and
4. Defining and naming themes.

5.9.1 DATA SATURATION

After the initial FGDs and KIIs were completed, the researchers reviewed or familiarized themselves with the data (both the observer notes and raw transcripts) to identify if there were recurring codes or themes. Aside from some of the issues affecting adolescents which varied between communities, it was concluded that data saturation had been reached and the analysis commenced.

5.9.2 CODING

Coding of the data progressed through several phases. The analysis was an iterative process and ended only when the accounts of the participants were considered appropriately represented.

5.9.2.1. PHASE 1. FAMLIARIZATION OF DATA

During the first phase of the analysis, the research assistants separately reviewed the raw transcripts for each FGD and KII and assigned codes to each response. Whilst the raw transcript was in Bisaya (the local dialect in Cebu), the coding was done in English.

5.9.2.2. PHASE 2: INTER-CODER AGREEMENT OF INITIAL CODING

After initial codes were formed, the analysts met to discuss the similarities or differences between their codes and agree upon the final first code. Where there were differences in codes, this was resolved through discussion and debate, with a third research assistant available to help resolve differences if needed. Undertaking this process helps to ensure intercoder agreement and reliability (Creswell, 2009). The coding was then reviewed by Mr. Khael Quinain and modifications made according to his suggestions.

5.9.2.3. PHASE 3: CODING STAGES 2 AND 3

This phase involved analyzing the initial codes for overlaps and differences. Codes that are deemed to be similar were merged and codes that are distinct from each other were treated separately. The researchers met together and undertook these two rounds of coding as a team. The codes were merged until it was deemed that no further simplification was possible.

5.9.2.4. PHASE 4. THEME GENERATION AND MAPPING

The third phase of the analysis involved theme generation and mapping. The final codes were reviewed and themes and sub-themes identified. This involved checking whether all coded data for each theme truly related to a central organizing concept and whether the themes related to the

whole dataset (Braun & Clarke, 2006, p. 12). Necessary adjustments were done to the codes during this phase, particularly at the direction of the lead researcher, and codes added, deleted, or adjusted as coding was considered as an "organic ongoing process" (Braun et al., 2006). Lastly, theme names were assigned and defined and maps were generated for each research question.

5.10 VALIDATION OF FINDINGS

Validation of the findings was undertaken using multiple approaches described below.

5.10.1 RESEARCH PARTICIPANT VALIDATION GROUPS

Data validation was also undertaken by conducting post analysis FGDs with both adolescent participants and program facilitators at school and community locations. Thematic maps together with a basic summary of results were generated for the four groups and presented separately to each group. Validation participants were then invited to comment on the findings and provide feedback as to whether they reflected their experiences or if adjustments were needed. Any new comments from the groups were then incorporated into the initial data transcription. Groups included facilitators and adolescent program participants who had not participated in the initial FGDs as doing so was considered to strengthen the validation. Each group strongly validated the findings presented and, although there were additional inputs given by the groups, they were to expound upon previous experienced shared.

5.10.2 COMPARISON WITH OBSERVATIONAL DATA

The observational data collected during field or program visits and the FGDs was reviewed and compared against the findings from the interviews. This review demonstrated high cohesion between the observational and interview data.

5.10.3 COMPARISON WITH QUANTITATIVE SURVEY DATA

Separate quantitative research was undertaken via pre and post program surveys to evaluate 'A Healthy Me' as described in Section 1: Introduction. This included demographic information and outcome data, including changes in knowledge and attitudes. The survey results are outlined in Appendix A. A comparison of the results of the two research arms is included in the Discussion.

5.10.4 REVIEW BY THE INDEPENDENT LEAD RESEARCHER

The transcriptions, coding, and thematic mapping were audited by the independent lead researcher, Mr. Khael Quinain, at multiple stages of the analytic process to confirm the accuracy and authenticity of the research findings. Furthermore, team meetings between research assistants and Mr. Quinain were conducted on multiple occasions to discuss and enhance the research process, coding, theme generation and mapping, and reporting.

5.11 ETHICAL CONSIDERATIONS

Prior to the research, members of the research team attended a workshop on research ethics conducted by Consuelo Foundation. This included discussion about best practices for research involving vulnerable populations and strategies to avoid potential harm caused by participation. These recommendations were incorporated into the research protocol.

5.11.1 TREATMENT OF VULNERABLE GROUPS

The respondents of the study included some adolescent girls aged under 18 years who are considered vulnerable. Therefore, particular care was taken to ensure participation was voluntary with no coercion or pressure and the informed consent was obtained from both a parent or guardian and the adolescent. The safety, privacy, and confidentiality of the participants was also ensured as outlined in Section 5.8.

5.11.2 POTENTIAL RISKS

5.11.2.1 LOSS OF TIME AND MONEY

There were no anticipated adverse physical risks for the participants joining the research. Any costs for transportation to the venue were refunded and only adolescents who were not working (formal or informal economy) were invited to join. Time required for participation was minimized by selecting participants who had easier access to the venues.

5.11.2.2 SHAME AND STIGMA

It was recognized that some of the topics being discussed are stigmatized within the broader community and may result in feelings of discomfort or embarrassment by participants. The researchers endeavored to minimize this by ensuring that parents and participants were informed that the curriculum addresses multiple health topics, not just those related to SRH and does not promote sexual activity. Furthermore, it was ensured that the parents and participants understood the goals of the research, and that it was not a personal evaluation, and were aware of their rights to privacy, and to refuse or withdraw from participation.

5.11.2.3 TRIGGERING EMOTIONAL DISTRESS AND DISCLOSURE

The risks of triggering emotional distress were also recognized due to the inclusion of topics related to abuse and exploitation, particularly if previously experienced by the participants. This possibility was discussed during the introductory section of the FGD and the participants reassured that they would not be judged based on their responses and that they were able to discontinue their participation at any time. At the conclusion of each FGD, a brochure was distributed to each participant outlining how to report abuse and the services available to victims (see Appendix C).

A protocol was developed to the research assistants' responses signs of emotional distress or if disclosures of abuse were made during the session. The 'Emergency Response Protocol' is outlined in Appendix C.

During the FGDs, only one adolescent disclosed abuse (workplace sexual harassment) but was not distressed at the time. The Emergency Response Protocol was activated, and the participant was approached after the FGD was completed. She agreed to participate in a KII during which she described having already brought the issue to her HR department and that it had been resolved. She expressed that her participation in 'A Healthy Me' had provided her with the confidence and skills to take this action.

Several facilitators shared that an adolescent participant had disclosed abuse during the course of the 'A Healthy Me' program. They were also approached after the FGD and provided with written

information regarding the available options to refer the victims for both reporting of the abuse and psychological support.

5.11.3 BENEFITS OF THE RESEARCH

5.11.3.1 PARTICIPANT BENEFITS

The researchers believed that the benefits of joining 'A Healthy Me' and its research outweighed any potential risks. This program has been thoroughly and thoughtfully developed to address many issues affecting adolescent girls. The FGDs were an opportunity for participants to share their perceptions and experiences within a friendly and open environment, and to further consolidate their knowledge of themselves and adolescent issues through self-reflection, hearing the stories and reflections of other participants, and via direct interaction with researchers during the sessions. Based on the observational data collected during the FGDs, most participants were empowered to share about their personal experiences within the group discussions, with some participants remaining quiet if they were not comfortable sharing.

Participants were not given a stipend or monetary incentives to join the FGDs. However, they were given a meal following the FGD and a token of appreciation (e.g. tumbler, tote bag).

5.11.3.2 STAKEHOLDER BENEFITS

The research findings will be shared with current and future program partners and other stakeholders which will enable them to make more informed decisions about program implementation. Furthermore, recommendations arising from the program will enable enhancement of the program and its impact.

Government and non-government stakeholders will also have access to more rigorous program evaluation data which will also be published in an open-access journal for broader dissemination of the findings. This is expected to help build the knowledge base regarding effective SRH educational programs for Filipina adolescents and add to the understanding of health and wellbeing experiences of this population, including those related to sexual and reproductive health, body image, social media, mental health, and prevention of abuse and exploitation.

6. RESEARCH FINDINGS

A total of five FGDs involving adolescent participants were conducted. Three groups involved participants from a health center-model, one group from a school-based program, and one group from a purok-based model. A total of 22 adolescent girls participated in the research. The average age was 17, ranging from 13 to 24 years. Four adolescent participants were teenage mothers, 15 were in-school, and three were school dropouts. Twenty adolescents recorded their civil status as single, three had live-in partners and one was married. One KII was conducted with an adolescent who disclosed abuse during the FGD.

Two FGDs involving 12 health-professionals who were program facilitators were undertaken, being divided into those above and below the age of 35 years. The division according to age groups was done to differentiate the program experience vis-à-vis their years in health service provision and to allow open discourse. Four KIIs were undertaken for facilitators whose schedules did not allow them to participate in group sessions, of which three were teachers and one was a midwife. The years of experience in their respective fields ranged from 1 to 38 years among health center-based facilitators, whilst school-based facilitators had between 6 to17 years' experience. See Appendix D for the demographic profile of research participants.

Additional data was collected during the validation groups which involved eight girls and three teachers from a school-based program, and 32 facilitators from a health-center based program. During the subsequent validation groups, 22 facilitators and four adolescent girls had not participated in the original FGDs.

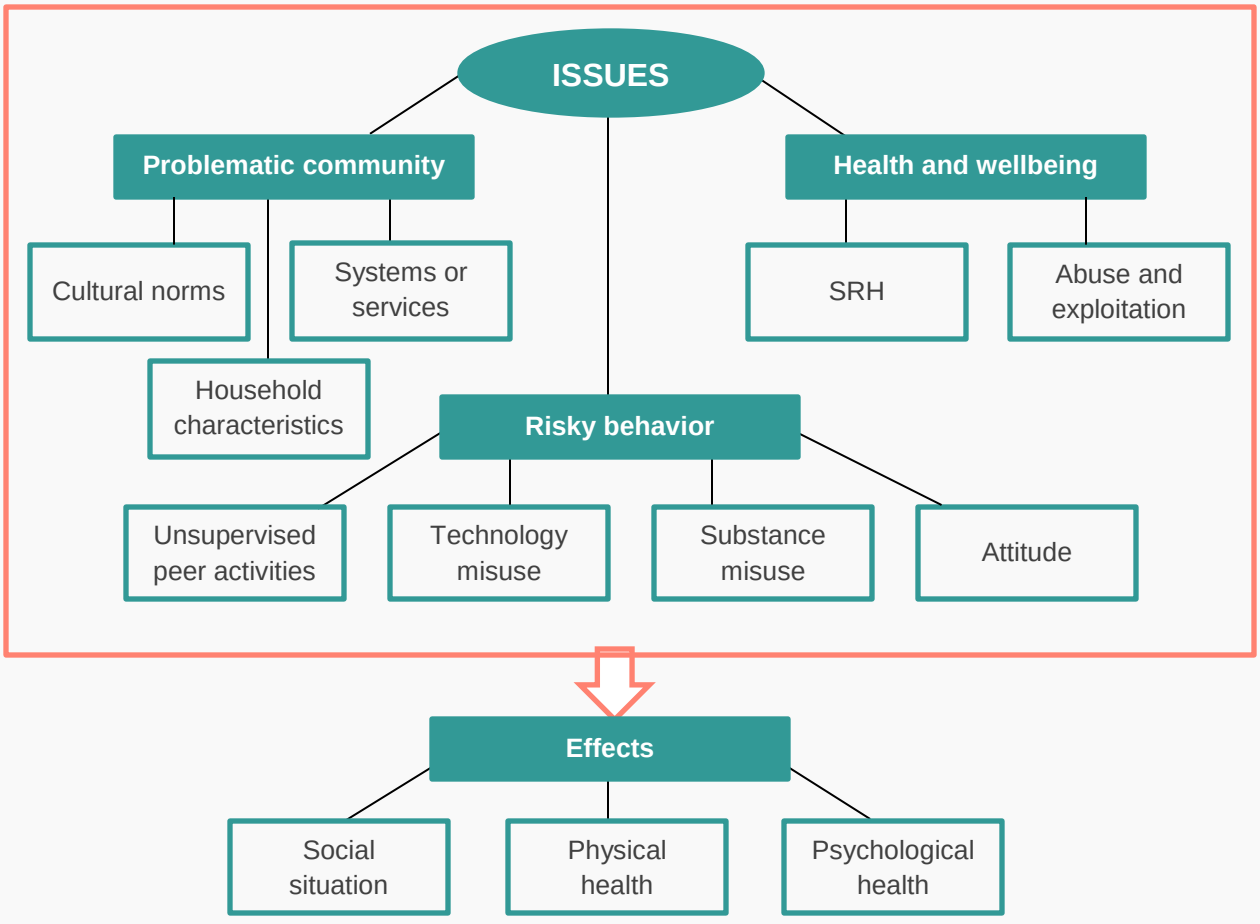
The findings are divided into three sections as per the research questions explored in the study. These are (1) Issues affecting adolescent girls in the community, (2) Experiences during and after 'A Healthy Me', and (3) Recommendations for 'A Healthy Me'

Overall, there was strong confluence between the issues, program experiences, and recommendations shared by the adolescent participants and program facilitators in each of the program models. The areas where differences were noted related to problems within particular communities (e.g. problematic cultural norms), how technology was misused by adolescents, the acquired skills and behaviors from the program, and how relationships were described between facilitators and adolescents. These differences are explored in more detail under each theme and sub-theme. It was also noted that program facilitators typically gave deeper and more detailed responses compared with the adolescent participants. There were no new areas explored or divergent themes or subthemes expressed during the validation meetings, with facilitator and adolescent participants extrapolating on the summary of the findings presented to them.

6.1 FINDINGS: ISSUES AFFECTING ADOLESCENT GIRLS IN THE COMMUNITY

The issues affecting the adolescent girls were described by participants under the themes of (1) Adolescents live in problematic communities, (2) Adolescents engage in risky behaviors, (3) The health and wellbeing of adolescents is negatively affected, and (4) There are secondary effects caused by the issues. The issues were presented as being multifaceted with many issues being interconnected with each other. Underlying factors which were thought to cause the issues were also described. Other secondary effects caused by the issues were also mentioned. These not only affected the adolescent girls but also the people around them, including their children and parents, and the professionals involved in providing care. These effects also lead to another problem layer for adolescents, including their social situation and physical and psychological health.

FIGURE 2. THEMATIC MAP OF THE ISSUES AFECTING ADOLESCENT GIRLS



THEME 1. ADOLESCENTS LIVE IN PROBLEMATIC COMMUNITIES

Participants described the conditions of their social environment as conducive to the emergence of adolescent issues. Respondents characterized the problems in the community according to (1) cultural norms, (2) household characteristics, and (3) systems or services. Much of the discussion focused on unhealthy cultural norms.

Cultural norms were presented as unwritten rules that were considered as ongoing or emerging traditions, beliefs, lifestyle, and social expectations unto which people abide or view as normal and which influence choices and behavior. Within the full findings from the study, cultural norms demonstrated the most varied responses between groups. The norms which were consistent between all groups were use of illegal drugs, gambling, partner abandonment or infidelity, and gender norms and inequality. Heterosexual men engaging in sex with gay men to earn money was also described by both facilitator groups. However, many communities appeared to have unique values and practices, with one school-based community particularly struggling with parents encouraging engagement with foreign men and the normalization of online sexual exploitation. The experiences of the facilitators also influenced how they reported norms, with teachers focusing on the value placed on education and health professionals discussing attitudes related to sexual and reproductive health education and services.

Use of illegal drugs and gambling were reported by all groups. Using and selling illegal drugs such as shabu (methamphetamine) and marijuana was described as rampant in their communities, with even young children selling drugs due to poverty:

> *"Ang uban pareha anang mga edara kay ang uban sa kanang kawad-on na jud ba kanang bata pa kayo sila kanang mamaligya nalang sila ug kuan drugs. [Other people, even at a very young age, are drawn to sell drugs because of poverty.]"*
>
> *(Purok-based adolescent 1, 13 years old)*

One program facilitator also mentioned that even parents with dependents use illegal drugs:

> *"Pero naa diri drugs man gyud… Oo naa sad babaye mag drugs, naa man sad gali mag-tiayon gyud. [Our problem here is really about drugs. Even women use drugs and couples too.]"*
>
> *(Midwife facilitator 8, female, 45 years old)*

Gambling is also illegal in the Philippines but was an activity described as being a common pastime for adults which is highly visible within the community. This refers to mahjong and tong-its (card game):

"... and then we have this culture, ay sa ilaha kanang sugal. Oo ang sugal, mahjong, tong-its unya mag atbangay nalang. [And then we have this culture about gambling, mahjong and card games out in the open.]"

(Teacher facilitator 2, male, 26 years old)

Another common norm shared by both adolescent participants and program facilitators was ***partner abandonment or infidelity***. It was felt that men often abandoned adolescent girls when they became pregnant, moving on quickly to form new intimate relationships. One program facilitator shared about a participant who was abandoned before she gave birth:

"Isa sa akong participant kay kuan 15 years old naa na siya baby ingon ana. Unya kuan uhm wala unta toh siya'y bana kay wala siya panaguti ba silbi pagka mabdos niya, nawala ra ang laki kay kato galing naka kuan mo atong mga rides dira trabahante siya diha. Diha sila nagkaila. So, di ba after sa fiesta mo layas nana sila sa laing lugar. So igo ra siya napamabdosan. [One of my participants is a 15-year old young mother. Her partner did not take responsibility for the child. He works at the temporary amusement rides during fiesta fairs. They met there. When she got pregnant, the father of her child fled to another place because of his work. So, she just got impregnated.]"

(Nurse facilitator 4, female, 32 years old)

Research participants felt that men were unaccountable of the consequences of their actions. This promotes ***gender inequality*** because adolescent girls bear the burden of unintended pregnancy:

"Mahay pod kay mabuntisan ang babaye then biyaan sa laki. Ang babaye kay ni undang, unya ang lalaki padayon. Murag wala ra sa iyaha nga naa siya nabuhat sa babaye. Unya naa na sad siya bag-o. [I feel pity about her being pregnant and left without any support from the father of her child. She stopped school while the boy went on. It's as if he doesn't care about what he did to the girl. He even went on to another relationship.]"

(School-based adolescent 3, 14 years old)

One program facilitator recalled that during the program, one of her participants (aged 17) discovered per partner had left her for another woman:

"As of the moment nga mag session mi didto iyang partner is naa nay lain. Kuan pa gyud iya edad 17 so it's common. [When we had sessions there, her partner was already in another relationship. It happens and it is common even among young adolescent girls - she was 17 years old.]"

(Nurse facilitator 2, female, 33 years old)

Likewise, it was mentioned that partner abandonment and infidelity is also experienced by parents of adolescent girls. Together with the presence of gambling in communities, this had led to neglect of children for some families. As revealed by a program facilitator, one of her participants expressed her struggles related to her father's unfaithfulness and her mother's poor coping strategies:

> *"Ang ako maam, ang sa pag guide sad gyud sa bata maam. Kay naa koy daghan teenage pregnancy katong last year hangtod karon. Unya ako gi-interview ang bata, ni ana siya nga "Maam ang ako pud mama kay inig ka buntag sayo, dili ma atiman sila, mo diretso sa tong-itan." Unya naa sad lain na kuan naay lain babae iya papa. Ing-ana gani so ang mama sa iyang ka guol so mo tong-its na lang siya para siya malingaw. So ang mga bata mabilin. So, nag uyab-uyab sad. So namabdos so mao na siya. [For me, it's the lack of parental guidance of children. I had many teenage pregnancies last year until now. I interviewed one and she replied "Maam, my mother can't take care of us as she goes straight playing card games early in the morning." Her father has another woman too. That was the situation that prompted her mother to play card games as a distraction. So, children are left neglected, entered early in relationships, and got pregnant.]"*
>
> *(Midwife facilitator 3, female, 49 years old)*

Both school-based and health center-based program facilitators shared that it was becoming increasingly common for ***heterosexual adolescent boys or men to engage in paid sex with gay men*** and some had provided care to girls who had acquired STIs from partners engaging in this behaviour. This is colloquially dubbed '*pamayot*'.

> *"Labi na ilahang mga boyfriend ba ron gigamit og bayot… [Adolescent girls get STIs, most especially if their boyfriends were in sexual contact with homosexual men.]"*
>
> *(Nurse facilitator 4, female, 32 years old)*

During the validation meetings, program facilitators from the school model further emphasized that this was becoming normalized in the conversations among male high school students as they tease each other about it being a source of income:

> *"Then sa mga lalaki pod, ako pod madunggan nga mga cases kanang pamayot, murag which is accepted na kaayo ba kay kanang makakwarta man ka. [Among the males, what I often hear is about cases of prostituting oneself to a homosexual man. This is widely accepted because they can actually earn from it.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

The school-based program facilitators focused on cultural norms related to ***parental values concerning education***. They observed that in their community, parents did not value education and girls were encouraged to leave high school before graduating, particularly if the parents had a low education level. Instead parents encouraged their daughters to marry at a young age.

> *"Naa sad tay problems when it comes to the family. Kay ang family culture pod didto sa isla, majority of the people gyud or the parents the educational background are very poor. So sometimes nga mo ana lang sila nga "basta makahuman lang ka anang grade 10 okay na kay ka mag-minyo." [We also have problems when it comes to the family. The family culture in the island is that the majority of the parents are really poor. Sometimes they would say, "As long as you finish up until Grade 10, it's fine if you get married."]"*
>
> *(Teacher facilitator 2, male, 26 years old)*

Online commercial sexual exploitation (OCSE) of children was also normalized and increasing in one school community, which is known as a hotspot for this activity. It was believed that people in the community were protecting each other by not reporting the issue to authorities or that, when reported, local government officials did not respond.

> *"Mga way back mga year 2006, dili paman kaayo rampant ang kanang mga ingon ana nga cases, like teenage pregnancy, kanang mga cyber kuan, kanang mga children nga at risk of sexual exploitation mga ing-ana, wala pa kaayo na siya. Nikuan siya mga five years ago, so that would be mga 2015, 2014, dinha na siya... Karon daghan na gyud nga kuan ba, alarming na siya. Then another, aside sa teenage pregnancy kana bitawng cyber sex or ang mga bata na mismo maoy mag chat-chat… Ang uban man gani murag kuan pa protector pa noon sa mga ingon ana, kaila paman gani sila, pero pagkangan nga ilang kaila, ilang silingan dili nila i-report, even if naa sila sa... dako sila'g position sa barangay. [Way back in 2006, cases of teenage pregnancy and cyber sex are not very rampant. There aren't many cases of children at risk of sexual exploitation around 5 years ago, that would be 2015 or 2014. Now, cases are increasing and it's alarming. Aside from teenage pregnancy, there are also cases of cybersex or adolescents who proactively chat [strangers] online. Others would act as a protector to these exploitative acts. Just because they know the person, or their neighbor, they don't report it to authorities. Even if they hold a high position in the Barangay.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

The program facilitator continued sharing how the community had developed ***distorted values regarding OSEC*** and justified their actions even though they are aware that it is unlawful.

> *"Kani among gibuhat wa man mi nangawat ani, wa man mi nasakitan ani" ana ba, ing-ana na distorted na kaayo ilang values. [They would say, "we are not stealing, and we are not getting hurt by doing this." That's how distorted their values are.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

It was common for neighbours to be competitive regarding the amount of money they received from foreigners. Although this may not necessarily always involve sharing sexualized images, ***parents push their children to chat with foreign men*** and recount their household needs to acquire financial assistance.

> *"Then makadunggog kog mga istorya from communities especially during our CRPU meetings nga mo ingon nga murag ang mga silingan ba magpadak-anay na sila pilay hatag sa foreigner. Mo ana na ba, kanang, "Oy, chatti sa to didto kay ingna na kuan naguba atong bongbong, naguba atoang kanang atop" ana ba para palit bugas ana, ang mama na ba, maoy magkuan, oy si kuan gitagaan og ingon ana. [I often hear stories from the communities during our CRPU (Child Rights Protection Unit) meetings that they compare how much they get from the foreigner. They would say, "Why don't you send a message [to the foreigner] and say that our ceiling is damaged, our roof needs to be fixed." [They ask money] to buy rice. The mothers are the ones encouraging their children to engage with foreign men.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Moreover, the school-based program facilitators observed that ***parents also pressure their children form relationships with foreign men*** believing it would lead to a better life, which was an aspiration they transferred to the children:

> *"Naa gyud ing-ana nga mga mentality and even sa mga communities ug sa parents nila mao nay ingon nga, "mayntag mangita na lang kag Amerkano para mahaw-as tas atong kalisod" which is lisod baya gyud pag kuan sa ilang huna huna nga… Kay naa gyud mga ingon ana. [There are really people in the community who have that mentality. Even parents would say, "I hope you can find a foreign man (American man) so we can get out of poverty." And it's really hard to get that out of their minds.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

On the other hand, the health center-based program facilitators, who were health professionals, focused more on ***stigma related to sexual and reproductive health education and use of modern***

contraception. Conversely, they described that teenage pregnancy was normalized and considered acceptable. Conducting SRH education was seen as challenging because parents were conservative and opposed it, believing it would lead to earlier sexual initiation. Because of this, some program facilitators were reluctant to openly discuss sexuality and modern contraception with adolescents.

> *"As of the moment kay ga advocate mi og kanang Reproductive Health, Adolescent Health ing-ana ba mga talk maam ba, lectures ari sa eskwelahan. Maglisod mi og kuan gani kanang mag direct into ladlaran nga sex education kay kontrahan man sa parents. Kuan maam ipa agi gyud namo siya maam og more on the reproductive health na side and then dili kaayo mi mo kuan sa kanang family planning gani when it comes to reproductive health. Even sa mga early high school ing-ana kay ang parents dili mo sugot kay something na gi introduce daw namo sa ilang pag huna-huna getting involved at an early age. And bisag unsaon nimo storya gani about sa reproductive health, wala man ta nag introduce at an early age of sexual activity. But we educate them that these things will happen eventually. [As of the moment, we are advocating about reproductive health, adolescent health – those kinds of lectures in schools. We have a hard time directly educating the students about sex because the parents are not in favor of it. We discuss it through reproductive health but not specifically about family planning. The parents do not allow this because it seems like we are introducing these topics to their children's minds and to get involve in [sexual acts] at an early age. We are not really introducing sexual activity at an early age, but we educate them that these things will happen eventually.]"*
>
> *(Nurse facilitator 2, female, 33 years old)*

This stigma and lack of SRH education was viewed as a cause adolesents having unprotected sex:

> *"Kuan lahi man sad nabantayan nako kay mga bata pa gyud kaayo. Wala bitaw jud sila idea of protection bitaw. Murag taboo gyud ba para nila, mag condom, mo tumar… [I also observe that young people today do not have any idea about protection [during sexual activity]. It's still a taboo for them to use condom, to take [pills].]"*
>
> *(Nurse facilitator 2, female, 33 years old)*

Household characteristics were described by the research participants as the different family conditions and dynamics that adolescent girls were living in. It was relayed by all groups of research participants that ***poverty*** was a key cause of family and adolescent problems. This was described as leading to attempts to increase household income by selling drugs and forming relationships with foreign men to alleviate poverty. One facilitator described her conversation with a participant

regarding her aspirations to marry an American man (white foreign men of varying nationalities are often named 'Amerkano' by some Filipinos).

> *"Mga bata noh ganahan, ma excite sila. I even have had 1 student nga ni ingon nga, "Mag-ampo lang ta ani, maswertihan ta nga kanang naa tay Amerkano," or ingon-ana ba. Mao to ni ana ko nga "Day, please don't depend or kanang kuan sa imohang kapalaran, sa imohang swerti ana, you should strive hard nga ma successful ka sa imong kaugalingon nga paningkamot rather than makakita ka og somebody or foreigner nga mogasto nimo na nadato ka ana, dili gyud na siya mao," [The youth today want, and get excited about the thought [of marrying a foreign man]. One student of mine even said, "Let's just pray, who knows, we might get lucky and have an American man [foreign man]". I then said, "Please don't depend on that for your future, you should strive hard to be successful on your own hard work rather than depend on a foreign man to give you money, that's not right."]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Both facilitators and adolescents believed that poverty exacerbated the issue of ***inadequate parental supervision and guidance*** because both parents needed to work to provide for their families. As described by one adolescent:

> *"Sa teenager kay kuwang man sila sa pag atiman sa ginikanan. [Teenagers lack care from their parents.]"*
>
> *(Health center-based adolescent 8, 24 years old)*

Program facilitators were able to describe of the negative impact on the children and their involvement in risky behaviour in greater detail:

> *"Sa akoang community nga gidala, usa sad na siya pero kanang tungod sa kawad-on nga dili pwede nga ang papa ray manarbaho kay kuwang gyud ang ilang pagkaon ug ang pagpa edukar sa mga bata. So kinahanglan both magti-ayon manarbaho. So, the rest wala nay mahabilin sa mga bata… Mao nay nagkuwang nila… Kuan ang mga bata dili naman sila ma monitor. Like pananglitan ilang mama papa trabaho ba ron og gabie so mga bata maglaag. [In the community that I'm facilitating, poverty is also one of the reasons. It wouldn't suffice if only the father is working. [His salary] would not be enough to provide for their needs and to pay for the children's education. Both parents should work. Because of this, no one is left to watch the kids - this is where the parents fall short of their responsibility to care for their children. The children*

are not monitored. If both parents are working, the children will be out loitering.]"

(Midwife facilitator 5, female, 48 years old)

Even without the influence of poverty, it was described that some ***parents have inherent attitudes to neglect their children***. As added by another program facilitator, some mothers did not adequately attend to their children. They practiced poor parenting by allowing their children to do whatever they wanted.

"Ang ako sad maam nga daghan di tarong na mama ba. Usahay walay paki-alam sa ilang mga anak. Mapasagdan lang ba, maglaag, kung feeling lang pangitaon na nila. [In my opinion, there are a lot of mothers who are irresponsible. Sometimes, they don't care about their children. They just allow them to loiter and not even look for them.]"

(Midwife facilitator 4, female, 61 years old)

Similarly, one health professional described a mother who gave consent for her 15-year old daughter to enter into a new relationship so that her daughter's child would have a father. Rather than supporting her daughter to go back to school, the mother encouraged the new relationship and was proud of there being a father for her grandchild:

"Oo unya maglagot ko sa iyang mama... Proud kaayo mag post sa facebook bitaw, naa nay nag amahan sa iyahang kuan sa iyahang anak. Naka ana ko ba "sa inyo ka pobre, inyo pana gi kuan imbis gi encourage ba nga mo eskwela para maka human" ing-ana... Dili unta bitaw kay 15 years old ra biya na. Dapat dili na niya i-involve og laki kay naay tendency nga masundan ingon ana unya bata pa kaayo. Unya mga iresponsable puros. [I am also mad about the adolescent's mother. She's very proud of it and even posted it in Facebook that someone else is taking responsibility to be the father of her child. I said to myself, "With your financial status, you should have encouraged your daughter to finish school." That shouldn't be the case because their daughter is only 15 years old. She should not be involved with any other guy because she might get pregnant again and she's still very young. They are all irresponsible.]"

(Nurse facilitator 4, female, 32 years old)

Another program facilitator highlighted that some parents don't behave responsibly, noting that they don't have an effective parenting style or monitor their children's whereabouts:

"Dili kay sila, ilahang training when it comes towards their children kay dili kaayo rigid, dili kaayo kana galing particular sila, murag chillax lang if ang ilang mga

anak, most especially babaye unya maglaag laag lang sa bisag asa unya dili gyud nila pangitaon ba, nga mao ni asa atoang anak unya as in mura ra silag wala. [Their training when it comes to their children is not very rigid. They seem to be lenient towards their children, especially the girls who loiter anywhere. They don't really monitor where their children are.]"

(Teacher facilitator 2, male, 26 years old)

However, it was argued by another program facilitator that despite the provision of proper parental guidance, some adolescents were just hard-headed and disobeyed their parents. They display hostile behavior towards their parents and insist on doing what they will.

"Sa kuan di sad ta makaingon sa parent noh. Naa man sad gyud bata nga tungod sa curiosity nag barkada sila, unya curiosity ilang suwayan. So mosupak sila sa kung unsay mga guidance sa mama. Naa sad gyud sila nga ilaha sad gyud nga pagka supakero, supakera. [We can't really solely blame the parents. There are youth who, out of curiosity, get involved in peer groups. They disobey their mother's advice. There are also some who are really defiant.]"

(Midwife facilitator 2, female, 44 years old)

Family breakdown or dysfunction was also a household characteristic which was viewed as a precursor to other adolescent issues. Conflict between parents affected their children as expressed by one adolescent participant:

"Then about sad sa family problem. Dili baya ingon nga perfect akong family kay nobody is perfect baya. Akong family, akong mama'g papa, wala gyu'y adlaw nga di sila mag away, di sila magsinabtanay. Silbi ako kay ma affect jud ko. [About the family problem, we cannot really say that there is a perfect family. There isn't a day in my life when my parents aren't arguing, aren't disagreeing. I also get really affected.]"

(Health center-based adolescent 6, 15 years old)

A program facilitator further explained that having a broken family was an indicator for risky behavior by adolescents:

"Kasagaran gyud kay broken family gyud maam. Unya usa nani sa hinungdan nga mag drugs dayon, enjoyment. [The usual [reason really is] being in a broken family. This is one of the reasons why they get involved in drugs, for enjoyment.]"

(Midwife facilitator 1, female, 42 years old)

Systems or services were expressed as the society-level structures and government programs present in the community that either address or exacerbate the issues involving adolescents. When asked about existing community programs, several of the adolescent participants said that they hadn't encountered any programs.

Other government and non-government programs and services were identified by other research respondents and these are listed in Table 1. However, both adolescent participants and program facilitators mentioned that they felt that many ***existing community programs were limited and ineffective***.

TABLE 1. COMMUNITY PROGRAMS IMPLEMENTED TO ADDRESS ISSUES FACED BY ADOLESCENTS

Research Group	Programs
School-based adolescent participants	• Enforcement of curfew • Barkada Kontra Droga: a school anti-drug awareness campaign program
Health center-based adolescent participants	• Enforcement of curfew • Pag-asa Youth Association Philippines (PYAP): a youth membership organization that provides awareness programs on different youth issues • Barangay Council for Protection of Children (BCPC): address issues concerning protection of children or adolescents against abuse, violence and exploitation • School programs such as drug awareness seminars, self-awareness seminar, value formation (chastity) • New Youth for Community Enhancement (NYCE): a local youth organization providing youth programs • Programs for drug surrenders • Barangay information dissemination on breast cancer and feminine hygiene

School-based program facilitators	• Short orientations on health in partnership with RHU • School implemented Personal Safety Lesson (PSL) to students in partnership with a Non-Government Organization (NGO). • LGU, in partnership with NGOs, implements programs during Children's Month celebration • NGO conducted capacity building on child's rights protection and case management to teachers • School partnered with an NGO to deal with CSEC issues • Presence of youth groups in the barangay with volunteer programs • Livelihood programs for the youth • Scholarship programs for youth
Health center-based program facilitators	• **Advocacy programs on reproductive health and adolescent health at schools and barangay** • **Presence of youth camps at selected barangays** • **Summer sports league for boys** • **Community partnership with TESDA to provide skills training** • **Livelihood programs for unemployed mothers and drug surrenders** • **Enforcement of curfew** • **Police designated a smoking zone** • **LGU implemented discipline zone** • **Street lighting program**

An issue identified by the research participants was that some of these ***programs were not sustained***. During the validation meetings, it was further emphasized that there are health programs but, due to the lack of government funding and prioritization, these programs are not implemented and sustained in all local government units. The level of success of the programs and interventions also depend on the communities where it is being implemented. One example commonly discussed was the enforcement of curfews for minors. This is conducted to ensure that by 10pm youth are at home. Otherwise, they will be reprimanded or arrested by the police or barangay tanod (community peace and security officer) as explained by adolescent participants:

> *"Badlongon ang mga naa sa kalsada ba nga naglakaw-lakaw pa. Murag apil man sad siguro mga edaran miss. Maong mingaw na kaayo ang dalan. [They call the attention of those who are still loitering in the streets. This also includes the adults. This is the reason why our streets are already quiet in the evening.]"*
>
> *(Health center-based adolescent 2, 22 years old)*

Some program facilitators felt this was an effective intervention with fewer young people out at night and drinking:

"Labi na naay police mag roving ba. Mahipos na sila, wala nay mag-inom sa daplin. [Especially if there are roving officers on patrol. People will then pack-up and stop drinking.]"

(Midwife facilitator 1, female, 48 years old)

"Oo visible sad gyud kaayo ang effect, nawagtang sila. Nawala sila. [The effect is very visible. Adolescents were not seen.]"

(Nurse facilitator 2, female, 33 years old)

Whilst other adolescents and facilitators believed that youth had just got better at evading the attention of law enforcement or were meeting in different locations:

"Sa amoa maam kay curfew ra sad ang program unya kanang makabantay sila kay abtik man kaayo unya managan dayon sila basta makakita sila sa curfew. Unya ang uban badlongon unya wala ra gihapon. Ang uban kay mosukol pa gyud. [In our place, the curfew program is also being implemented. Adolescents are quick to notice once the roving police officer is around. They run home once they notice that it's already time for their curfew. Some don't change their ways even if they are reprimanded. There are also some who resist authority.]"

(School-based adolescent 4, 13 years old)

"Curfew og kanang pag implement nila anang discipline zone gani kay sugod atong nag implement na sila anang discipline zone, wan-a gyud batan-on nag tapok sa plaza. [inaudible]... daghan kaayo na sila pero sugod atong nag implement sila og discipline zone, Nawala sila sa plaza, didto na sila dapit sa ngitngit. [crosstalk] Pero sauna man gud ladlaran na sila. [There is also a curfew and they also implement a discipline zone. Ever since they implemented the discipline zone, adolescents are no longer hanging around the plaza. There were many of them before, but since the discipline zone was enforced, they transferred to another place. Before, they were really out there.]"

(Nurse facilitator 1, female, 26 years old)

On drug programs, both groups of adolescent participants reported its ineffectiveness. An adolescent participant cited that barangays had put their efforts to capture drug users but failed to stop everyone who's using it:

"Naa. kay bisag unsaon og kuan sa barangay captain nga mag meeting nga dili nana angay buhaton, mga drugs kay naa lang gihapo'y uban nga kanang mag drugs gihapon sila. Bisag kapila nani i-raid diri ang [location withheld] wala gihapon silay paki, mobuhat gihapon sila, unya ilang rason kay para sa ilang

pamilya. [Despite the barangay captain's effort to gather them in a meeting and discuss why they should not get involved in drugs, there are still some who still do it. No matter how many times we got raided here in our area, they still don't care. They still get themselves involved in drugs. And their reason is always because they [need it for] their families.]"

(Health center-based adolescent 7, 15 years old)

Urbanization and the lack thereof were seen as a culprit for the adolescent issues. One program facilitator described that, in some communities, the limited supply of electricity at night meant that parents couldn't locate their children. Whilst in other communities increasing urbanization and the rise of commercial establishments had caused other issues:

"Kay maybe because pod siguro usa pod sa factor kay ang ilahang kuryente, the electricity because it's until 10 pm and then maybe it's very difficult for them to find sa ilahang mga anak because no more electricity at that specific time. [One of the factors [for the increase of adolescents engaging in risky activities] is also the availability of electricity. The light goes off at 10pm and maybe it's difficult for parents to look for their children if it's too dark.]"

(Teacher facilitator 2, male, 26 years old)

"Nagka grabe siya mga kuan 3 to 4 years ago nga nanay 7-Eleven, nanay Grandmall, dili siya ingon ana gyud ka rampant before, karun na lang nga naa nanang mga establishments ba. Nagkakuan pud siya, nagka modern ang [location withheld], nagkakuan pud ang mga, mga bata. [The past 3 to 4 years, there has been a great addition in terms of private establishments in our community, for example 7-Eleven, Grandmall. There hasn't been much of these before. Our place is becoming modernized, and with this, there is also a change in the behavior of the youth.]"

(Teacher facilitator 1, female, 39 years old)

Both school-based and health center-based program facilitators shared that there are ***no or limited programs for adolescent girls*** about sexual and reproductive health. One teacher that they didn't have a SRH program in their school and are often just short-term activities like lectures or orientations of certain topics.

"When it comes to the... we don't have any program. We only have a 1 day, or its a half day orientation, or it only covers 2 hours and then we'll just discuss what are these, what are these, what are that, and then what are those things and then also the RHU from the municipality they will also have orientation. but when it comes to hands-on application like one on one, no. It has never

happened in our school since I started here. [We don't have any programs. We only have a half-day orientation, or it only runs for 2 hours where we discuss [specific points]. Then the RHU (Rural Health Unit) from the municipality will also have an orientation. But when it comes to hands-on or one-on-one application, we don't have any. It has never happened in our school since I started here.]"

(Teacher facilitator 2, male, 26 years old)

An adolescent participant mentioned that she hadn't encountered programs addressing early teenage pregnancy:

"Sa drugs ra among nadunggan, sa mga early pregnancy wala man. Drugs, mga sugal. [We are only aware of programs on drug or gambling issues. There hasn't really been any program addressing early pregnancy problems.]"

(Health center-based adolescent 8, 24 years old)

According to health center-based program facilitators, most programs implemented by the Sanguninang Kabataan or SK (youth council) are for adolescent boys such as sports league and none of the programs are designed for women or specifically addressing sexual and reproductive health issues:

"Kana maoy wala gyud kaayo ko nakita nga naa silay gihimo nga mga program ug activities about ana bisan siguro ang kanang mga SK, murag wala. Wala koy nakit-an ana. Wala man kaayo programs, Mga lalaki ra pod, basketball…Liga liga…Murag wala kaayo koy nakuanan, kay ang ALS murag out of school youth ra sila murag dili man kaayo, more on education man di man siya about sa ingon ana. Wala siya nag focus sa issue, sa teenagers… Wala, wala kay koy nakit-an. [I haven't really observed that they are implementing any programs or activities [specifically for women]. Even the Sangguniang Kabataan is not implementing any programs. For the males, they only hold basketball leagues, that's all. I don't really know if there's any. For the alternative learning system (ALS), they only cater to out of school youth and their programs are more on education. They are not very focused on the issues involving teenagers. I'm thinking there is really none.]"

(Midwife facilitator 8, female, 45 years old)

In response to the question about community programs, both adolescent participants and program facilitators said that 'A Healthy Me' was thus far the only program implemented in their barangays for adolescent girls that tackled various health issues.

"Sa barangay kato ra gyud, kani ra gyud 'A Healthy Me'. [In our barangay, 'A Healthy Me' is the only program that we have.]"

(Midwife facilitator 5, female, 48 years old)

"Sa akoa nga side miss kay kini nga Renewsiya. Maong nisugot si Kap nga naa mo sa among... mga atubang ron kay for us nga ma knowledgeable pa about unsa ang teenage pregnancy, unsaon namo pag protect, like unsaon namo pag care sa amoang health. [In my case, Renewsiya's program [A Healthy Me - is what the community is only doing]. The reason why our barangay captain agreed to partner with Renewsiya is for us to be knowledgeable about teenage pregnancy, how we can protect ourselves, and how we can take care of our health.]"

(Health center-based adolescent 5, 17 years old)

THEME 2. ADOLESCENTS ENGAGE IN RISKY BEHAVIORS

Research participants believed that the activities the adolescents were involved with and their attitudes had the potential to cause negative outcomes. The different groups of respondents described these risky behaviours being related to (1) unsupervised peer activities, (2) technology misuse, (3) substance misuse, and (4) adolescent attitudes. The risky behaviour most commonly mentioned across all groups of adolescent participants and program facilitators was substance misuse of alcohol, drugs, and cigarettes. For adolescent participants, school absenteeism or cutting classes were the leading risky behaviors discussed. While for program facilitators, going out and engaging in early relationships were the prevalent behaviors. Both adolescents and facilitators discussed the increasing issue of technology misuse, with adolescents limiting their focus mainly to excessive use whilst program facilitators expressed greater concern about more serious issues including sharing self-harming and sexualized images, cybersex, and meeting strangers online, including foreign men. Lastly, adolescent participants and program facilitators suggest that these behaviors were influenced by the attitudes of adolescents such as being disrespectful or disobedient, giving in to peer pressure, curiosity, and low self-esteem.

Unsupervised peer activities were described as activities undertaken by adolescent girls with peers without parental supervision. These activities were seen as being risky with those repeatedly mentioned being cutting classes or absenteeism, going out, and forming romantic relationships at an early age. An observation by a program facilitator illustrated that, as early as the sixth grade, ***adolescent girls and boys create or join peer groups***.

"They have this kind of culture nga kasagaran gyud sa mga babaye ug mga lalaki, at the age of, even elementary, so starting from Grade 6 until senior high school or junior high school and magrupohay sila and then maglingaw-lingaw. [They have this culture wherein most girls and boys, even at a young age,

beginning at Grade 6 until senior or junior high school, they form into peer groups and have fun.]"

(Teacher facilitator 2, male, 26 years old)

Both adolescents and facilitators described that these peer groups could be community-based fraternities or gangs as described by one adolescent participant:

"Mag sige nalag barkada, mosulod og fraternity. [They always go with their peer groups, some even join fraternities.]"

(Health center-based adolescent 7, 15 years old)

Almost all of the adolescent participants and several facilitators cited that students often skipped class together. One of the adolescent participants highlighted that, whilst previously this was mostly done by boys, ***girls were increasingly cutting class***:

"About sa pag eskwela. Mga cutting classes, mga ing-ana, bisag, diba atoang [inaudible], na-andan man kay ang mga boys man gyud kasagaran mobuhat ana. Karon kay na observed nako nga moapil napud ang mga babaye. [In school, some students skip class. We are used to boys doing this but now, I observed that even girls are [skipping classes].]"

(Health center-based adolescent 6, 15 years old)

Groups of adolescent girls were described as often being seen out of their homes, hanging out with their friends in public places. Even program facilitators are alarmed by this as they see more and ***more young adolescent girls roaming around*** the streets.

"Daghan nang laagan miss nga babaye. [Many adolescent girls are always going out.]"

(Health center-based adolescent 2, 22 years old)

"Kanang mga batan-on nga mag sige'g laag, duol sa risgo, peligro. [The youth today are always out and about which puts them at risk or in danger.]"

(Nurse facilitator 3, female, 25 years old)

Another unsupervised activity commonly mentioned ***forming romantic relationships at a very young age.*** Program facilitators were particularly concerned that they are too young to be in a serious relationship, often without any parental guidance. A program facilitator pointed out that adolescents can be emotionally unstable leading to short-term relationships which pose potential risks in their sexual and reproductive, and mental health.

"Risgo gyud kaayo oy kay kuan man kahibaw mga batan-on pa kaayo noh kana ganing naay gamay bikyas sa uyab – buwag noh. Unya usa ka semana tuay naguyab lain, unya lain na pod lain na uyab. [It's very risky because they are still very young and for example, they have a slight misunderstanding with their boyfriend or girlfriend, they immediately break-up. After a week, they will find another relationship.]"

(Nurse facilitator 4, female, 32 years old)

Misuse of technology was described as being an excessive and problematic use of computers, cellphones, internet, and social media that had affected the values and choices of adolescent girls. Whilst the adolescent participants had a more limited focus on the excessive use of cell phones or computers for social media and forming relationships quickly via social media, program facilitators expressed far greater concern and discussed more serious issues including sharing self-harming and sexualized images, non-consensual sharing of images, cybersex, and meeting strangers online, including foreign men.

Adolescent participants from the school-based model mentioned that they ***spent a large amount of time using their cell phones and visiting social networking sites***, Facebook in particular. One of the adolescent participants explained how excessively she uses her cell phone to the point that she feels she can't stop:

"Kung mag every time ka mo gamit og cellphone mura kag di naka ganahan mo hunong. [Every time you use your cellphone, it seems like you can't stop.]"

(School-based adolescent 2, 14 years old)

For adolescents who don't have cell phones, they were described as having ***easy access to internet cafes*** which are widespread in their communities. In fact, during the validation, school-based adolescent participants mentioned that some internet cafes never close. Thus, they can use the internet at any time. An adolescent participant shared a common habit of excessive computer use:

"Kung walay cellphone sa computeran. Unya dugay naka makamata. Unya inig kamata pa gyud diretso na computer. [For those who don't have cellphones, [they go to the] computer shop. This is the reason why they wake up late. And when they wake up, they also go straight to using the computer.]"

(School-based adolescent 4, 13 years old)

Because of misuse of technology, health center-based program facilitators reported that adolescents don't help with household chores:

"Like for example sa gadget, sa cellphone [CT]… Oo, di na nimo masugo tungod lang ana. [You can't make [adolescents] do chores because they are stuck to using their gadgets like their cellphones.]"

(Midwife facilitator 5, female, 48 years old)

Meanwhile, health center-based adolescent groups were more likely able to share their encounters of risky online activities. This involves exposure to cybersex, pornography, and meeting strangers or foreigners online, eventually forming relationships with them. Adolescent participant revealed that she experienced being ***forced to send nudes and being sent pornographic materials***. Because of this, she mentioned her fear that the person might make rumors about her because she refused.

"Cyber sex, and pornography. Dili jud malikayan nga naa kay friend sa facebook nga mo chat lang og "send nudes" or kung dili ka pangayuan og nudes kay sila mismo mo send og mga naked videos nga dili ilaha… then ilahang mura gani'g ikatag ang rumor sa taw, para ma daot. Mura ka'g maka relate kay what if kung magbuhat siya'g second upload or buhatan ka niya'g rumors like bisag wala nako gi send basin moingon to siya nga kana baya siya [name] kay nag send baya na nako'g picture, nya bisag wala gud pero ang mga taw kay basin niya'g motuo ba, diri mo blame nako. Nagbuhat rato siya'g istorya. Naa say uban ana nga sendan kag videos kay ma addicted sila ato. [Cyber sex and pornography. It's inevitable to have a friend on Facebook who will send a chat message like, "Send nudes" or if not, they will send you naked videos. Then, they will spread a rumor to malign you. You can also relate to this because what if the person will make rumors about you sending nude photos even if you did not really do it. What if the people will believe these rumors and blame me when the person is just making it up. There are some adolescents who send [pornographic] videos and they become addicted to it.]"

(Health-center based adolescent 5, 17 years old)

Different types of online behaviors were shared by the two groups of program facilitators. For school-based program facilitators, it was common in their community for adolescent girls to ***chat with foreigners online*** and to accept random friend requests from foreign men:

"Kana bitawng cyber sex or ang mga bata na mismo maoy mag chat-chat, Oo pero risky kaayo ang mga behaviors nga ilang gi kuan like makig chat ug foreigner it's so easy for them ba, kita mahadlok ta mag imagine lang ta ba, mo-accept lang tag friend request ani wala ta kaila niya ingon ana. [About cyber sex, sometimes the adolescents are the ones who first send messages. They display very risky behaviors, for example, chatting with foreigners. It seems very

easy for them, but the thought of accepting a [social media] friend request of someone you don't know is too scary for me to imagine.]"

(Teacher facilitator 1, female, 39 years old)

While health center-based program facilitators described it being ***easy for adolescent girls to meet in person the strangers they befriended online***, as mentioned by a program facilitator:

"So murag nagpalabi lang og kuan kay nag meet-meet tungod sa social media. [It's easy for adolescents to meet people and arrange meet-ups because of social media.]"

(Nurse facilitator 1, female, 26 years old)

An adolescent participant from the health center-based group described how easy it was for adolescent girls to ***form relationships though online courtships***:

"Unya dali na kaayo nila ang makig-relasyon ba kanang through cellphone nalang, sugot kay sugot nalang kung kinsay manguyab. [It's very easy for adolescents to enter into a relationship through electronic media. For example, they immediately say yes [to being their girlfried] to the person courting them even through their cellphone [messaging apps].]"

(Health center-based adolescent 2, 22 years old)

Other risky online activities observed by program facilitators included the sharing of sexualized images or videos which contain sexual and harmful content, with or without consent. Program facilitators in the health center-based group were alarmed by the negative influences of social media. They argued that ***adolescent participants copied the risky behaviors online*** out of curiosity. One program facilitator explained that content involving drug use and sexual violence were viewed:

"Kuan sa media sad guro, usa sad na Kanang mga makit-an nato sa social media nga drug, rape. Kana sila…Daghan pod mo kuan maka-suon sad siguro. Nakahimo man didto, pina ana ba. Oo unya ma-koryoso. [Also with what we see in social media, for example, drugs and rape cases. Many would want to copy these behaviors. These would make them more curious.]"

(Midwife facilitator 1, female, 42 years old)

Other program facilitators spoke of suicide attempts, stating that these are common among young adolescents. In relation to unstable relationships, when they break-up with their partners, they resort to ***self harming such as slashing their wrist and posting these things online***. She said that adolescent girls indeed have those tendencies especially when they can't share it to their families:

"Kanang ma broken hearted, mga buwag-buwag… Yes, kanang sa mental health ni nga...Usually mag suicide attempt kay mga batan-on pa. Experimental stage pa sila ba. So samot makit-an nila sa social media, nga maoy buhaton, picturan. So dali ra kaayo sila maka commit ana kay kanang pamilya madaganan wa sila wala pa sila… mauwaw pa sila kay siyempre bata pa kaayo sila ba unya kuan mauwaw sila mo share. Naay tendency gyud nga mo commit sila ana. Mao toh…Post post dayon sa social media [slashing]. [Those who get broken hearted, couples breaking up… Yes, it's mental health-related [issue]. Usually, those who have suicide attempts are very young, those who are still in their experimental stage. If they see it in social media, that other people are doing it, it makes it easier for them to commit the same thing. They also do not have a functional family to run to. They are shy to share what they are going through because they are still very young. There is really a tendency for them to commit [suicide attempts - slashing] and post it on social media.]"

(Nurse facilitator 4, female, 32 years old)

Substance misuse was described as use of alcohol, drugs, and cigarettes in amounts which may be harmful. The statements of all groups of adolescent participants and program facilitators were coherent on this issue. With a lack of parental guidance, peer influence, and poor decision-making, adolescents became susceptible to experimenting with these substances and potentially misusing them. It was mentioned by all groups that at an early age adolescent girls and boys start smoking cigarettes, drinking alcohol, and taking drugs such as marijuana and 'shabu' (methamphetamine).

During the validation, health professionals added that using e-cigarettes is also an increasing trend among adolescents. According to school-based adolescent participants and program facilitators, there were instances when adolescents were caught smoking during class hours. Health center-based program facilitators highlighted that adolescent girls drink alcohol with boys. The table below includes some of the comments about substance misuse.

TABLE 2. RESPONSES RELATED TO SUBSTANCE MISUSE OF ADOLESCENTS

Smoking cigarettes	
"Kanang estudyante nga mo sigarilyo maam. Then daghan pod sa lugar namo nga bisag ga eskwela pa mag tago-tago og sigarilyo maam. [There are students who smoke. There are also many students in our area who go to an inconspicuous area just to smoke.]"	School-based adolescent 2, 14 years old
"Kana mo apil na sila anang mga bisyo, magkuan sila og smoking, kay mao gyud na akong maproblema karon diri sa	Teacher facilitator 3, female, 46 years old

atoang, especially sa atong school kay naa man gyud na, as a guidance counselor man gali naa man mi mareport nga gabuhat ang bata ana, madakpan nila masakpan sa mga kuan diha sa guard, unya i-saka nila diri, " Unya unsa may kuan man ana guard?" "Maam nasakpan ni maam nag smoking." Ana dayon na sila. Mao na risgo gyud kaayo na. [They have vices like smoking. This is really my problem especially here in our school. As a guidance counselor, we report students who do these things. They are then caught by the guard and sent to our office. I would ask "What's their [violation], guard?" The guard would say, "Maam, I caught them smoking." This is very risky for them."]"	
"Ang uban karon dali nisulod bisag bata pa gani nisulod na og bisyo kay manigarilyo og kanang inom mao na siya. [Other adolescents today, even at a young age, already have vices like smoking and drinking.]"	Health center-based adolescent 3, 21 years old
Alcohol	
"So as an overall ang main problem gyud sa school and even sa community is the vices like alcoholic drinks. [The main problem of the school and even the community is that [adolescents get involved in] vices like [drinking] alcoholic drinks.]"	*Teacher facilitator 2, male, 26 years old*
"Oo to think ha gagmay pa kaayo. Barkada sila ha nag inom ngadto. Pero ambot ngano nakasod toh sila noh. Oo alcohol. Kuyog mga lalaki, lalaki bababe toh sila. [They are still very young. There was a peer group caught drinking but I'm not very sure why they were allowed to go inside. There were both boys and girls drinking alcoholic drinks.]"	*Nurse facilitator 4, female, 32 years old*
Drugs	
"Karon gyud mo apil na sila og take anang marijuana, sometimes naa ng shabu. [These days adolescents engage in taking marijuana, sometimes use shabu.]"	Teacher facilitator 3, female, 46 years old
"Kasagaran mga drugs. [The use of] drugs is also very rampant.]"	Health center-based adolescent 10, 23 years old

The risky behaviors mentioned were believed to be accompanied by poor attitudes. The **attitudes of adolescents** were described as a way of thinking and feeling which influenced the decision making and actions of adolescent girls. A common sentiment among research participants was that adolescents can be ***disrespectful and disobedient***, not just to their parents, but also towards other authority figures.

Two adolescent participants reiterated that some adolescents are aggressive, uncooperative, and do not listen to their elders.

> *"Ang uban kay gahi kaayo, ang uban dili magpatuo. [Some [adolescents] are hard-headed, some are also defiant.]"*
>
> *(Purok-based adolescent 6, 16 years old)*

> *"Maminaw sila pero murag gipalapos ra gud nila sa dunggan. Gi baliwala ra nila ang message sa Kapitan. Ipadayon gihapon nila ang mga kanang bati nila nga gibuhat. [They listen but they are not putting what they learned into action. They are not taking the message of the barangay captain seriously. They still continue with their wrong doings.]"*
>
> *(Health center-based adolescent 7, 15 years old)*

Adolescents were also commonly described as being ***curious and easily influenced by peers***, readily trying something unfamiliar or following trends. One adolescent participant shared her personal experience of how curiosity led her to consider engaging in risky behavior:

> *"Then maka affect sad nako kay naay time nga mosud man gud sa utok, what if kaya kung maka ing-ana ko someday, mosud rana ang imong curiosity ba kay maka kuan kaayo. [It also affects me because there are times when I think of [trying out risky activities], what if [engage in risky acts] someday. Your curiosity will lead you to try out these things.]"*
>
> *(Health center-based adolescent 5, 17 years old)*

Peer groups were thought to greatly influence adolescents towards making poor decisions and risky behaviors. Program facilitators described that adolescents were influenced by their peers to skip classes:

> *"Then sa ilahang mga peer groups. Usually ingon ana man gyud na ang kuan karon sa mga bata. Unya usahay mao sad nay factor nganong kuan sila maka-absent sila kay mo focus sila sa ilahang mga barkada o unsa pana ilang buhaton diha sa gawas, maka-absent. Unya pagbalik mao nana ang reason. [Another factor why they skip classes is because they are too focused on their peer groups*

and whatever it is that they do outside school. When they come back to class, [being with their peer groups] is usually the reason that they provide.]"

(Teacher facilitator 3, female, 46 years old)

When they spend a lot of time with their peers it was felt that their behaviour deteriorated, as added by a program facilitator:

"So eventually makita gyud nato nga wala gyud silay proper behavior or management sa ilang kaugalingon. [So eventually, we will see that they don't really observe proper behavior or self-management.]"

(Teacher facilitator 2, male, 26 years old)

Pressure to be in a romantic relationship was also mentioned as described by facilitators, as outlined by one health professional:

"Sila karon kay murag ikamatay nila kung wala sila'y uyab. Murag ingon-ana gani. Ma pressure sila ba. [It seems like adolescents today are going to die if they don't have a boyfriend or girlfriend. They feel pressured [to be in a relationship].]"

(Nurse facilitator 1, female, 26 years old)

Low self esteem was thought to make adolescent girls vulnerable, with social media then being used to bolster this through the number of likes received. One facilitator observed that this led some girls to post sexy images online to receive more like:

"Kuan sad in connection sa social media ba, nakabantay sad ko karon. Nakabantay mo sa generation karon? Grabe na gyud ilaha thirst sa attention. Grabe nga bahalag mag ladlaran ka sa imohang lawas basta daghan kag likes. Kana gani. Gi equate man nila ilahang kuan man to unsa man likes, smiley, heart. Sa self… Self-love ba tawag ana or? Unya the more you get worth, the better you are. [In connection with social media, I also observe that the generation today thirst for attention. It doesn't matter if they're flaunting their bodies [on social media] just to receive a lot of "likes". They equate their [self-worth] on the number of likes, smileys, or hearts they receive on social media. Do you call that self-love? The more you get worth, the better you are.]"

(Nurse facilitator 2, female, 33 years old)

THEME 3. THE HEALTH AND WELLBEING OF ADOLESCENT GIRLS IS NEGATIVELY AFFECTED

Research participants expressed significant concern for the health and wellbeing of the adolescent girls in their communities. These concerns were described as being related to (1) their sexual and reproductive health, and (2) the experience of abuse and exploitation. Both the adolescent participants and program facilitators identified teenage pregnancy as the leading issue for adolescent girls. Adolescent also focused on behaviours such as early sexual initiation and risky sexual activities, compared with facilitators who expressed more concern about STIs, commercial sexual exploitation, and child abuse.

Issues related to the **sexual and reproductive health** of adolescent girls referred to their SRH-related choices and the outcomes of these. Much of the concerns mentioned centered on the issue of teenage pregnancy. Teenage pregnancies in the Philippines were observed to be increasing and happening at earlier ages, with most pregnancies thought to be unintended. ***Teenage pregnancies*** were believed to be caused by the increasing sexual activity among adolescents, who were entering romantic relationships and sexually initiating at a younger age.

Both adolescent participants and program facilitators told many stories of girls getting pregnant at a very young age. They also suggested reasons for this situation. One adolescent participant shared how the lack of knowledge led to unintended pregnancy:

> *"We all know that teenage pregnancy is one of the rampant issues nowadays. And here in our barangay, kay dominant na gyud ang, mas daghan ang mga batan-on pa ba at early age kay nanga buntis na, knowing nga lack kay silag knowledge about unsaon pag care sa ilang virginity and how to preserve sa ilang pagka babaye. [We all know that teenage pregnancy is one of the rampant issues nowadays. And here in our barangay, there are a lot of young girls who get pregnant at an early age. They lack knowledge about how to take care or preserve their virginity.]"*
>
> *(Health center-based adolescent 5, 17 years old)*

Another adolescent participant mentioned that the availability and accessibility of venues where adolescents can easily have sex is a factor too. She cited a personal experience hearing young couples having sex in the secluded areas of the neighborhood.

> *"Sa among lugar kay kanang naay lain lugar nga, kay ngitngit man among lugar ba, naay mga mag-uyab nga di taga amo didto. Tungod sa kahilom adto sila mag saba-saba unya kuan murag naay mahitabo nga wa ta kahibaw [sex]. Mabuntis na lang dayon ba. Hilom didto. [Couples who live in our neighboring*

barangay head to this secluded place in our area where it's dark and quiet. They do lewd acts there and next thing we know, the girl is already pregnant.]"

(School-based adolescent 3, 14 years old)

Other related reasons described were that adolescent girls were not adequately prepared to be in a serious relationship and engaging in early sexual initiation:

"Unya mag uyab-uyab unya wala kahibaw sa mga gi-dili. [Engaging in early romantic relationships without knowing their boundaries or limitations.]"

(Teacher facilitator 1, male, 26 years old)

In connection to early sexual initiation, program facilitators noted that adolescent girls were pressured by their peers to have sex early in a relationship, through which they ***acquired STIs or STDs.*** A health center-based program facilitator recalled their experience treating these infections:

"Ma pressure sila. Unya mag kita-kita dayon sila… Unya naa dayon mo piyong lagi. Mo ana… usahay man gud nga kapila na gud mi naka entertain dira sa city health og mag inject mi og antibiotic kay naa nay STD, STI. [They are pressured [to engage in sexual intercourse]. They meet and get drawn to have sex. There were many times when we were able to assist patients at the City Health Office to inject antibiotics for STD or STI.]"

(Nurse facilitator, 1 female, 26 years old)

An adolescent highlighted that adolescent girls have become vulnerable to STIs because of their risky sexual behaviors. She said:

"Siguro ang mga batan-on nga babaye karon kay prone sa mga let's say STD, mga aids ana ba tungod sa kanang ang kuan pud ron lahi na og [linihokan] ang mga batang babaye karon siguro akong opinion is mao to prone siya sa STD ug STI. [The adolescent girls today are prone to STD and AIDS primarily because of how they behave. [Their risky behaviors] put them at risk of acquiring STD or STI.]"

(Health center-based adolescent 1, 21 years old)

One commonly mentioned risky sexual behavior was having ***multiple sexual partners***. A program facilitator elaborated that adolescents have unstable relationships and move quickly from one relationship to another. Thus, they are exposed to different sexual partners and their risk of STIs increases:

"Unya mostly gyud nila labi na batan-on pa kaayo mosulod naman gud sila anang mga intimate sexual nga kuan ba relationships. So murag gikan sa usa ka laki gigamit siya tas nagbuwag sila, bag-o na pod ang uyab. Unya as early as 13,14, 15 years old. Mura naman ka multiple partner ana oy ining abot nimo sa imohang sakto nga edad. Daghan na kaayo lalaki nakagamit nimo. Unya mao na ang tendency STDs mao na kanang sakit nga matakod gyud. [Most adolescents enter intimate sexual relationships at a young age. For example, a girl would have sex with her boyfriend and then they break-up, and then they find another partner. [They do this] as early as 13, 14, 15 years old. It's just like having multiple partners when you reach the right age because you already had sexual contact with a lot of men. This increases the tendency for STD which can also infect others.]"

(Nurse facilitator 4, female, 32 years old)

Program facilitators believed that a ***lack of knowledge and misinformation*** was a primary reason for the sexual and reproductive health issues experienced by adolescent girls. This was accompanied by the reluctance of some adults with conservative beliefs to educate younger adolescents. Health center-based program facilitators, in particular, shared their experiences of encountering students with poor SRH knowledge, including the following nurses who discovered that Grade 9 students believed that washing their genitalia with soap would protect them from STIs:

"Kay wala mana sila kahibaw for example kanang mga high school, kahibaw kaha na sila once mag engage sila og sexual intercourse automatic mamabdos ba na sila, unsa ba or STI per se, mao nay thrust karon sa amo gi kuan sa barangay if possible i-apil ang school kay mo ana man ang school nga bata pa kaayo ang unsa na grade 7 grade 8, bata pa daw. So ari mi sa mga SK 9 and pataas. Mas maayo pa na manubag lagi… Kuan bitaw isa ka kanang unsa ni STI lecture, Kanang kuan mangutana ko unsa man nahibaw-an ninyo tambal sa sira? As in ma stress ka. Naa pa gyud to "perla perla". [They don't know, for example, those who are still in high school, I'm not sure if they know the risks of engaging in sexual intercourse - that they might get pregnant or have STI. This is the current thrust of our barangay, if possible, the schools will be involved. The school will tell us that they are still too young, like Grade 7 and 8, are still too young [to learn about sexual and reproductive health]. We do it instead with students in Grade 9 or above. When we do lectures about STI, and I ask them what they know about the medications for STI, you will really get stressed out when you hear their answers. They have this misconception about using bar soap [for STI medication].]"

(Nurse facilitator 2, female, 33 years old)

Another program facilitator agreed on that. She said that it's a common practice for adolescents to treat possible STI symptoms with soap:

> *"Perla kanang imnon. I-boil nimo then ikutaw. [The bar soap will be dissolved in boiling water and drank to treat the infection.]"*
>
> *(Nurse facilitator 4, female, 32 years old)*

Other program facilitators shared that, in their community, many girls believed that coconuts could treat STIs in men, where they cut a hole into the shell and insert their penis into the contents:

> *"Lubi…Kanang lubi buslotan isulod ilang kinataw. [They also shared one about] using coconut. A hole will be drilled into the coconut shell where the man can put his penis in.]"*
>
> *(Nurse facilitator 3, female, 25 years old)*

The program facilitator further mentioned that misconceptions and myths were more easily disseminated than factual information. She encountered a case of a young couple who got pregnant due to incorrect application of the calendar method, where they used the calendar to lie on rather than to find the 'safe days' to have sex:

> *"Naa pa gyud lack of knowledge, naa pa gyud siya on-going nga mga misconception, mga myth about ana… Murag mas paspas mutatak ang myth kaysa klaro nga [CT: tinuod] nga information. Kanang unsa pa toh, kanang unsa na? kana sang, kani joke man siguro toh pero wa ko kahibaw ngano na joke… kanang buntis daw iyang uyab. Ana ko unsa diay gigamit ninyo? Dili biya siya batan-on jud kaayo. Ana siya "calendaryo maam" Nag expect ko is rhythm of calendar method. "Gi unsa man, gi unsa man ninyo og kuan? Gi unsa nimo pag implement ang calendar method?" Nangutana ko specific ba. Kay gi hapin ra… Naka ing-ana ko "Joke lang unta ni Lord, joke lang unta ni Lord" Piskot biya. Namabdos kuno iyang uyab. Gi unsa ninyo pag gamit ang calendar? Pak! Gihapin… There is really a lack of knowledge and a lot of misconceptions and myths. Myths are easily spread and believed by them compared to factual information. [There's this situation which I was hoping this was a joke when a guy shared that his girlfriend is pregnant. I asked, what contraception method did you use? He replied, "the calendar [method] maam". "How did you use the calendar method?", I asked specifically. He then said they used the calendar as a blanket. I said to myself, "I hope this is a joke, Lord." His girlfriend got pregnant because he took the use of the calendar literally – as a blanket.]"*
>
> *(Nurse facilitator 2, female, 32 years old)*

Abuse and exploitation were described as any act of maltreatment perpetrated by adults to minors that violated their rights as a child or under the law. This constituted all forms of abusive and exploitative behaviors which harmed the child. All program facilitators spoke of the involvement of adolescent girls in commercial sexual exploitation (CSEC), sex trafficking, and different types of abuse cases. Only one adolescent participant shared a story of abuse or exploitation during the FGDs.

Although many of the adolescents shared stories with the facilitators during the course of 'A Healthy Me', they were largely silent about their experiences and those of other adolescent girls in their communities during the FGDs, despite many of them living in areas which are widely known to be hotspots for these issues. It was observed by the researchers that some of the research participants incorrectly termed experiences on abuse and exploitation. For instance, the term 'cybersex' was used for online sexual activities instead of online sexual exploitation of children.

A school-based program facilitator reported to have a first-hand experience of dealing with ***children at risk for commercial sexual exploitation***. The school partnered with a nonprofit organization who rescued children who were considered at risk of exploitation, which include some of their students:

> *"Previous years, mga 3 years ago, we partnered with [name of organization withheld], then na shock mi nga, kay ang ilaha mang gyud work is manggawas sila tungang gabie hantod kadlawn, so daghan silag mga bata nga na rescue sa plaza mao na ilang himoag focus group discussion, mag lecture sila about anang kuan, then mo ari sila, mo come in sila sa school kay i-inform sila, i-inform mi nila nga mao ni mga bata nga beneficiary namo niya nag undergo nig programs, pagtan-aw nako didto kadaghan gyud diay both lalaki and babaye. Niya kuan sila termed as CSEC or kanang murag at risk sila of kuan ba kay naa pa man sila nag suroy suroy sa dan mga alas 3 sa kadlawn, alas 2 sa kadlawn. [Three years ago, we partnered with a nonprofit organization [name withheld]. We were surprised to know about their work, that they go out in the wee hours to rescue children loitering in the plaza. They conduct focus group discussions, do lectures, and come to the school to inform us that, "These children are our beneficiaries and are part of our programs." When I took a look, there were really many who are our students – both boys and girls. They are called CSEC or at risk because they are out in the streets even at dawn (2:00-3:00 AM).]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Likewise, health center-based program facilitators were aware that ***sex trafficking*** was happening in their communities. One of the program facilitators had provided condoms to a man who disclosed that some adolescent girls offered him sex for only fifty pesos (about $1USD):

"Sa akoa sad naay nangayo og condom trabahante ba sa construction. Naa kuno'y kanang teenage siya kuan... unya kanang nangayo og condom ang lalaki kay naa kuno tag singkwentahon didto mo duol nila sa ilang barracks. [In my case, a construction worker asked for a condom. He said that there are teenage girls offering sex for 50 pesos near their barracks.]"

(Midwife facilitator 7, female, 32 years old)

For the above community, adolescent girls involved in sex trafficking were given different labels according to their practice. Some girls were called *'Karton girls'* ('carton' - a piece of cardboard) and visited construction areas pretending to be collecting cardboard for recycling. Program facilitators said that they were very young and that their price for sex had increased from only twenty pesos to fifty pesos:

"Karton girls, twenty. Gagmay kaayo na sila. [They are called Karton girls worth twenty pesos (P20). They are very young.]"

(Nurse facilitator 4, female, 32 years old)

"Singkwenta (P50) na sad oy. [They are now worth fifty pesos (P50).]"

(Nurse facilitator 5, female, 27 years old)

Other adolescent girls engaged in commercial sexual exploitation disguised themselves as 'candle vendors. According to a program facilitator, the candle vendors were often very young:

"As in ang batan-on ana is 12-15. [They were aged 12-15 years old.]"

(Nurse facilitator 2, female, 33 years old)

Another program facilitator recalled an incident where the barangay official attempted to apprehend the girls, sharing that they had a pimp who stayed at the plaza (city square) and texted each girl when he had a man to refer:

"Pero nakadungog mo na sauna naa na sila'y grupo mga babae katong mamaligya kandila, nabaw sila og gukod hasta ang tanod, kapitan. Oo mga bata pa kaayo. Murag naa silay kuan diha, naa silay bugaw, anha na sila tambay sa plaza. Diha mag ginokdanay sauna kay dakpon... Aw gi kuan lagi ang bata, gi kuanan sa iyang mama ba. Kuan gani hands off na gyud iya mama niya kay di na gyud siya makuan, di na gyud siya patuo. Unya ang naka kuan niya is daghan lagi siya amiga, mag textanay na sila "mag abot ta diri" ana- ana. Naa silay ireto-reto mga laki. Dayon ing-ana ba pero so far karon kuno wala na. [Have you also heard before about the group of girls who sell candles... the barangay captain and officials really went after them. Yes, they were still very young. They have a

pimp and they hang around the plaza. This is where they get chased after officials because they refuse to get caught. The mother of one of the girls already refused to get involved in the situation because the girl was really hard-headed. The girl communicates to her friends through text messages to arrange meet-ups and recommend guys. This was before, but now they said it's no longer the case.]"

(Nurse facilitator 4, female, 32 years old)

A health center-based program facilitator from a different community also mentioned encountering sex trafficking happening in their community, although described as adolescents being "paid for sex" rather than the terms sex trafficking or CSEC. She mentioned that prostitution happens in her community too and that she is concerned about the risk for HIV.

"Siguro og ingnana possible nag multiple partners sila murag naa baya gyud say ingnana noh bisan diri naa sad baya gyud magpabayad, paying sex ba, naa baya, kuyaw silag HIV. [It's really possible that they have multiple partners, because even here [in our community], there are those who ask payment [for sex] and it puts them at risk for HIV.]"

(Midwife facilitator 8, female, 45 years old)

There were also stories of other forms of abuse related during the focus group discussions. Forms of abuse mentioned were domestic violence, intimate partner violence, child slavery, and child sexual abuse. Health center-based program facilitators shared that some participants disclosed their abuse experiences during their sessions. Thus, the following stories are real accounts from the adolescent participants relayed by the program facilitators during the FGDs.

One program facilitator had a participant who left Bohol (a neighbouring island) to escape from her abusive father. The adolescent participant revealed that she and her mother are victims of ***physical violence and death threats***:

"So ang iyahang kuan experience sa bohol kay iyaha mama pirmi kuanan bugbog sa iyahang papa asta siya. So mao toh usahay naka hisgot toh siya nga murag daghan ipanulti iyang papa kay patyon lagi iya mama hasta siya. Mao toh iyaha sila og tago, iyahay sila'g hilak sa sulod ingon ana. [In her experience in Bohol, she and her mother always get physically beaten up by her father. She mentioned that her father threatened to kill them. [When this happens], they just hide and cry in a corner.]"

(Nurse facilitator 5, female, 27 years old)

Another story concerned a teenage mother who was battered by her unfaithful partner. According to the program facilitator, three out of her 12 adolescent participants shared similar experiences. She said:

> *"Based sa atong mga na client didto sa Renewsiya sa A Healthy Me kuan usa siguro naka strike gyud nako kay katong kuan teenage mom siya and then it turned out nga kulatahon siya sa iyang partner and as of the moment nga mag session mi didto iyang partner is naa nay lain. Kuan pa gyud iya edad 17 so it's common… Ah so in general nila murag three out of 12 man siguro toh, naay same-same og story ba. [One of the clients [who participated in] Renewisya's 'A Healthy Me' program was a teenage mom. Her story struck me the most. It turned out that she was always beaten up by her partner and around that time when we were having sessions there, her partner was already involved with another woman. They were still 17 years old and it's common for that age. Three out of 12 participants had similar stories.]"*
>
> *(Nurse facilitator 2, female, 33 years old)*

One faciliator shared the story of an adolescent participant who was prevented from studying and was ***forced into domestic servitude*** by her family. She reported she was responsible for all of the household chores and felt trapped:

> *"Then sa first pa lang ni share na siya nga ganahan unta siya mapadayon iyahang skwela, wala lang siya ka eskwela kay iyahang papers kay nabilin sa Negros, Negros man sila gikan taga Negros iyahang mama unya taga diri sa [location withheld] iyang papa. Didto ni share siya kanang iyaha daw tanang trabaho sa balay. Mao siguro ganahan kaayo siya mo attend para maka ikyas siya ba: bantay bata, maghakot og tubig, mag lung-ag, limpyo tanan. Mo ana gud siya nako "mura sila'g dili kalihok maam kung wala ko." Ana ko "mao ba unsa man imohang kuan?" Ana siya "Ganahan jud lagi ko unta mo eskwela." Ana ko "Unsa man atong pamaagi para makatabang nga makuha toh imong mga gamit?" Ingon siya "Nawa naman kuno maam kay napada na sa prinicipal unya wala naabot sa ilaha" something mga ing-ana ba. Murag dili gyud gusto iyahang lolo or lola nga mo eskwela siya. Basin gitago ba ron ingon ana ba. [At first, she shared that she wanted to pursue her studies, she wasn't able to do so because she left her documents in Negros (a neighbouring island). They were originally from Negros. Her mother was from Negros and her father was raised here. She shared that she did all the household chores. I think this is the reason why she really wanted to attend ['A Healthy Me' sessions] so she can escape her responsibilities at home: babysitting, gathering water, cooking, cleaning the house, etc. She told me, "It seems like they [the girl's family] can't do anything if I'm not around." I*

said, "What can I do to help you get all your things?" She said, "My documents are no longer there, they said they sent it to the principal but it turns out, [the school] did not receive it." It seems like her grandparents did not want her to pursue her studies, it's like they are hiding her or something.]"

(Nurse facilitator 4, female, 32 years old)

The last story was shared by a school-based program facilitator whose community is considered a hotspot for child sexual abuse and CSEC. Aside from the issue of online sexual exploitation of children in their community, ***sexual abuse*** was also viewed as being common. As a guidance designate teacher, she had referred a number of child sexual abuse cases to DSWD. She highlighted that most of the students experienced sexual abuse since they were young and only disclosed it during their teenage years. Isolated cases of incest were also described:

"Another thing is, child sexual abuse nga cases gyud, daghan tag na refer, ni disclose nga mga bata diri nga na refer na didto sa DSWD. There were some success stories pod, pero naa poy uban nga wala gyud kaayo na tabangi, ing-ana…So kasagaran ma victimize, mga babaye, usually mga 5 years old, 6 years old pa sila then it continued until nahimo na silang highschool, incest na mga cases, so… Oo, some of our students. Murag ni dili na kay siya grabe lang run, mga isolated cases na lang. Kay kato man gyud to nga time nga nag implement mi og personal safety lessons, naa mi mga recollection then mura gani naka disclose sila. Unya sauna paman toh nga mga, mga panghitabo, niya mura bag ila lang gyud gi keep wa gyud sila nasulti mao to nakasulti sila. [Another thing is child sexual abuse cases. We were able to refer a lot, children disclosed [sexual abuse] here and we referred them to DSWD. There were some success stories though, but there were also others who weren't very successful. The victims are usually girls, around 5 or 6 years old, [the abuse] continued until they were in high school. There were also cases of incest. However, it is not as grave as before. We only have isolated cases now. There was a time when we implemented personal safety lessons and we had a recollection where they were able to disclose [cases of abuse]. But these happened years ago, it's just that they never had the guts to report it.]"

(Teacher facilitator 1, female, 39 years old)

THEME 4. THERE ARE SECONDARY EFFECTS OF ADOLESCENT ISSUES

The issues outlined in the first three themes were thought by the research participants to lead to other short and long-term negative effects. These were described as affecting the adolescents' (1) social situation, (2) physical health, and (3) psychological health. All groups mentioned wasted education as being an impact of teenage pregnancy with health center-based program facilitators

describing the long-term physical health and psychosocial effects of teenage pregnancy in significant detail. Whilst all groups of adolescent participants and program facilitators expressed being troubled by these secondary effects, the health center-based program facilitators felt a particular burden because they provided antenatal, obstetric, and infant healthcare to the teenage mothers.

Social situation refers to the social conditions of the adolescent participants which have resulted from the issues they experienced. The most common secondary effect under 'social situation' for all groups of adolescent participants and facilitators was wasted education. Program facilitators also observed that early marriage and poor parenting were common consequences of teenage pregnancy. In comparison, the adolescent participants who were already teenage mothers mentioned poverty and financial or employment problems were the common secondary issues affecting them.

Adolescent participants inferred that, because of teenage pregnancy and substance misuse, adolescent girls dropped out of school with little chance of returning. Thus, their ***education was considered to be 'wasted'*** as described by one school-based adolescent participant:

> *"Sayang kaayo ilang pag eskwela nga ila na gibiyaan tungod sa sigeg panigarilyo, inom. [Their education is wasted as they left it for their vices – smoking and drinking.]"*
>
> *(School-based adolescent 2, 14 years old)*

Program facilitators support this notion. However, in addition to teenage pregnancy and substance misuse, program facilitators believed that educational attainment was also affected because of the experience of abuse and exploitation. For instance, the adolescent girl described earlier who experienced domestic violence from her father, was unable to study because she did not have the official papers required by the school.

> *"Unya mao toh didto na sila nag puyo pero wala na siya nag school, nahunong siya kay iyahang birth, mga papers naa pa sa bohol. [After escaping, they lived here. But she is not attending school. She stopped because her birth certificate and other papers were left in Bohol.]"*
>
> *(Nurse facilitator 5, female 27 years old)*

Early pregnancy was observed to lead to poor parenting by all groups of adolescent participants and health center-based program facilitators. The teenage mother's age, lack of emotional preparedness, and lack of financial resources were considered determinants of ***poor parenting***. One of the adolescent participants described how teenage mothers lacked the skills for raising a child:

> *"Mga teenager nowadays nga magpa kuan sila sa ilang uyab pero di sila kabalo mupadako sa bata. [Nowadays, teenagers get impregnated by their boyfriends but they don't know how to raise a child.]"*
>
> *(Health center-based adolescent 7, 15 years old)*

In some cases, teenage mothers who were abandoned by their partners become single mums. As a result, the grandparents took responsibility for raising the child: *"Ang parent maoy mabilin mag take care sa anak og sa apo. [The parents carry the responsibility of taking care of their daughter and their daughter's child.]" (Nurse facilitator 2, female, 33 years old).* Being a single mother also left the adolescent girls with no choice but to look for a work to support the needs of their child. This was challenging because they can't be legally employed at their young age. In the Philippines, employing workers under the age of 18 is illegal. In addition, even if they are of legal age, their low educational attainment often results in low-paid, informal employment. These challenges result in ***unemployment and deeper poverty for many teenage mothers***.

> *"Financial gyud oy. Kay magkina-unsa, wa ta'y kan-onon asa man ta mangita? Mao man gyud, wala tay trabaho. Kinahanglan maningkamot ta. [I am affected financially. For instance, if we don't have food on the table – where to find it? I am unemployed so I have to strive harder.]"*
>
> *(Health center-based adolescent 8, 24 years old)*

Meanwhile, some ***adolescent participants married early*** after they became pregnant. According to a program facilitator, "*Kuan sayo gyud sila mga minyo, kuan 16, 17 ang isa kay 19. [Adolescent girls get married early at the age of 16 to 19.] (Nurse facilitator 2, female, 33 years old).* An uncommon but important effect resulting from illegal drug use was children becoming orphaned when their parents were killed because of their alleged involvement with drugs during 'Tokhang' ('knock and plead') operation, which is how the Philippines' police operation for the war on drugs is termed.

> *"Ka kuan ka atong diha katong naay mag tiayon nga dinha mismo gipatay sulod sa balay unya naay mga bata? Oo sa [location withheld]. Unya ang mga anak murag naa man sigura sa DS. [Have you heard of the married couple who were killed inside their home in the presence of the children? Yes at [location withheld]. I think the children were brought to DS[WD].]"*
>
> *(Midwife facilitator 8, female, 45-year-old)*

Lastly, program facilitators who were community nurses and midwives described the impact of teenage pregnancy on their workload – an ***increase in their workload***. They not only had to provide healthcare to the adolescents during pregnancy, but act like mother-figures in guiding the teenagers through motherhood.

"Kami maoy nakuanan sa ilang responsibility sa mother na anhi na padong namo. Oo, so diri na namo kay nasulod naman na sa amoang trabaho kay naa na padulngan, pag displikar nila unsaon, ang buhaton, unsay ing-ana. Kami maka murag mo facilitate nila unsay angayan og dili. [We are burdened with the responsibility that should have been carried by their mothers on teaching them on motherhood. We discipline and teach adolescent girls on the do's and don'ts of pregnancy. We have been facilitating this as part of our work.]"

(Midwife facilitator 2, female, 44 years old)

Risky behaviors and sexual and reproductive health issues were also described as impacting the **physical health** of adolescent girls. ***Lack of sleep*** was commonly mentioned by both groups of adolescent participants because of technology misuse or child rearing responsibilities. Lack of sleep may also be accompanied by ***poor eating habits*** and ***dizziness*** as shared by one adolescent participant:

"Dugay ka makatog kay nalingaw naka sa cellphone. Dili na lang ka makabantay unsa nang orasa, dili naka makakaon. Kung mag every time ka mo gamit og cellphone mura kag di naka ganahan mo hunong. Ingon-ana ba di na nimo buhian Naka affect pod na siya nako maam katong mag lipong-lipong akong ulo kay dili na kaayo ka ka… maghigda ka mag cellphone ka then inig ka barog nimo malipong naka. [You sleep late because you enjoy using your cellphone. You can't keep up with time so you missed your meals. Everytime, I use my cellphone, I just can't stop myself. I can't let go of it. It had also affected me that I experience dizziness every time I stand up after prolonged usage while lying down.]"

(School-based adolescent 2, 14 years old)

Health center-based program facilitators reported having to address the consequences of teenage pregnancy such as ***abortion***, which is illegal in the Phlippines, increased infant mortality, and pregnancy and postpartum complications. The issue of abortion was described by a health professional as follows:

"Mao na mag teenage pregnancy dayon, unya mao na mag teenage abortion. Ang anak maoy luoy. Kay di pa man andam… unwanted naman pagbuntis mao na buhaton. [Teenage pregnancy leads adolescent girls to commit abortion. The unborn child is pitiful. Because they are unprepared... it was unwanted pregnancy then they resorted to that.]"

(Midwife facilitator 1, female, 42 years old)

Some teenage pregnancies were denied or hidden by adolescent girls and thus they did not receive antenatal care. Other teenagers ignored the advice of the midwives. These issues were described as leading to ***pregnancy complications*** and ***infant mortality***. Another program facilitator encountered an adolescent girl who denied being pregnant and unexpectedly gave birth in a toilet. The infant died from drowning.

> *"Mao toh wala pa jud nagpa prenatal hangtod nga naabot na ang time nga gi rescue na sa midwife. Ni adto si maam [name] ang bata naa na sa bowl. [CT] Balay nila oo luyo ra. Concerning kaayo siya ba kay what if nag bleeding siya, siya ra usa ngadto sa sulod, ana. Pero ang luoy ang bata jud, luoy gyud ang bata oy healthy kaayo, himsog kaayo, sakto gyud. Pero nalumos… patay. After ato ang mama parang wala lang. Mura ra gyud siya'g wa. Didto gyud toh gi utong sa bowl. Luoy kaayo. Unya iya mama noh mura ra gyud wala as in. [The adolescent girl did not have any prenatal until she was rescued by our midwife. When maam [name] arrived, the infant was in the toilet bowl. Their house is located just at the back of the health center. It's very concerning because what if the adolescent girl had bleeding, she was alone while giving birth. But I felt more sorry for the infant, it looked healthy but died from drowning. After the incident, the mother lived as if nothing happened. The adolescent girl really gave birth sitting in the toilet bowl. There wasn't any hint of remorse on the mother's face.]"*
>
> *(Nurse facilitator 4, female, 32 years old)*

Psychological health connoted to the emotional and mental state of adolescent participants and program facilitators as an effect of the issues experienced by adolescent girls. All groups showed great concern for the adolescent girls facing the difficult circumstances and experiencing various psychological difficulties. All groups of adolescent participants had mentioned a loss of self-confidence because of the issues they faced. Meanwhile, program facilitators felt blamed and had anxiety because of the rise of sexual and reproductive health issues among teenagers. Other effects on psychological health included feeling judged by adults, feeling hopeless about the issues, depression, trauma, and suicide or self-harm.

When asked about how they were affected by the issues, some adolescent participants said that they are indirectly affected by it. According to one adolescent participant, she felt ***concerned as a woman*** when other women engaged in risky behavior:

> *"Kuan miss para nako maapektuhan ta kay kanang same ta nga babaye syempre. Unya ma kuan pod ta sa ilaha pong health, murag ma kuan pud ta ba nga kapwa babaye unya nisod sila og mga ingon ana, apektado pod ta. [For me, I get affected because I am also a woman. I also [get concerned] about their health. I*

get concerned that other women have risky behaviors. We will also get affected by that.]"

(Health center-based adolescent 1, 21 years old)

Another participant reported that they were judged when their siblings are faced issues due to the rumors being spread about them:

"Makaapekto kay maapil man ka sa tabi, mo-ana ba nga wa kabadlong. [I get affected because you get dragged into the talks in the communities. They make it appear like you're partly to blame because you never reprimanded them]"

(Health center-based adolescent 10, 23 years old)

With the responsibility of child rearing, some adolescent participants have observed that teenage mothers are not able to take care of themselves. During the validation, health center-based program facilitators emphasized that teenage mothers ***lack self-care***. They don't give attention to their physical appearance. An adolescent participant said:

"Kani pud nangabuntis ba nga naay mga anak ang uban kay dili na kaatiman sa ilang kaugalingon unya kanang stress na kaayo sila ba mura na silag dli batan-on. [Some of the teenage mothers can't look after themselves. They looked very stressed. They don't look their age anymore.]"

(Purok-based adolescent 6, 16 years old)

Program facilitators described feeling ***emotionally burdened*** by the issues affecting adolescent girls. Many were mothers with children the same age as the teenagers they worked with. A program facilitator shared how she empathized with an adolescent girl who became pregnant at the age of 14:

"Ang problema namo maam kay luoy ka ba kay affected sad ka kay inahan man sab ka mobati ka gawas, labi na nako nga naa koy 14 years old karon nga pregnant so tanan giingan nako, istorya, advise advise tanan pero mura ra'g wala ang bata kay tungod kay wala man iyang mama. Nagdako sa iya lola. So didto tipon sa laki. Nitipon siya 11 years old. Unya namabdos siya 14. [Our problem is that we pity them, and we also get affected because we are mothers too. Like me, I have a 14-year-old client who is pregnant. I talked to her and gave her advice but it's like the girl doesn't care because she doesn't have a mother. She grew up with her grandmother. When she was 11 years old, she went to live with her partner and then she got pregnant at 14.]"

(Midwife facilitator 5, female, 48 years old)

Other program facilitators ***felt hopeless and frustrated*** that, despite efforts to provide services to address the issues, their recipients were unresponsive. A program facilitator said:

> *"Kuan maam murag ma murag maguol sad mi maam kay bisag unsaon namo og extend sa amoang knowledge or kanang services gani, naa man juy uban nga dili. [We also get frustrated because no matter how hard we try to extend our knowledge and services, there are really some who don't change.]"*
>
> *(Nurse facilitator 1, female, 26 years old)*

There are instances when the health center-based facilitators ***felt blamed by parents*** who believed the SRH education they provided caused their children to be sexually active and acquire STIs. One program facilitator highlighted an experience when STI rates were rising in her community and they conducted an information drive to address this. However, one mother blamed the health center staff for her daughter's illness:

> *"Usahay man gud ma push gyud sa amoa kay ang amoang kanang STD rates gyud namo nitaas. So, siyempre automatic mag reproductive health dayon mi. So murag kami pod usahay ma blame kay "unsa mani?" kay nakasuway mi ngadto sa [location withheld] nga ang kuan ato... ni duol ko ato sa mama man ata toh sa babae ingon siya "Maam kaila mo ni…" Murag sige siya og tutok… "Kaila mo ni kuan…". Wa ko kaila man, ni tap dayon ko sa BHW "kinsa manang household?" Ana siya kuan maam kanang diri daw nangayo og condom ana-ana… na sakit kuno iyang anak kay murag nag uyab-uyab ba. Mura bitaw murag iyahang i-point ba nga kami ang nag introduce nga mo enter siya ana nga kuan gani ana ba. Ingon dayon ko "maam kanang honestly wala pa ko kita anang bataa." Ana siya batan-on man kuno ang nihatag. So murag ako na blame ani batan-on kay si Maam [name withheld] man naa dira. Unya di man pod si maam [name withheld] kay di man toh family planning. "Wa ko kabantay nga ni ari na siya" Wala say record wala pod kuan. Kuan man gud maam kanang akong anak ba nasira daw lagi kuno. Oo maam sunod ani amo lang adtuon unya di naman siya pa tan-aw sa centro after ato. Mura bitawg iyaha ba kay "sige mo push aning family planning awa naka kuan nuon mga batan-on". Kami bitaw, kita bitaw ang i-blame. [When STD rates increase, it's automatic that we do a program on reproductive health. Sometimes we get blamed for this. We experienced that in [place withheld], I was approached by a mother, she said, "Maam do you know...", it seems like she's staring at me. I didn't know the person so I tapped the BHW and asked whose household was that. She said that it was the mother of the adolescent who went to the health center to ask for a condom. Her child got sick because of getting into a relationship. It's like her point was that we were the ones introducing these thoughts [entering a relationship] to the adolescents. I*

then said, "Honestly maam, I really don't know who the child is." She said that the younger health worker gave the condom. I was the one blamed for it. I told them, "I didn't even notice that she came here, she also doesn't have a record here" but the mother insisted that her daughter got a sexually transmitted infection. I told her that we will check on her. Her point was that we always promote family planning and it's having a [negative impact] on the adolescents. We are the ones blamed for it.]"

(Nurse facilitator 1, female, 26 years old)

When providing care for pregnant adolescent girls, the midwives described ***feeling anxious*** because of the increase risk of complications:

"Actually, makuan baya ka labi na naay mga bata pa kaayo nga buntis noh? Makakuan sad ka ba nga problema nasad ni unya manganak, unya mostly baya kay mag premature unya mamatay ang bata. [Actually, you will also get affected seeing those who get pregnant at a very young age. Usually, they give birth to a premature baby and the baby dies, it really becomes a problem.]"

(Midwife facilitator 8, female, 45 years old)

Meanwhile, for school-based facilitators, they also felt anxiety and pressure especially when in the role of guidance-designated teacher. A program facilitator revealed his personal reflections about his role and search for effective responses:

"Yes, as a teacher because as a teacher you know that a teacher always teaches the proper behavior at the same time the good manners, I am not just a teacher in the school, I am also the guidance teacher designate, so it's really my duty, it's really my obligation to implement or to inform these highschool students about the issues in their community and it greatly affects in myself because sometimes I can think, or I will have self analysis, so sometimes I will have my self evaluation, if what are the things to do, is there any program or is there any methods that we can prevent this kind of issue inside our school or in the community"

(Teacher facilitator 2, male, 26 years old)

Another school-based facilitator said she was greatly affected as the 'second mother' to the students. She worries for the students when they are not present.

"As part as a teacher? Oo kay kana ra ba gyud na, mura ra ba gyud na og atong mga bata, anak, noh? Kay second parent baya ang mga teachers sa school unya sa gi-ingon ko na ganiha, usa sad na sa factors nga kanang mao na ilahang

absences, mao na nakakuan sila og absent. Ana…Oo, as second mother. Mao sad noh kay maguol baya ta, pangitaon baya nato ang wala diha nga mga bata. [As a teacher, yes [I get affected] because the children are already like our own. Teachers are their second parents. That is also one of the factors when you learn about their absences, you will also get worried. We always look for them when they are not around.]"

(Teacher facilitator 3, female, 46 years old)

With the existence of a problematic community, it has, and it will be difficult to transcend from the pressing issues of adolescent girls. First, these cultural norms had created a limitation for people to be open-minded about sexual and reproductive health education. Thus, becomes a barrier for adolescent girls to receive early SRH education that could potentially prevent SRH related problems from arising. Additionally, some communities had developed poor mindset or practices, had normalized illegal activities such as use of drugs and gambling, and to some extent had engaged in CSEC or OCSE. Technology has become accessible too which was unseemly used. Second, dysfunctional family relations and poor parental values and attitudes had resulted in the inappropriate activities, behaviors and attitudes of adolescent girls. Teenage pregnancy, going out with peers, and substance misuse were few of the repeatedly mentioned issues. Lastly, the systems put in place by the communities such as programs or policies responding to some of the adolescent issues had ineffectively addressed the issues. Consequently, its ineffectiveness and limitations became an issue itself. Overall, these issues had greatly affected the health and wellbeing of adolescent girls and as described by a program facilitator, it has become a never-ending cycle:

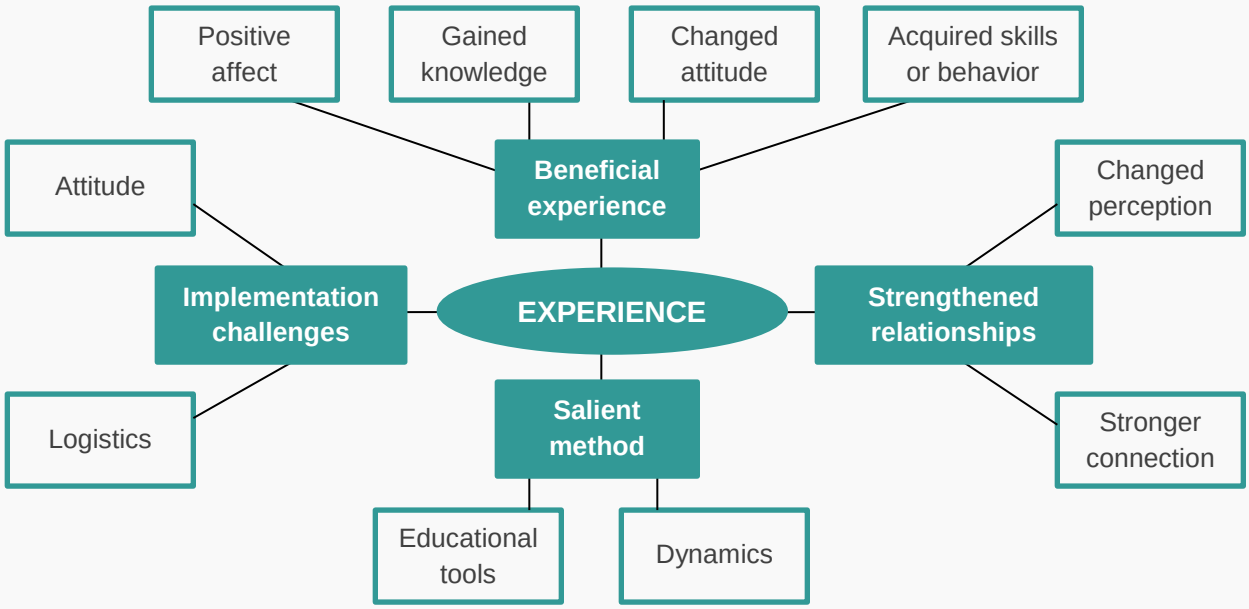
"Kuan example teenage pregnancy per se. Kuan man siya kanang cycle ba walay kahumanang cycle. For example, teenager manganak. Conflict inig ka gawas sa anak naa nay problema daan kay dili prepared ang mama. Ang mama na problema pod emotionally unstable pa ang mama. Mogawas ang anak, so GG ang mama ang lola pa sad. And then it will turn out ang iyahang teenage pregnancy maka caused na nuon na ma further into poverty ang family. Then additional costs. Usually biya basta teenage kanang bata pa gyud kaayo daghan kaayo'g unsa na health risks after gani manganak, post-partum. Usahay ang poverty maoy caused sa teenage pregnancy kay mo escape ang bata sa iyang kapungot sa iyang pamilya. Then mag think siya ang laki, maoy makabuntis niya, maoy iyang superhero. It turned out mao na say maka cause sa iyang poverty puhon. [For example, teenage pregnancy per se. It's a cycle of issues – a never ending cycle. For example, a teenager gives birth. There will be a conflict since by the time she delivers her child, she's unprepared – the mother of the teenage child becomes problematic, plus the teenager is emotionally unstable. When the child comes out, it's chaotic for the teenager's mother and grandmother. And then it will turn out that her pregnancy would lead her family into further poverty

because of the accompanying additional costs [of childcare]. In addition, usually, there are many health risks that may happen for very young adolescent girls who are pregnant. After pregnancy, they may develop postpartum. Sometimes, it's poverty that has pushed them to escape from their dysfunctional families. They runaway with a boy, who they thought as their superhero [savior], only to end up getting pregnant by that boy. It turns out, this would be the cause of their future poverty.]"

(Nurse facilitator 2, female, 33 years old)

6.2 FINDINGS: EXPERIENCES DURING AND AFTER 'A HEALTHY ME'

FIGURE 3. THEMATIC MAP OF THE EXPERIENCES OF ADOLELESCENT PARTICIPANTS AND PROGRAM FACILITATORS DURING AND AFTER 'A HEALTHY ME'



The experience of 'A Healthy Me' was described in very positive terms by all groups of research respondents, notwithstanding some challenges encountered during the program's implementation. The holistic nature of the program experience was consistently described by all groups. The experiences of adolescent participants and program facilitators were described under the following themes: (1) it was a beneficial experience, (2) participation strengthened relationships, (3) implementation methods were salient, and (4) implementation challenges were experienced. Although 'A Healthy Me' is a shared experience and many common dynamics were described by the adolescents and facilitators, there were also experiences which were unique to each group. Program facilitators were able to share both personal benefits and experiences, whilst also reflecting upon experiences of adolescents and the parent participants' during their respective sessions. In contrast, the youth were solely focused on their own experiences. The facilitator groups also outlined their challenges along the program implementation with few comments being made by the adolescent participants.

THEME 5. 'A HEALTHY ME' WAS A BENEFICIAL EXPERIENCE

The research respondents described how they were positively impacted or benefitted from participation in 'A Healthy Me'. The beneficial experience was perceived to prevent or mitigate many

of the issues identified earlier in the study findings. The beneficial experience was described in terms of (1) positive affect, (2) knowledge gained, (3) changed attitudes, and (4) acquired skills or behaviors. For this theme, it is important to note that program facilitators presented not just their personal experiences, but also the experiences of adolescent participants and parents.

Positive affect refers to how the adolescent participants and program facilitators positively described their emotional experiences and interactions with others during the program. Generally, all research groups were happy and grateful to have been part of a program that they described as 'good' and 'relevant'. The program facilitators highlighted that they also had a fulfilling and enlightening experience and were hopeful that the adolescent participants would apply their learning to transform their lives. Lastly, they found the session as a safe place for adolescent participants to express their emotions and to share their stories openly without judgment.

TABLE 3. TERMS USED BY PARTICIPANTS TO DESCRIBE THEIR AFFECT DURING 'A HEALTHY ME'

Adolescent participants	Program facilitators	
Fun/enjoyable	Grateful/thankful	Fulfilling
Grateful/thankful	Good/positive	Emotional
Good/positive	Relatable/relevant	Safe
Relatable/relevant	Supportive	Fun/enjoyable
Awkward	Enlightened	Varied
Happy	Hopeful	Happy
	Amusing	Engaging/interested
	Happy	

Adolescent participants particularly recalled having fun while learning and felt grateful for the experience.

> *"Lingaw nga naay sagol nga nakat-onan miss ba. [It's fun and we also learned something.]"*
>
> *(Health center-based adolescent 2, 22 years old)*

> *"Nagpasalamat mi nga gi imbitar mi nila mo apil sa 'A Healthy Me' kay daghan pud mi og nakat-onan. [We are thankful that we were invited to join 'A Healthy Me' because we learned a lot.]"*
>
> *(Health center-based adolescent 3, 21 years old)*

Likewise, the program facilitators enjoyed facilitating the sessions to the adolescents due to their amusing stories and striking experiences which they learnt from:

"Overall, generally I am so thankful, I never treat this as an additional burden, but I treated this kind of program as a great opportunity that as guidance facilitator or guidance coordinator in the school, I already had this program that is really relevant to the current issues at school."

(Teacher facilitator 2, male, 26 years old)

"Abi nimo ako noh nalingaw ko pagkatinuod lang nalingaw ko. Nalingaw baya ko kay ingon ngano dili lang sad baya ingon sila ray na learn murag ako naa sad koy na learn sa ilahang experience ba. Ka kuan sad nako, kadali sad nako. Oo naa sad kay malearn, naa sad kay malearn sa ila experiences Nalingaw kos ilang gipang share oy, nalingaw baya ko. [I really had fun. I had fun because I also learned from the adolescents' experiences. I really had fun hearing what they had to share.]"

(Midwife facilitator 8, female, 45 years old)

The program facilitators observed that there was good engagement between adolescent participants and themselves during sessions and that they adolescent participants showed interest in the topics as described by the following facilitators:

"Interesado sad gyud sila. Ganahan sad sila sa topic. [They are really interested. They like the topic.]"

(Midwife facilitator 3, female, 49 years old)

"Unya ganahan sab ko sa ilaha maam mo participate sab sila. [I also like that they are participative.]"

(Midwife facilitator 6, female, 43 years old)

However, the sessions were not all light and fun. Some sessions induced heavy emotions, especially when there are negative experiences disclosed. Program facilitators empathized and felt pain for the adolescent participant's situation:

"Kay dili lang ka nalingaw, mura sab ka'g kanang naluoy sa sa usa ka kuan namo na ni share siya ba katong sharing sa ing-ani gihapon. I-share nimo imong gibati. Unya siya kay ang iyang sharing, ang iyang share niya kay kuan dili pa unta, kay naa naman siya anak, dili pa unta siya ma ing-ana nga ma minyo og or magka anak kay gusto pa unta siya mo eskwela. Unya wala pa man mo support ang iyahang ginikanan. Kutob ra kuno ingon siya na kanang sakto nana imong nahuman nga naka graduate ka'g high school. Maayo na lang na nimo dili naka ma ilad sa mga taw. Kutob ra ato nga gusto pa unta siya taas-taas pa iyang makab-ot unya didto murag nasakitan pod ka nga luoy gyud kaayo siya ba. Hilak

siya kay iyang bata ba kay 6 months pa man katong higayona. [It's not only fun, there are also times when you feel pity when you hear their sharing. One of them already had a child and it was not really planned. She didn't want to get married or have a child yet because she still wants to finish school. But her parents were not supportive of her. They would just tell her that whatever she has achieved in terms of education is already enough, it's enough that she has graduated from high school. That means that you will no longer get easily duped by people. But, she wanted to aim for higher education. You will get hurt and feel pity for them. She cried because her child was only 6 months old at that time.]"

(Midwife facilitator 5, female, 48 years old)

Community-based program facilitators mentioned that the parent session was also quite emotional because mothers had significant revelations about their parenting:

"Mao sad akong gi emphasize sa ilaha ba i-ensure gyud nga kahibaw sila nga kamo ang safe person to talk to rather than iyang friends. Mao toh nag hilakay sila. So medyo na emotional diay toh nga session. Katong mama gyud ni kuan gyud siya kay katong iyang anak lagi is minor. [I emphasized to the parents that they must ensure that their children know that they are the safest person to talk to rather than their child's friends. They cried during the session. It was an emotional session. The mother of one participant [was also affected] because her child is still a minor.]"

(Nurse facilitator 4, female, 32 years old)

Under **'knowledge gained'** the research participants described their direct learnings from the program. Both adolescent participants and program facilitators believed that the adolescents learnt a lot during the program, with facilitators also mentioning knowledge they had gained during the program. When asked about specific learning, they mentioned varied topics as detailed in Table 4.

TABLE 4. SPECIFIC KNOWLEDGE GAINS MENTIONED BY THE ADOLESCENTS AND FACILITATORS

Adolescent participants mentioned:	Program facilitators mentioned:	
	Facilitators learnt	*Adolescents learnt*
• General topics • Contraception and safer sex • Puberty and menstruation • Physical health • Social health • Healthy eating • Effects of social media	• Menstruation and feminine hygiene • Contraception and safer sex • General topics	• General topics • Self-awareness • Delaying sexual initiation • SRH • Contraception and safer sex • Emotions • Knowing their rights

• Body image • SRH • Emotions		

Common knowledge gains described by both adolescent participants and program facilitators related generally to sexual and reproductive health and, more specifically, to menstruation, feminine hygiene, modern contraception, and safer sex. Interestingly, some health center-based program facilitators claimed to have gained additional knowledge about family planning despite being health professionals for many years.

One teacher-facilitator described how 'A Healthy Me' was an important learning experience for both the adolescent participants and herself:

> *"Ang sa akoa experience kay kuan nindot siya'g effect kay ikaw mismo sad nakahibaw, murag nadugangan among knowledge about sa like family planning. Kanus-a mo uban ang mga kabatan-onan mo-engage ana. Kanus-a siya mo gamit kay sa karon sa pagka karon kuan naman gud kaayo kanang sa silingan lang or kaila or amiga oh gamita ni oh. Unya dili, dili gani maayo nga makagamit. Ilaha rang ka gustohan kay maoy gitudlo sa silangan which is wrong nga makadaot diay nila. [In my experience, the program had a good effect because you will also become knowledgeable, it can add to what we know about family planning. For example, when should adolescents engage in or use [contraception]. Right now, they only learn it from their neighbors or friends - this is not safe and can be harmful for them.]"*
>
> *(Midwife facilitator 5, female, 48 years old)*

Changed attitudes refers to how the research participants described the impact of the program on their values and perceptions. Although varying attitudes were thought to have changed, all research groups observed an increase in adolescents' self-worth and self-confidence and their ability to make better choices because of the ability to distinguish 'right from wrong' and anticipate the consequences of their actions. The attitude changes most commonly described by the adolescent groups were valuing 'what is right', valuing sex, being more self-accepting, and having higher self-worth or self-esteem. School-based facilitators highlighted that the adolescents started valuing their bodies more compared with the health-center based facilitators who described changing aspirations, particularly among out-of-school youth.

One of the adolescent participants described how 'A Healthy Me' was a platform that helped ***build or boost their self-confidence and self-esteem***:

> *"About kuan akoa, self-confidence. Diba dili man jud tanan nato naka, naa man jud tay mga shy-type nato, dayon didto sa 'A Healthy Me' program, kay naa mi, opportunity, naa mi chance sa among kaugalingon nga ma build namo among self-confidence, self-esteem ba. [About self-confidence. There are really some of us who are shy. In the 'A Healthy Me' program we had the opportunity to build our self-confidence and self-esteem.]"*
>
> *(Health center-based adolescent 6, 15 years old)*

The increase in the adolescents' self-confidence became more evident as the sessions progressed, being revealed in the way they interacted with each other and with their program facilitator. One program facilitator witnessed how one of her participants became more sociable after the program, stating that *"Unya nakabantay ko mo socialize na siya after ato. Di na siya mauwaw.* [*I noticed that she socialized after that. She was no longer shy.]"* (Nurse facilitator 5, female, 27 years old). This observation was confirmed by an adolescent participant who added that, because of the program, they learnt how to socialize with other people by going out of their 'comfort zone':

> *"Akoa miss kay kung unsaon nato pagpalambo atoang kaugalingon. Like makipag-socialize sa ubang tao, mo-go out ta sa atoang comfort zone. Sauna ba manggiuwawon ta, karon kamao nata makig halo-bilo sa ubang tao. [About improving my self, like how to socialize with other people and go out of my comfort zone. Before, we were shy but now we already know how to socialize with other people.]"*
>
> *(Health center-based adolescent 1, 21 years old)*

Program facilitators often noted that the program also ***strengthened the adolescents' self-worth***. One facilitator believed that the messaging uniqueness and not comparing yourself to others was an important part of this:

> *"Katong dili nimo i-compare imohang self sa lain. So ikaw mismo is naa kay unique mao toh siya, ang uniqueness niya. [The one about not comparing yourself to others. You are unique.]"*
>
> *(Nurse facilitator 4, female 32 years old)*

This greater self-worth and self-confidence, together with knowledge gained, was believed to have enabled adolescent participants to begin addressing concerns on their own and seeking help if needed. One of the adolescent participants disclosed that after participating in the program, she experienced harassment in the workplace where she is a student trainee. She applied her learning by being assertive and reporting the case to the relevant authorities at work:

"Then kana sang assertive, katong mga ingon ana. So, kuan Miss, kay ang first man nakong gibuhat ato kay nagpahibaw ko sa mga taw nga kahibaw ko nga masaligan. Like nagpahibaw na ko sa HR, sa among manager, sa akong mga kauban sa F&B. [About being assertive – the first thing I did was to inform the people I trust. I also informed the HR, our manager, and some of my colleagues in F&B.]"

(Health center-based adolescent 5, 17 years old)

In addition, the adolescent participants suggested that the ***program inculcates morality***. They described adolescents as generally lacking discernment between good or bad behavior and acting impulsively. According to one of the adolescent participants, joining the program enabled one of her fellow participants to understand 'what is wrong', have better judgement, and become less impulsive:

"Iyang mahuna-hunaan nga dili diay to sakto iyang gibuhat. Makarealize siya nga mao diay ni angay buhaton sa iyang kaugalingon. dili kay magpayaga-yaga ra siya. [She realized that what she did was wrong. She realized that this is what she was supposed to do for herself, not to be reckless.]"

(School-based adolescent 2, 14 years old)

Further accounts also reflected how the adolescent girls' attitudes toward sex changed because of program participation and how they were able to reflect and develop personal values about when sex was appropriate in a relationship. Generally, they became more conservative about when to have sex as described by the following adolescent participant who realized sex was 'not a game':

"Na kuan pud me sa katong ang sex kay dili lang duwa-duwa lang ba. dili lang na basta basta buhaton kung ganahan ka ana. Ang sex kay kailangan gyud nga mag asawa na or di… after nig human na sa kasal. Dili lang ka basta-basta mohatag. [We also learned that sex is not just a game. You should not easily do it just because you like it. Sex should be for married couples; you should not freely give it to anyone.]"

(Purok-based adolescent 6, 16 years old)

Another adolescent participant shared how 'A Healthy Me' had enabled her to influence her friend's decision about when to have sex with her boyfriend, advising per friend not to immediately give into pressure from her boyfriend but consider his level of commitment to her as follows:

"Naa koy classmate...ni ingon man uyab niya nga once magkita daw sila ana nga day kay pwede ba daw mag kuan [sex] sila. Then niana ko niya nga dapat mo effort siya kay dili tanang butang makuha instant dayon, di man ka pancit canton

gud. Timan-an jud na nimo, then ni ana siya nga harsh ra daw, mao to ni ana ko niya nga bisag harsh pana siya imo na siyang isulod sa imong utok nga naa sad diay impact ingna nga naay reason, kay kung once imo siyang i-allow nga makuha dritso imong pagka babaye maka siguro ka nga inig ka human ana uyab pa mo? Mao toh pagka kuan ana miss, kay gi chatan siyag balik, nga asa na daw siya then iyang gi sanong-sanong nga on the way na siya pero ang tinuod ato kay wa niya tungaha. [I had a classmate who had a boyfriend who asked her if they could have sex once they meet. I advised her about it by saying that her boyfriend should show that he made efforts first because you can't get everything you want in an instant. I told her to always remember that. She said that I was too harsh. I said that even though my advice is harsh for you, you should think about it. I said, once you allow him to get your virginity easily, how can you be sure that after that you will still be together. After that, her boyfriend chatted her and asked where she was and she just lied that she was on her way but the truth is, she never pushed through with the meet-up.]"

(Health center-based adolescent 5, 17 years old)

Program facilitators also described how adolescent participants became more ***equipped and empowered to make better choices***, to value their bodies and be assertive in protecting themselves. One facilitator believed that these attitudes should enable adolescent girls to delay sexual initiation and to protect themselves against teenage pregnancy and abuse:

"Tingali kung naay 'A Healthy Me' they learn to stand in their own they know what is the right thing to do during that time nga mo stand up sila sa ilang kaugalingon rather than murag baya gi-incorporate na lang nila nga mao na, okay raman ni kay dili raman ako ang nagbuhat ani and the other one, tingali mo lessen ang cases of teenage pregnancy and child sexual abuse cases, ma lessen siya kay empowered man ang mga bata. They know nga dili ni siya sakto, kanang letting other people see their bodies or touch their bodies in exchange of something or engaging in early sexual encounter is not okay because it will not help you physically, emotionally, and socially. [Maybe if there was 'A Healthy Me', they will learn to stand on their own and know what is the right thing to do. [It's better] rather than thinking that it's okay because they are not the only ones doing it. Maybe, it will also lessen the number of cases of teenage pregnancy and child abuse. The number of cases will decrease because the children will be empowered. They will know that letting other people see or touch their bodies in exchange of something or engaging in early sexual encounters is not okay. It will not help you physically, emotionally, and socially.]"

(Teacher facilitator 1, female, 39 years old)

Like adolescent participants, program facilitators from health center-based group shared that the program ***increased their self-acceptance***. The program facilitator mentioned that she was reminded not to compare herself with others and to value her uniqueness as an individual.

> *"Katong dili nimo i-compare imohang self sa lain. So ikaw mismo is naa kay unique mao toh siya, ang uniqueness niya. [On not comparing yourself to others. Every individual has his or her own uniqueness.]"*
>
> *(Midwife facilitator 5, female, 48 years old)*

A unique change in attitude that transpired only for health center-based program facilitators is the ***change of aspirations*** among out of school youth. Since they are catering to this population, they were able to elaborate on this change. Program facilitators shared post program stories of adolescent girls aiming to have better lives. For instance, some adolescent girls enrolled in Alternative Learning System (ALS) after participating in the program. The program facilitator felt emotional that she was able to enlighten and motivate the adolescent participants to finish their education through the program.

> *"Ang uban kay ni enroll na pod og ALS after. Mga ing-ana gani so mura bitawg tungod nimo kay na enlighten sila. Hilak sa ta char! Bitaw maam. Naay uban na imbis mag sige lang sila latagaw kay nag enroll na sila sa ALS. [Some of the adolescent girls enrolled in ALS (Alternative Learning System) after the program. Because of me, they were enlightened – things like this make me cry. Instead of wasting their time on unproductive activities, they are now enrolled in ALS.]"*
>
> *(Nurse facilitator 1, female, 26 years old)*

Acquired skills or behaviors were described as new or enhanced skills and behaviors acquired during the program by the adolescent participants and program facilitators which were applied after the program ended. Adolescent participants and program facilitators shared skills or behaviors that they had personally acquired and also those that they believed would be helpful to girls who had experienced abuse and exploitation as part of their recovery, which was explored as an additional research question.

The acquired skills and behaviour mentioned by adolescents and participants are displayed in Table 5. All groups frequently mentioned increases in the adolescent's ability to make better health choices with other commonly mentioned skills related to avoiding risks and protecting themselves from harm. Despite generally having less input than facilitators in other questions, the adolescents were able describe many more skills acquired.

TABLE 5. SKILLS AND BEHAVIOURS ACQUIRED THROUGH PARTICIPATION IN 'A HEALTHY ME'

Adolescent participants mentioned:		Program facilitators mentioned:	
		Facilitators acquired:	*Adolescents acquired:*
• Refusal skills • Making better health choices • Avoiding risks • Managing emotions/ mental health • Properly managing menstrual/ feminine hygiene • Communication skills • Healthy eating • Educating others • Using condoms properly • Seeking help (disclosed abuse)	• General life skills • Reducing substance misuse • Making better SRH choices • Confronting harassment/ abuse • General self-care • Critical thinking • Advocating to authorities • Ability to reduce cellphone/social media use	• Managing adolescents • Communicating with adolescents • Guiding adolescent • Educating and facilitating	• Making better SRH choices • Making better health choices • Managing emotions/mental health Educating others • Reducing substance misuse • Avoiding risks • Protecting self • Confronting harassment/ abuse • Avoiding abuse

The ability to make ***better health choices*** was described as making decisions and choices that would benefit the overall health of the adolescents. This included actions such as choosing to eat healthier food, drinking alcoholic beverages in moderation, reducing cell phone or social media use, taking action to avoid risks, and practicing good self-care. According to an adolescent participant, she realized to eat more nutritious food and even guided her siblings in their choice of food:

> *"Unya mao toh kuan ra diay mag fruits nga healthy nga mga fruits. Pag apply. Sa among mga igsoon kay mag sige sila og kaon og junk foods. Ako sila ingnan nga kanang mga biscuit ingon-ana. [About [eating] healthy fruits and how to apply. My siblings always eat junkfood. I tell them about the [dangers of eating] biscuits and the like.]"*
>
> *(School-based adolescent 4, 13 years old)*

The ability to make better health choices was strongly connected with the ***refusal skills*** that the adolescents acquired during the program. All adolescent groups mentioned that they are more capable of saying 'No' to temptations and risky peer invitations. One adolescent participant

described her personal experience of refusing her friends' invitation to drink alcohol and her greater ability to resist peer pressure:

> *"Sauna miss kay kanang mo inom gani ko miss. Unya karon kay human nga naka apil ko, ang naa nay okasyon miss ba muinom na lang dili pareha sauna nga naay barkada ba manggal-gal dali ra. Karon kay naay okasyon na lang. [Before, I drink alcoholic drinks. Now that I finished 'A Healthy Me', I only drink if there's a special occasion unlike in the past. Before, I easily get convinced to drink because of my peer group but now I only drink if there is an occasion.]"*
>
> *(Health center-based adolescent 2, 22 years old)*

An adolescent participant also shared how she changed her poor habit on social media use upon participation from 'A Healthy Me':

> *"Sa ako kay mag sige ra ko og facebook. Usahay mag tago tago ko maam ba mag facebook. Usahay dugay matog. Unya karon tungod sa 'A Healthy Me' kay ni undang ko kay mura kog nakonsensya. [I always use Facebook. Sometimes, I hide while using Facebook. Sometimes, I sleep late. Now, because of 'A Healthy Me', I stopped that habit because I felt guilty.]"*
>
> *(School-based adolescent 3,14 years old)*

On avoiding risks, one adolescent mentioned that the program equipped them to consider the intentions of other people and the risks of acting out of curiosity. She said that she became more aware of the potential risks, thus she became more cautious in her dealings with other people, especially men:

> *"Sa akoa nga side, gihatagan mig awareness, labi na sa safety karun ba nga grabe na ka dangerous, dili na ka magpatakag salig sa mga kuan ba, sa palibot, kay maski sa tawo dapat labi na sa lalaki kay dili ka dapat dali mo salig ba kay dili man nato matag-an kung unsa iyang gi huna-huna. [We were made aware of the safety especially nowadays as it's very dangerous. You can no longer easily rely on other people around you. Especially men, you should not easily trust them because you wouldn't know what is going through their minds. Nowadays, you're not really sure of the intent of men if for example, they invite you for a drink, you will never know what they plan to do.]"*
>
> *(Health center-based adolescent 5, 17 years old)*

Lastly on improving their self-care habits, adolescent participants realized through the program that their old habits of taking care of themselves are not helpful. Thus, after learning from the program, they made changes in their self-care practices, as mentioned by an adolescent participant:

"Gi-apply nako miss kay sa pamaagi nga unsaon nako, gi-atiman nako akong kaugalingon sa... Like naa man gyu'y kalahian nga sauna kay mura rata og wala. Wala man ta kahibaw nga sayop diay atong nabuhat. Human sa katong programa miss kay sayop diay to sauna nga gibuhat nga pamaagi sa pag amping sa atong lawas. [I was able to apply it on how I take care of myself. There really is a difference because before we didn't really care. We are not aware that we are already doing the wrong thing. After the program, I realized the wrong practices I did before about taking care of my body.]"

(Health center-based adolescent 2, 22 years old)

A more specific example of applying proper self-care was illustrated by the response of another adolescent participant. She said that she ensured getting enough rest by not overworking and by looking after her body properly.

"Usahay, di ka palabi og trabaho kay ara ra gihapon ma stress ra gihapon ka. So, control, mupahuway ka, dili nimo pasagdan imong lawas. Kay kung imo na siyang pasagdan imong lawas, ikaw ra gihapo'y magmahay kay naa man kay mga anak. Oo, para lang sa mga bata. [You should not work too hard because you will only be stressed out. You should also control, get some rest, and not take your body for granted If you do that, you will just regret it because you also have children. [You must take care of yourself] for the welfare of your children.]"

(Health center-based adolescent 10, 23 years old)

Indeed, adolescent participants were making better health choices after graduating based on the testimony of a program facilitator. From her experience, she had been receiving messages from her participants asking schedules for health check-up. As such, she observed that they have changed from being reckless to being mindful of their health.

"Naay uban mo chat nimo "maam kuan gi ubo pa siguro kanus-a sunod schedule sa bakuna?" Ing-ana gani. Di na sila mo "ahh di lang ko…" ana bitaw. Reckless na sila sa ilahang self ba pero karon mo chat na. [There are some who send you a chat message, "Maám my child has cough, when is the next schedule for the vaccine?" They no longer decline like before that they were careless about themselves. Now, they really send me a chat message.]"

(Nurse facilitator 1, female, 26 years old)

All groups of adolescent participants highlighted various types of risk. This includes risks from being in an early relationship, abusive or toxic partners, unsafe activities, peer pressure, and all other that pose harm and negative outcomes. With the ability to decide on healthier choices, these risks can be prevented. Thus, adolescent participants and program facilitators believe that if an adolescent girl

had attended the program and is faced with such risks, she will be able to avoid them by taking necessary precautions. Likewise, if an adolescent girl had already experienced a risky situation, then she will be able to take action about it such as confronting the situation, seeking help and protecting oneself. For instance, as stated by an adolescent participant, one would be able to seek help:

> *"Unya kung ma-abuso sila naa baya toy gi discuss kung asa ka mutawag asa ka muduol kung maingon ana ka sa imong bana or sa imong kaipon. Kahibaw gyud ka asa ka moduol ba, asa ka mosumbong. [If they are being abused, they already know who to call. When their husband or live-in partner abuses them, they already know whom to ask for help, who to inform about it.]"*
>
> *(Health center-based adolescent 8, 45 years old)*

Aside from better health choices, health center-based adolescent participants and all groups of program facilitators were convinced that adolescent girls would have ***better sexual and reproductive health choices*** because of the program. In relation to sexual and reproductive health, all adolescent participant groups mentioned that they can now protect themselves against pregnancy and STI with the knowledge on the proper use of condoms, and improve their menstrual or feminine hygiene. In one of the discussions, an adolescent participant shared how she applied her learning on SRH by choosing to avoid random sexual encounters.

> *"Unsa atong mga likayan, sa mga makighilawas bisag kinsa Miss ba unsa atong likayan. Unya kung kanus-a nato ihatag ang atong pag ka babaye miss ba. [One of the things that we should avoid is having sex with anyone. And also, we should know when we should give up our virginity.]"*
>
> *(Health center-based adolescent 2, 22 years old)*

Another adolescent participant agreed on this, stating that if an adolescent girl happened to join the program, she would be able to reflect on her choices involving her sexual and reproductive health like them:

> *"Murag kung kaapil lang siya og 'A Healthy Me' program, maka ingon siguro siya sa iyahang kaugalingon nga kanang "maypa wa ko ni sulod ato kay nagkasakit na nuon ko karon". Siguro daghan siya og makat-onan nga sama namo ba nag-apil sad sa programa kay kanang sakit ang makuha niya sa pakighilawas sa lain-laing laki. Kung ni apil lang siya og 'A Healthy Me', maka kuan siya sa iyang huna-huna ba nga dili diay to angay mosud og ingon ana. [If she was able to join 'A Healthy Me' program, she would have realized that she never should have had [sexual contact] because that's the reason why she's sick now. She would have learned a lot like us who joined the program. We learned*

about the infection that you can get out of having random sexual encounters. If she joined 'A Healthy Me', she would realize that she should not have done it.]"

(Health center-based adolescent 1, 21 years old)

Similarly, program facilitators believe that with better sexual and reproductive health choices, cases of teenage pregnancy, abortion, and sexually transmitted infections will be minimized. As shared by a health center-based program facilitator:

"Ma minimize na ang teenage pregnancy unya drugs, mga abortion mga ing-ana. Ma minimize na if mapadayon sa siya. Ma aware ang mga batan-on. Kuan sad para prevention pod siya sa mga sexually transmitted disease. Ma aware ang mga batan-on or mabati sila og kahadlok nga mo kanang mo apil anang kanang daghang multiple partners maskin sa ilang kabatan-on nga walay panagang. Unya wa sad kahibaw makadaot sa ilang lawas. [It will minimize the cases of teenage pregnancy, drugs, and abortion. The adolescents will be more aware. It can also prevent sexually transmitted disease because they will be aware or be more careful about having multiple sexual partners.]"

(Midwife facilitator 1, female, 42 years old)

Furthermore, a health center-based program facilitator cited that for her participants who were already teenage mothers, they would be able to prevent succeeding unplanned pregnancy as they now have choices.

"So atleast kahibaw na sila unsay buhaton, buntis man to naa na silay choices unsa ila buhaton nga dili na sila mabuntis og usab mao na ilang kuan naa na silay mga choices. [At least, they will know what to do. They will know that they have a choice and avoid unplanned pregnancy.]"

(Midwife facilitator 2, female, 44 years old)

In fact, some of the teenage mothers who were participants of the program had enrolled in family planning after the program as shared by another program facilitator *"So ang uban maam kay ni enroll na gyud sila og family planning. [The others really enrolled in family planning.]" (Nurse facilitator 1, female, 26 years old).* Adolescent participants had also promoted the use of condoms or use of family planning to their peers. The adolescent participants shared different stories of them giving advice to their peers. According to all groups of adolescent participants, educating others is also a skill they acquired from the program. With the gained knowledge, they feel ***equipped to educate other adolescent girls*** in the form of advice. One adolescent participant advised young girls in her neighborhood to use condom especially during first sexual encounter:

"Kung mosulod gani sila anang sexual... advice... mga sex, kailangan mag gamit gyud sila ug condom...condom paman na first time baya, kasagaran ingon ana. [When they get involved in [sexual acts], they should use condom. If it's their first time, they should at least use condom.]"

(Health center-based adolescent 8, 24 years old)

Another adolescent participant encouraged teenage mothers in her community to use birth control to avoid succeeding pregnancies. Most especially when she observed that the teenage mother is struggling:

"Sa akoa kay kasagaran diri kay naa na may anak, ako lang gyud sila ingnon nga ingon ana kung dili namo ganahan masundan mag gamit gyud, mag control gyud ba para di gyud dayon kay lisod baya kaayo. Samot na inig tan-aw nimo nga nagkalisod siya. [In my case, adolescents in our area have kids. I tell them that if you do not want to get pregnant again, you should use [contraceptives]. You should also control because it's really difficult when you see them struggling.]"

(Health center-based adolescent 9, 22 years old)

Meanwhile, on proper menstrual or feminine hygiene, adolescent participants pointed out that because of the program, they were able to ***correct their wrong practices***. This includes debunking some of the menstrual myths of taking a bath and learning the do's and don'ts such as when to change napkins and vulvar care. An adolescent participant said she applied her learning on how to clean the vulva by not using any soap as she learned that it kills the good bacteria:

"Ako na apply pud nako sa akong kaugalingon manghugas ka sa private part nato ba kay dili maggamit gani og soap kay mamatay ang good bacteria. [I was able to apply it to myself like when I wash my private part, I should not use soap because it will kill the good bacteria.]"

(Purok-based adolescent 6, 16 years old)

Another adolescent participant shared that she was able to apply what she learned on puberty and menstruation when she got her first period. She felt thankful as the program prepared her on what to do. She said:

"Katong dugo. Kay kuan wala pa man ko ato gidugo ato sa 'A Healthy Me'. Unya thankful kaayo ko nga nagamit pod nako maam ba nga kailangan diay maligo kay kuan maligo ta. Then four hours taga kuan sa napkin [mag ilis], dili siya pabuntagan. [About menstruation. I did not have my menstruation yet when I joined 'A Healthy Me'. I'm very thankful because I was able to apply what I

learned. I learned that you should take a bath even if you have your period. After four hours, you should change your napkin.]"

(School-based adolescent 2, 14 years old)

Other commonly acquired skills or behaviors across all groups of adolescent participants include ***managing emotions or their mental health***, and ***communication skills***. Most of the adolescents had mentioned different ways on how they were able to manage their mental health. According to an adolescent participant, the program taught them how to manage their emotions. She cited her actions taken to improve her wellbeing such as avoiding minding other people's business by staying at home and minimizing social media use to stay away from its negative effects on her emotions.

"Tungod atong programa kay kahibaw naka mo-handle sa imong emotions. Kanang sa imohang social, imohang well-being ba. Kahibaw naka di ka angay manghimantay sa uban para di sad ka mabawsan. Di ba mag likay ka nga di ka manghimantay, so ang imo lang buhaton mag pundo na lang ka sa inyo para wala nala'y storya ba. Dayon about sad anang social media tungod sad sa social media mao na mo kuan sad ang emotion. [Because of the program, we learned about how to handle our emotions, or social well-being. We learned that you should not meddle with the affairs of other people. What you should do is just stay at home to avoid conflicts. Also, about social media, it can also affect your emotion.]"

(Health center-based adolescent 3, 21 years old)

One of the adolescent participants mentioned that she learned to process her thoughts before venting out her anger.

"Daghan siya epekto pareha atong kung masuko ka dapat dili sah ka mag diretso sad og kasuko. Unsa gani pangan ato oy? Di sah ka dali masuko [huna-huna] before ka mo sulti. [It has a lot of effects like for example if you get angry, you should not act on it immediately. You should think first before saying anything.]"

(School-based adolescent 1, 13 years old)

Another adolescent participant articulated her experience on coping with the effects of implant particularly on mood swings.

"While mag implant ta kay musurok man atong dugo, ma-control na nako ba. Kay magdala man gud siya og stress kund di nimo i-control ang pagka-init sa imong ulo. Okay ra. Ma-control na nako akong ka-isog ba tungod aning wala tay dugo dugo. Ingon ani man ang implant. [If you have an implant, you get easily

irritated. I can now control it. It will stress you out if you don't know how to control your anger. I am able to control my anger even if I have an implant.]"

(Health center-based adolescent 9, 22 years old)

Program facilitators, on the other hand, highlighted that the program developed or enhanced their education and facilitation skills especially on ***managing and communicating with adolescent girls.*** Health center-based facilitators in particular mentioned that the program broadened their approach in educating adolescent girls to address their issues on health. A health center-based program facilitator found the program innovative, stating that as a health professional she realized that they could actually discuss other topics that address adolescent issues using the program.

"Professionally siguro. Naa siya'y lain nga attack. Kay ga eskwela mi medical ra biya. Then iyang katong about body, self-preservation topics, ma widen gamay imo perspective ba nga naa pod pwede ingon ani klase sa attack nga mo address aning batan-on. [Professionally, as we are only educated on the medical aspect, the program has a unique attack – we had topics about the body and self-preservation. This widened our perspective that there's this kind of attack (innovative approach) to address the issues of adolescents.]"

(Nurse facilitator 2, female, 33 years old)

Furthermore, health center-based program facilitators mentioned that they learned how to effectively communicate the topics with adolescent girls. One said what works is to openly talk about the issues and let them understand it slowly.

"Dili necessary ing-ana ang approach sa issues. Pwede ra gyud na like storya. Di gyud na necessary ing-ana ka strikto nga kuan generalized dayon. Naka ana sad ko ba "bitaw noh hinay-hinayan na sila og explain kay di na ni mao da". [Approaching the issue is not necessarily done abruptly. It can be done in a calm discourse, not necessarily in a strict manner that you impose your generalizations. I realized "This isn't right. I need to slowly explain".]"

(Nurse facilitator 2, female, 33 years old)

Even teachers with years of experience in education said that the program enhanced their skills in dealing with adolescent girls. One of the school-based facilitators expressed that he learned how to facilitate sensitive topics. In addition, he also improved his communication skills that he was able to listen more to the adolescent participants with an open-mind.

"So ang skills gyud na learn out from the program kay it's how to handle students who are girls and then at the same time unsaon gyud pag facilitate og tarong most especially nga ang atoa galing mga topics kay very sensitive… Then

ang skills also kana galing skills nga communication, that is open communication at the same time you will listen. Skills and attitude na open minded sad ka. [The skill I learned from the program is how to handle female students and how to properly facilitate most especially that our topics are very sensitive… Another skill is on open communication - at the same time you listen. The skill and attitude to be open-minded too.]"

(Teacher facilitator 2, male, 26 years old)

Lastly, program facilitators suggested that the program allowed the parents to ***improve their parenting skills*** specifically on communication with their children and protection of their children. A program facilitator recalled her memorable parent session experience wherein parents had many inquiries on reproductive health and had articulated their realizations on the importance of talking with their children about it. She recalled:

"Parent session. Kay daghan kaayo sila pangutana gyud on reproductive health. About sa kato ganing nag hisgot ta sa unsaon nimo pakigstorya imohang bata. Ing-ana ba. "Mao ba diay?" Murag para nila is "kinahanglan gyud diay ta makig storya sa atong anak noh sa ingon ana nga topic?" [crossover] Mao ni dapat ni… kanang di ba gi discuss man nato dapat ang kinataw dili jud nimo ipakita sa laing taw. Sila mismo "bitaw maam noh" makatabang biya gyud na siya ay, murag ma protektahan gani nimo maam imong anak, privacy sa imong bata ingon ana... Unya ang mga mama mas daghan og pangutana, mas daghan sila'g concerns ba kaysa sa ilahang mga anak. Ang mga bata kay maminaw ra. Okay daghan information. Wherein ang mga mama is daghan gyud sila mga pangutana, concerns gyud para sa ilang mga anak. [Parent session was a memorable experience since parents had many questions about reproductive health - on how to talk with children about it. Parents had realized "Is that so?... We really need to speak with our children about this topic". They agreed when we discussed that even younger children shouldn't expose their private body parts publicly and that this can protect them from harm. Mothers had more inquiries and concerns regarding their children than adolescent participants during sessions. Adolescent participants just listen and digest the information provided.]"

(Nurse facilitator 4, female, 32 years old)

Another program facilitator from the school assumed that the parent session informed and guided the parents on how to better deal with their own children. He said:

"Sa side sad sa parents [On the side of parents], majority of them, from the start of this interview I said that majority of them are not studying so the educational

background is really low, so they are informed and then they are also guided on what to do on with the process and how to deliver their actions, how to respect their children, the girls and then how to make their family nga very productive na since a healthy program does not focus one aspect but the totality which is the holistic, holistically speaking so it covers everything."

(Teacher facilitator 2, male, 26 years old)

Overall, the program was able to effectuate positive impacts both to the adolescent participants and program facilitators. The gained knowledge, changed attitude, and acquired skills and behaviors altogether could help address the various issues faced by adolescent participants. The program is indeed equipping and empowering adolescent girls in different ways. As described by one adolescent participant:

"Ang 'A Healthy Me' man gud kay mura siyag guide nimo, para dili ka masaag, mupadayon gihapon ka sa right path sa imong kinabuhi para dili ka mag sacrifice og ing-ana. ['A Healthy Me' is like a life guide so that you will not get lost and will go on taking the right path to avoid sacrificing a good life.]"

(Health center-based adolescent 6, 15 years old)

In essence, all groups of adolescent participants and program facilitators believe that the program could help improve and transform the lives of adolescent girls. With their experiences, they could infer that the program can help adolescent girls avoid the negative outcomes of their risky behaviors. As such, teenage pregnancy, abortion, STI including HIV can be prevented, and cases of substance misuse will be reduced. In addition, adolescent girls will be empowered to stand up against abuse, protect themselves, and seek help. Below is the aspiration of a program facilitator for the graduates and the succeeding participants of the program:

"I am looking forward nga with the sessions that we had conducted with the first batch of girls, and kung naa pay mga future batches, nag look forward nga after the sessions they are more empowered to protect themselves, to say no to kuan, and choose more mature and more intelligent decisions and choices mao gyud na akoang gi-dream… They will be able to reach their full potential, mao gyud na ang pinaka ultimate nga goal, nga kanang happier, more successful life nga walay mga regrets, waly mga hung ups, mga unfinished business in the past, noh? Yes, na that as women, as girls, they know their rights, they know the options and the choices and they can choose the right things over those mga confusions, over those kanang mga… Yes, without necessarily kuan they're independent, they can protect themselves. [I am looking forward to the sessions that we conducted with the first batch of girls, and if there are future batches, I look forward after the sessions that they become more empowered to protect themselves, to say no, and to choose more mature and more intelligent

decisions. That is really my dream. They will be able to reach their full potential. That is the ultimate goal - they are happier and successful in life with no regrets, hang ups or unfinished [unresolved] business in the past, right?... Yes, that as women or as girls, they know their rights, they know the options and the choices. They can choose the right things over those personal confusions, over those [insecurities]. Yes, without necessarily [adult supervision], they're independent and they can protect themselves.]"

Teacher facilitator 1, female, 39 years old)

THEME 6. 'A HEALTHY ME' PARTICIPATION STRENGTHENED RELATIONSHIPS

Facilitator and adolescent groups described how 'A Healthy Me' enabled them to form stronger relationships including between the facilitators and adolescents, amongst the adolescents, and even with adolescents outside of the program, including family members. The strengthened relationships were characterized by research participants as involving (1) changed perceptions and (2) stronger connections.

Changed perceptions was described as how personal perceptions, stereotypes, or initial impressions that the adolescents and facilitators held towards the other were challenged because of program participation. As the sessions progressed, they observed changes in their perceptions about the other which resulted in more mutual understanding, acceptance, and openness.

Adolescent participants and program facilitators described these changes differently, with the changes in perception explained by the facilitators being on a much deeper level. The adolescent participants were less able to identify their previously held views about facilitators and how these changed but instead described their realizations about the facilitators throughout the sessions. The adolescents highlighted that they experienced the program facilitators as helpful, friendly, concerned for them, and competent. They appreciated that they were careful to ensure the adolescents correctly understood the topics and injected humor into the discussions to help them feel more comfortable. One health center-based adolescent participant described how her ***initial impressions of the facilitator changed*** throughout the sessions as she came to see her as more friendly and relatable:

"Gitabangan mi nila. Gitabangan mi nila nga dapat dili mi mauwaw. Mas ma enjoy pa mi, dayon mas i-lingaw namo ba, i-as if namo nga ato-ato lang dapat mo share mo sa inyong na experience. Nalingaw ko niya ba bisag, abi nako snob ing-ana ba, dili mi close. Pero friendly siya ba, gi equal niya tanan, bisag kuan na siya edad-edaran na pero kami mga teenagers mi pero iyang gi feel nga teenager gihapon siya. [They helped us not to be shy. We were able to enjoy and be more comfortable in sharing our experiences. At first, I thought she was

being snobbish because we were not close, but it turned out that she was really friendly. She treated us equally and even if she was older than us teenagers, she was able to relate to us like she herself was a teenager too]"

(Health center-based adolescent 6, 15 years old)

"Kanang kung naa mi wala masabtan. Ila gyud pangotan-on nasabot ba mi unya kung wala tagaan mi og examples. [When we didn't understand something, the facilitators would ask to check if we understood the topic well. If not, they will give further examples.]"

(School-based adolescent 4, 13 years old)

On the other hand, all program facilitators described how their existing stereotypes and prejudices about adolescents changed throughout the program. Because of their interactions during the sessions, they have gained a better understanding of adolescent girls in terms of their experiences, behaviors, and outlook in life. They were able to see the adolescent participants through a new lens and came to ***understand how the adolescents' experiences shaped them.*** Many stories of changes in perception were shared by the facilitators. One story involved a facilitator's realizations about why one of her participants styled her appearance and behaved in a way the facilitator previously disapproved of:

"So, sauna man gud mo generalize ko ba makakita kog mas puwa pag nabil nato ba maglakaw gani unya mubo kaayog shorts, kilay kaayo ba. Ngil-ad kaayo ba. Maglagot ta ba mga ing-ana ba. Maka generalize ko ma stereotype nako nga "kaning batan-ona ron…" ing-ana ba. Pero after ato kay dili diay ana. Murag maka murag bitaw you can see sad the other side. Kay bitaw honestly before sa program, mo ana gyud stereotype gyud mga bataa, mga batan-on ing-ana og dagway kay ing-ana gyud mo porma ba kay mga ing-ana artihon, pero dili diay tanan. Ang uban man gud buhaton na lang na nila para ma appreciate sila, ing-ana gani. Dira na pod nako nabal-an sad sa 'A Healthy Me' nato. Kay naa man mi isa ka participant nga di gyud na mo sod sa 'A Healthy Me' nga dili puwa ang iyang nabil. Unya didto na namo nabantayan nga sa ilahang family mura bitaw siya'g mo barog na lang siya as a strong woman kay iyaha diay parent kay murag ang iyahang age gap sa iyang mama is very kuan… nambados iyang mama katorse sa iyaha. So murag kabantay siya dili kaayo strong iyahang mama. So siya kay para ma strong siya tan-awn, kinahanglan mag ing-ana gyud siya. Didto na nako nabal-an ba sa parent session si kuan diay mao diay ing-ana siya og pamorma mura siyag vocal kaayo kay murag compensation diay. [Before, I have this [stereotype] that if I see someone with red lips and skimpy shorts, I take it differently. I often get mad seeing that. I immediately apply this impression to all the youth. After the program, I was able to see the other side. Before the

program, I had a stereotype for the youth, but I realized that not all adolescents are like that. Some adolescents do that so they can be appreciated. I only learned about it during 'A Healthy Me'. We have one participant that consistently attended 'A Healthy Me' with a red lipstick on. We learned about her family that it's like she has to stand up as a strong woman. Her mother got pregnant at the age of 14 and we noticed that her mother was not very strong. She has to put up a strong facade instead. We only learned about it during the parent session that the reason why she was very vocal and liberated was because it was to compensate for her [lack of a strong maternal figure].]"

(Nurse facilitator 1, female, 26 years old)

Because of this, program facilitators became ***more accepting of adolescent girls***. They learned how to better engage with them and provide care or guidance. School-based program facilitators also felt that they are more motivated to help adolescents in general. Similarly, health center-based program facilitators became ***more open to providing SRH services to adolescents***. One midwife facilitator shared her realization that it was acceptable to provide contraceptives to unmarried girls and even men-who-have-sex-with-men (MSM) for their protection and became more comfortable doing this after the program:

"Di sad siya nimo i-judge dayun ba ing-ana. Aw dili sad kuan kay ang… sauna man gyud diba mostly noh og magkuha og magpafamily planning kanang kuan ra gyud, kanang mga nag live in na ba noh? So karun baya ako na realize nga pwede gyud diay bisan dili pa diay, wala siyay live in basin ganahan gyud sila mo, mo kanang mo used maka used ragyud. Unya samot nasad naay mga bayot mo ari ba, ni ana gyud ko "unsa man kaha ning mga bayot oy". Unya ni ana si maam [name], "tagai lang na unya i-sulod lang sad og balik". Ingon ko. "Aw pwede na diay ta mo hatag condom noh bisag kanang mga lalaki ba." Ni ana man si maam [name withheld]… "aw ako nalang sad tong i-enroll sad og apil". [You should not judge them immediately. Before, family planning is mostly availed by those who are cohabiting. Now, I realized that even if they are not yet cohabiting, they are just having casual sex, they can use [family planning methods]… Especially when homesexual men come here [health center] before, I asked, "what about the homosexuals?" Then Maam [name withheld] would say… "just give him [condom] and put it back [in the storage cabinet]". Now, I realized that we can actually give condom even to homosexual sex. Maam [name withheld] said so too. [I said] "if that's the case, I will enroll them".]"

(Midwife facilitator 8, female, 45 years old)

The change in perception was best captured in the account of a school-based program facilitator. She explained how her perceptions shifted upon having sustained interactions with the adolescent participants during the program. She said:

> *"When I implemented or facilitated the sessions, naa man gyud tay atoang preconceived notion dayun na ang mga bata ingnana gyud na. After that ang akong acceptance towards them is ni increase, niya dili na kaayo ko ing-ana, although dili gyud ko mo judge nila pero naa gyud tay atoa na dapat ingon ana, dapat ingon ani, naa tay kuan ba expectations towards them. Pagsturya nako nila, pag conduct nako sa session, na gamay na lang akong expectations, somehow I have accepted the fact nga they belong to a different generation, and this is their generation, ing-ani gyud diay ni mangisturya ang mga bata nga murag walay qualms, walay mga inhibitions usahay niya mukatawa open kaayo unlike my time katawa ta mu ana pa gali ta, kanang naa tay gusto isulti pero di ta kasulti, but sila they are so natural, ingnani na gyud diay ni na generation especially if tagaan nimo sila og chance to be themselves, to become natural, ing-ani gyud diay ni sila and it's a nice feeling to share this moment nga nakasabot ko, I have a deeper understanding of them. Although theoretically we know mao na sila, pero by experience na reinforce akong kuan ingon ani gyud diay ni ang post-millenials noh? Mao na gyud ni ilahang kuan. Acceptance nga… and deeper understanding. Somehow, they are just victims pod of the influences nga naa sa kuan modern world. [When I implemented or facilitated the sessions, we have a preconceived notion that the youth act in this certain way. After the program, I accepted them as they are. I no longer easily judge them. We have expectations towards them that they should be like this or like that. When I talk to them, when I conduct the sessions, my expectations diminished. I have accepted the fact that they belong to a different generation. I realized that in their generation, they talk that way, without qualms and inhibitions. They laugh out loud unlike my time when we were more modest. Before, when we want to say something, we cannot directly say it, but they are so natural. This is really the reality of the generation today especially if you give them the chance to be themselves, to become natural. It is a nice feeling to share this moment that I have a deeper understanding of them. Theoretically, we know that they are like that but by experience, I was able to reinforce my realization about the post-millenials. We should accept and have a deeper understanding that somehow, the youth are just victims of the influences of the modern world.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Stronger connections refer to how the adolescent participants and program facilitators described the connections which formed during and often sustained after the program. All

adolescent participants were grateful to the program facilitators for inviting them to join and for their efforts in facilitating. It was evident that adolescent participants and program facilitators were able to build relationships between each other. Likewise, adolescent participants had created bonds with their fellow participants. The rapport that flourished during sessions enabled adolescent participants to ***feel more comfortable and open*** toward their program facilitators. As a result, adolescent participants gained confidence asking questions and seeking advice from the program facilitators.

> *"Nagpasalamat mi nga gi imbitar mi nila mo apil sa 'A Healthy Me' kay daghan pud mi og nakat-onan. Since duol ra ko nila maam kay akong mama is BHW, mas ni samot na ang kuan tungod ato nga kuan program na kanang ka close gani dili naka ma uwaw mo open nila ba. Dili naka mauwaw mangutana nila about ana. [We are thankful to have been invited to join 'A Healthy Me' because we really learned a lot. My mother is a barangay health worker and because of the program, I was no longer shy to open up to them. I was no longer shy to ask them for help.]"*
>
> *(Health center-based adolescent 3, 21 years old)*

This trust and confidence were sustained after the program. Multiple program facilitators from both groups shared that they have ***ongoing interactions with the adolescent participants***, whether through online messages (chat) or actual visits during the three months after their graduation. This implies that the adolescent participants had increased access to health services at barangay health centers or counseling services for schools. A health center-based program facilitator shared her experience of adolescent participants continuing to seek her advice about health and personal issues. She noted that adolescent participants had learned to properly take care of themselves by seeking professional advice:

> *"So, every now and then after sa 'A Healthy Me' mo chat na sila "Maam naay consulta? Pwede mo adto sa health center kay magpa consulta ko ni doc didto." Naa pod "Maam, nag sakit na akong tiyan" Kay naa man koy mga pregnant ato. Ana siya "Maam nagsakit na akong tiyan, unsa akong buhaton". "Nag hilab ka ah doula lang si maam [name]. Adto didto pa IA". At least kay naa na silay kuan pangutan-an kay ang uban man gud sauna medyo dako na naka prenatal mga 6 months na. Naay uban mo chat nimo "maam kuan gi ubo pa siguro kanus-a sunod schedule sa bakuna?" Ing-ana gani. Di na sila mo "ahh di lang ko…" ana bitaw. Reckless na sila sa ilahang self ba pero karon mo chat na. Usahay mang invite pa "maam, adto sa birthday sa akong mama". Oo ing-ana. Usahay akong messenger mag saba-saba. Unya kaila naka ba nga mga pasyente ngan, mga 'A Healthy Me' nimo ba. [Every now and then after 'A Healthy Me', they will send me a chat message saying, "Maám, can we have a consultation at the health center? I would like to have a consultation with the doctor." Another one said,*

"Maam, my stomach is aching." There are pregnant women there. She said, "Maam, my stomach is aching, what should I do?" I would say, "Just approach Maam [name], you can request for IA". At least, they now have an idea of who to approach because before they come for prenatal check-up too late, like they are already 6 months pregnant. There are some who send you a chat message, "Maám my child has cough, when is the next schedule for the vaccine?" They no longer decline like before that they were careless about themselves. Now, they really send me a chat message. Sometimes, they would chat on Facebook messenger.]"

(Nurse facilitator 1, female, 26 years old)

Not only did the program facilitators describe developing stronger connections with their adolescent participants, but also with their own children. ***Relationships with their own children improved***. Both groups of program facilitators mentioned how they have shared and applied their learning from the program in their own families. One program facilitator recalled that while her adolescent participants were expressing themselves, she reflected about whether her own children felt the same way:

"Kuan sad, wait sa makalearn sad ka kay ngano maka learn baya sad ka unsa ilang sides, ma learn ka kanang mo share bitaw sila, unya unsa ilang sides, unsa ilang feelings, maka ana pod ko ba ingnana sad siguro ila feelings noh so maka relate ko nga naa sad baya koy mga anak ba, unya unsa ilang feelings ingnana sad akong makuan, ah ingnana sad siguro noh. Unya ang mga topics nindot baya mao to nangayo ko ato ni maam og kuan kay ako sad gigamit sa akong mga anak. Akong gi kuan kay naa man koy duha sad ka teenager nga babaye. [You will also learn about their perspective, they will share what they think and feel. I can also say that I can relate to how they feel because I also have children. Our topics are also nice. That's why I asked if I can borrow the journal so I can also use it for my daughters, I have two teenage daughters.]"

(Midwife facilitator 8, female, 45 years old)

Another teacher facilitator shared how they have relayed their learning with other teachers in a hope that they will realize how to better handle their students. She said that she could use her learning on managing adolescents with her future students as well as with her children as they grow older:

"Daghan kaayo, Miss. The way I will handle my future clients or my students will be in line with the learnings that I have with 'A Healthy Me', the sessions I sat down with the RHU, daghan pod kog na learn ato nga na apply pod nako sa akong personal nga kinabuhi and then I was also thinking nga akong mga anak mga babaye baya ni, tulo kabuok kanang naghinay-hinay nako og pangita og paagi nga magamit pod nako akong learning in trying to bring them up to

become responsible girls and also my one son nga mahimo pong responsible boy. [I learned a lot. The way I will handle my future clients or students will be in line with the learnings I got from 'A Healthy Me'. In the sessions that I sat down with the RHU (nurses), I also learned a lot and was able to apply these in my personal life. I was also thinking about my daughters. I am finding a way to use my learnings so I can bring them up to be responsible girls and my only son to be a responsible boy.]"

(Teacher facilitator 1, female, 39 years old)

THEME 7. THE IMPLEMENTATION METHODS USED WERE SALIENT

It was highlighted by the adolescent participants and program facilitators that 'A Healthy Me' possess salient methods that were remarkable to them. The salient methods highlighted were related to the (1) educational tools used and (2) dynamics created during the sessions. The methods mentioned between adolescent participants and program facilitators were paralleled. Group discussions and activities enabled two-way learning. These tools also served as an opportunity for program facilitators to address concerns and issues identified. In general, the tools used and the dynamics developed allowed greater understanding of the topics being discussed and of each other. Consequently, these led to their positive regard towards program

The **educational tools** used in 'A Healthy Me' were reported by the majority of the adolescent participants and program facilitators to be relevant and effective, both in the adolescent and parent sessions. The group discussions and activities were reported as being particularly important. For adolescent girls, the ***discussions and sharing*** times helped them learn more about the topics. Through the actual experiences being shared by their peers, their understanding was deepened about the issues faced by other adolescent girls, as shared by one adolescent:

"Ako kay, ato nga time kay mas daghan ko og nahibaw-an about sa amo nga teenager nga wala pa nako kaayo na familiarize ba. Bisag gamay rami ato kay naa mi chance nga mo share sa usag-usa. [That time [during sessions], I learned a lot about us teenagers that I wasn't very familiar with. Even though there were only a few of us, we had the chance to share with each other.]"

(Health center-based adolescent 6, 15 years old)

The same experience was described by program facilitators who also learnt directly from the adolescent participants. They appreciated that the program enabled two-way learning as cited by a program facilitator, with the following program facilitators describing who they learnt from the adolescents:

"Kuan siya sakto toh gi ingon ni maam [name] two-way learning gyud siya. I share based sa akong gi basa, mo share sila sa ila nabasa kay 1 perspective is good but many perspectives are better biya gyud. [What Ma'am [name withheld] said was right, it really is two-way learning. I share what I read, and they also share what they read. One perspective is good, but many perspectives are better.]"

(Nurse facilitator 2, female, 33 years old)

"So it was a very fulfilling experience for me and I learned something from them also. So dili lang kay silay ra ang nakalearn nako, nakalearn pod sila at the same time… [So it was a very fulfilling experience for me and I learned something from them also. They were not the only ones who learned from it.]"

(Teacher facilitator 1, female, 39 years old)

Group activities were also viewed to be salient methods, including role plays. Program facilitators observed that the role plays provided an opportunity for adolescent girls to express natural responses and emotions to real-life situations. This also provided an opportunity for program facilitators to guide them their responses. One facilitator also observed the the role plays helped remove barriers to participation and learning:

"The one katong nag role play sila sa katong different situations, naa silay situations nga gi-portray, then ila gi-role play. That was very memorable kay nakita didto ilang natural, natural nila na kuan nanggawas gyud, kanang it's not even scripted, scripted siya at first pero pag kuan na ang tinuod na gyud ni gawas. Nga reactions…even natural behavior gyud nila when confronted with those situations naka ingon ko ba nga possible gyud ni mahitabo ingon ani noh nga pwede man gyud nga mga bata… I find it a very good chance and opportunity to come in to teach them the more appropriate responses. Kay nanggawas naman gyud sila, dili man guarded ilahang responses ug actions, so didto na after ato mo come in na dayun kung unsa gyud ang kuan. Pero sila mismo moy mitan-aw ni evaluate sa situation and they will be the one to realize and reflect unsay impact ato sa kuan. So, after all sila gihapon maoy naglearn, nagreflect, ug nagdiscover nga mao diay na siya. [The one where they had a role-play about different situations. That was very memorable because they were able to show their natural [reactions]. It was not even scripted, the reactions and their behavior when confronted with those situations were natural. I find it a good chance and opportunity to teach them about appropriate responses. Their responses are no longer guarded so after that, I will come in and teach them. They were also the ones who evaluated the situations and reflected on the

impact. After all, they were the ones who were learning, reflecting, and discovering.]"

(Teacher facilitator 1, female, 39 years old)

Group activities such as composing songs and poems, and song and dance presentations were tools that the adolescent participants and program facilitators found to be fun, educational, and unforgettable. According to one adolescent participant, performing a song was fun despite the limited time they had to prepare:

"Katong, activity namo nga gipahimo mi og kanta. Basta, lingaw kaayo to nga time kay kana bitawng wala kay practice then kailangan naa kay i-present. [The activity where we were asked to make a song. It was really fun. We did not get a chance to practice and you really need to present something.]"

(Health center-based adolescent 6, 15 years old)

In addition, the group activities allowed the adolescent participants to showcase their talents. An adolescent participant said:

"Ang nahimo sa programa miss kay naa man gyud mi tagsa-tagsa nga mga talent mao pud among napagawas miss ba. Mosayaw, mokanta, unya at the same time, naa mi mga nakat-onan kay para sa among adlaw-adlaw nga kinabuhi. [We were able to showcase our individual talents. We were able to sing, dance, and at the [same time, we also learned about things that are useful for our day-to-day living.]"

(Health center-based adolescent 2, 22 years old)

Another memorable experience described by all adolescent participant groups was the ***demonstration of how to properly use a condom***, as described by one adolescent:

"Katong naa ta sa ubos kita tanan ba unsa toh oy… gitodluan ta unsaon paggamit sa condom unsa saktong paggamit sa condom. [The one where we were taught how to properly use a condom.]"

(Purok-based adoelscent 2, 13 years old)

Program facilitators also reported enjoying the performances of the adolescent participants or observing the fun the participants had, as described below:

"Katong mag kuan sila sa ilang kaugalingon about value [pag-aalaga sa sarili, loving yourself group activity]. Pwerte man nilang lingawa hasta ako naapil sa

kalingaw. [The one when they talked about taking care of themselves and loving yourself group activity. I had fun as much as they did.]"

(Midwife facilitator 5, female, 48 years old)

Other activities mentioned by some adolescent participants and school-based facilitators were the self-reflection activities, relaxation exercise, and the graduation ceremony. While a unique activity mentioned by health center-based is the parent session.

Dynamics were described as the interactions and engagement between participants and the program facilitators during the group sessions. Similar dynamics transpired in both the adolescent and parent group sessions. Overall, the program facilitators observed that the sessions served as a venue for ***adolescent girls and parents to disclose their personal experiences*** which were relevant to the topic being discussed. They were also given the opportunity to discuss their feelings. This gave the program facilitators an ***opportunity to address the issues adolescents faced***. The program allowed them to better guide the adolescent girls by correcting their misconceptions, misinformation and practices, and imparting values. Consequently, each group member reflected on the experiences shared, discussions, and group activities during each session. All of these dynamics are summarized by the words of a school-based program facilitator:

"The one katong nag role play sila sa katong different situations, naa silay situations nga gi-portray, then ila gi-role play. That was very memorable kay nakita didto ilang natural, natural nila na kuan nanggawas gyud, kanang it's not even scripted, scripted siya at first pero pag kuan na ang tinuod na gyud ni gawas. Nga reactions…even natural behavior gyud nila when confronted with those situations naka ingon ko ba nga possible gyud ni mahitabo ingon ani noh nga pwede man gyud nga mga bata… I find it a very good chance and opportunity to come in to teach them the more appropriate responses. Kay nanggawas naman gyud sila, dili man guarded ilahang responses ug actions, so didto na after ato mo come in na dayun kung unsa gyud ang kuan. Pero sila mismo moy mitan-aw ni evaluate sa situation and they will be the one to realize and reflect unsay impact ato sa kuan. So after all sila gihapon maoy naglearn, nag-reflect, ug nagdiscover nga mao diay na siya. It was a very fulfilling experience for me knowing that aside from talking about it, you get to input values, you get to input mga correct nga mga learnings sa mga bata kay natuo sila nga it's okay to feel this way. [The one where they had a role-play about different situations. That was very memorable because they were able to show their natural [reactions]. It was not even scripted, the reactions and their behavior when confronted with those situations were natural. I find it a good chance and opportunity to teach them about appropriate responses. Their responses are no longer guarded so after that, I will come in and teach them. They were also the

ones who evaluated the situations and reflected on the impact. After all, they were the ones who were learning, reflecting, and discovering. It was a very fulfilling experience for me knowing that aside from talking about it [discussing the topics], you get to input values, you get to input correct learnings [understanding] to the adolescent. Because sometimes, they think "it's okay to feel this way" [even if it's not].]"

(Teacher facilitator 1, female, 39 years old)

Status role change among facilitators played a role in the dynamic that was created during sessions. The same teacher facilitator also highlighted that as they took off their hats as teachers, they saw a different dynamic among themselves and the adolescent participants which was not observed during regular class settings. She observed that adolescents openly share their experiences without hesitations.

"So nakita nako ila response na positive kaayo especially kung, as a teacher or as a facilitator, kay dili naman ko teacher ato, so akong gi-take off akoang crown as a teacher. I facilitated and became one of them nakit-a nako na mukatawa sila, malingaw sila, niya mura ra silag nag share ug kuan, which is cannot be seen in a teaching-learning process. Kay murag naa paman gihapon, even if we try to become facilitators inside the classroom pero naa pa gyud gihapon ang imohang kuan as a teacher gyud. But during the session with them, it's as if we are one and they are talking about their experiences like I'm not their teacher anymore. [I observed a positive response from participants especially when we took off our crowns as their teachers. During sessions, I shift from being a teacher to a program facilitator. I facilitated and became one with them. From there, I saw they had fun. It seems as if they are just sharing [with their friends] – which cannot be seen in a teaching-learning process. Even if we try to become facilitators in the classroom, that does not happen. But, during the session with them, it's as if we are one and they are talking about their experiences like I'm not their teacher anymore.]"

(Teacher facilitator 1, female, 39 years old)

THEME 8. IMPLEMENTATION CHALLENGES WERE EXPERIENCED

Although 'A Healthy Me' was considered to be a positive and beneficial experience, the program facilitators experienced challenges with some elements of implementation. These challenges were related to (1) attitudes and (2) logistics. Relatively few comments were made by the adolescent participants about implementation challenges with facilitators sharing far more issues encountered during the program.

The challenges described by facilitators under **attitudes** related to the initial impressions and responses of adolescent participants and program facilitators toward the program. Some adolescents and facilitators felt shy or anxious participating in group discussion, particularly early in the program, and were uncomfortable with some of the more sensitive sexual and reproductive health-related content. Facilitators also expressed initial concern about how they would juggle the additional workload related to 'A Healthy Me' and whether their facilitation skills would be adequate. However, it was noted that most of the concerns were resolved throughout the program.

Many of the adolescent ***participants were initially shy and anxious*** when they first attended the sessions. One adolescent participant recalled her experience of feeling anxious upon joining the program but shared that she eventually felt comfortable as she knew her co-participants:

> *"Pag-una Miss kay murag nakuyawan ko unya nahadlok kay wa ko kahibaw kung unsa man mao to nga pagka naa na koy mga naka-ila, kay ka-ila man nako sila daan, murag ni gaan-gaan akung paminaw nga naa koy kauban ba. [At first I was nervous and scared because I didn't know what it was about. When I got to know else is participating, I got more comfortable because I already know them.]"*
>
> *(Health center-based adolescent 2, 22 years old)*

On the other hand, program ***facilitators described feeling hesitant*** to facilitate the program due various reasons. Health facilicators, in particular, were concerned that they are not skillful enough to facilitate. One facilitator shared feeling nervous about facilitating because of lack of experience and confidence:

> *"Akoa kay first kay pagkahibaw nako naa ni ang 'A Healthy Me' program unya murag kuan mo facilitate. Wala ko kahibaw unsa akong buhaton ba, kay gi kulbaan ko kay ako man gud ang type na person nga mauwaw man gyud ko kanang naa na laing taw gud sa atubangan. Kana ganing prepared kaayo ka then if naa naka in front nila murag mo blanko ka ba. [When I first learned about 'A Healthy Me' program and that I will be facilitating it, I did not know what to do. I was nervous because I am a really shy person if there are other people in front of me. Even if I prepare for it, I sometimes space out [because of anxiety].]"*
>
> *(Nurse facilitator 3, female, 25 years old)*

In addition to a lack of confidence in their facilitation skills, program facilitators from both groups mentioned ***apprehension related to their work schedule and the program logistics***. These were summarized in the response of a teacher facilitator whose experience with the program turned out to be positive despite worries:

"Ah, okay so about sa atong implementation sa 'A Healthy Me' program, at first noh hesitant gyud ko maam nga kanang mo… akoy mo facilitate. Hesitant in a way nga akong huna huna makakuan ni siya sa akoang time noh? Dayon usa pod wala pod sakto nga kanang, wala tay rooms unya ang number 1 gyud ana gyud kung, ang response sa bata ba, mga estudyante, kung kuan ba sila, willing ba sila, mo apil noh? Dayon, pagkahuman ato, sa pag start na gyud nato og implement sa program katong kuan na gyud, session na gyud naa naman gyud toy bata ato, nakita sad nako nga okay raman diay, bisan ang oras namo ba limited kaayo, kay 4 to 6 baya to siya unya gihimo na gyud to nato ug 5 to 6 kay ang mga bata or mga students nga participants mga working students niya kuan kaayo limitado sad kaayo ang ilahang time, o. Mao sad to siya. [About the implementation of 'A Healthy Me' program, at first, I was hesitant to facilitate. I was hesitant because it can affect the time [that I have for other activities]... Another thing is that, we also do not have a venue where we can conduct the program. And also, I wasn't sure if the students were willing to join. When we started implementing the program, I was able to see that implementation is okay. Even if time is very limited, we only did it every 4 - 6pm and then changed it to 5 - 6pm because the adolescents are also working students so they have very limited time as well.]"

(Teacher facilitator 3, female, 46 years old)

Moreover, some of the older program facilitators, typically more senior health-center based midwives, viewed the program as an added work on top of their mandated duties. A program facilitator expressed her sentiments about the program:

"Kuan lang kanang mura ba'g sa kadaghan na nga trabaho mo puno siya. Pero kato kay kuan 1 ½ hour ra man toh siya noh? Pero kuan everyday man gud. [It adds up to our workload. Although the program is only 1 hour and 30 minutes, we still do it everyday.]"

(Midwife facilitator 3, female, 49 years old)

However, many other health-centered based staff did not support the idea of the program being extra work and this, at times, appeared to create conflict between the older and young health staff. One health center-based facilitator described an alternative mindset for facilitating the program by focusing on what she was learning:

"Kay kahibaw gyud ko nga ang mindset sa akong midwife is "Ah additional trabaho na sad ni" So ing-ana. Yes, it could be additional trabaho. Di na lang tan-awn siya as additional trabaho but additional learning, or additional something. Well for me additional learning man gyud na siya. Kay wala man gud

sa, wala may kuan unsa [inaudible] wala man gud tay ingon-ani nga program. [I know the mindset of the midwife is like, "This is another additional work". Yes, it could be additional work but we should not look at it as additional work but as additional learning. For me, it is additional learning because we don't really have a program such as this.]"

(Nurse facilitator 2, female, 33 years old)

Additionally, ***some facilitators described themselves as 'conservative'*** and struggled with the thought of discussing more sensitive SRH topics with adolescents, even as health professionals. However, she was able to realize the importance of providing SRH education to younger women:

"Lisod oy! kay mga batan-on. Lisod. [CT] Murag kag maka ingon ka ipadayon pako ni og basa? Ipadayon pa ni nako nila og discuss or dili na lang? Mura bag lain kay mura bag batan-on pa kaayo unta ba pero huna-huna nako "ah sa eskwelahan naa naman gani ni human anatomy" kabalo na gyud ni sila ani. Ato gyud ni i-discuss kay naa mani diri sa module. Mao na siya. Ma kuan gyud mi bisan og lisod unta or para nako nga maka ingon ta nga murag conservative kaayo ba about ing-ana nga di na lang ta ni hisgutan oy kay mura bag lain paminawon. Imo jung… na sa ako kuan ba napaabot gyud nako nila ang mensahe gikan sa 'A Healthy Me' program. [It's hard because the youth today are so complicated. I question myself if it's worth going through with discussing this [sexual and reproductive health chapters] or not? I find it awkward but then I realized that even in school, they discuss human anatomy so they should already know about this. I should really discuss this because it is part of the module. Even if we are conservative about these things and choose not to talk about it, there's a need to do it. I was able to deliver the message of 'A Healthy Me' program to the participants.]"

(Midwife facilitator 5, female, 48 years old)

Likewise, some of the ***adolescent participants also appeared uncomfortable*** with some of the content, in particular the image of the female external genitalia as part of the session on the female reproductive system. One program facilitator described how he reassured the adolescent participants that they will later understand why it was included in the journal:

"Then naa sad toy times ang kato pong mga, usahay ang mga pictures pod kay grabe gyud kaayo ka realistic and then naa gyud didto nga mao gyud ni siya and nahitabo ron sa social media makita sa mga bata. Unya which, mahibong sa sila mga bata nga "sir nganong naa man ni sir, kaning kalain ani sir oy!" The moment they received the module, the first, "nge kalain ani sir oy" that's the first reaction, and then I understand the reaction but later on we will understand

nganong ingon ani, I instructed them, "Ah okay, Sir, abi namo ug kuan sir." Maybe because ingnani inyo reaction kay wala pamo kahibaw sa information kay ni react dayun mo. [There are pictures [external female and male genitalia] that are very realistic and these days these pictures can be seen at social media by adolescents. The students wondered "Sir, why is this included? It's indecent." The adolescent girls felt awkward about it. The moment they received the module, the first reaction was "Sir, this is obscene." I understand their reaction and explained to them that we will understand later on why it is like that. Maybe because they did not know anything about it yet that's why they reacted differently.]"

(Teacher facilitator 2, male, 26 years old)

Adolescent participants also shared they experienced discomfort with particular activities. One of the adolescent participants described the condom demonstration as a difficult experience, even though she acknowledged learning from it:

"Okay ra man. Naa sad mi nakat-onan ba. Pero negative toh paminawon para nako. [It's actually okay. We also learned something from it. But it was negative [awkward to hear] for me]."

(School-based adolescent 4, 13 years old)

Similarly, some ***parents or guardians of adolescent girls reacted strongly to the content of the program*** because of the stigma related to sexual and reproductive health education. During past program monitoring, it was observed that one of the factors for the decrease in participation of adolescents was the disapproval of their parents on their participation towards the middle of the program. Program facilitators reported that parents were pulling out their children from the program because of the 'obscene' image of female and male genitalia that they see in the journal. One program facilitator cited her experience in resolving this challenge after a guardian stopped his granddaughter attending the sessions:

"Unya mao toh ang rason sa lolo daw kay nag igat-igat ra daw unsa daw buhaton didto. Mao toh gipasabot sa treasurer sa barangay mao na ila buhaton didto naa silay kuan ana-ana. Mao toh nadala nila ana-ana. [The grandfather's reason why he won't allow his granddaughter to join is because he thinks that she will only learn about flirtatious behavior. The treasurer of the barangay explained further what they will do and that's why she was able to join back.]"

(Nurse facilitator 4, female, 32 years old)

In some instances, program facilitators observed that ***younger participants were less participative*** during group activities. This was also observed during program monitoring. Often younger

adolescents just listen and absorb the discussions. There was also sometimes different beliefs and values shared during the group discussions which caused conflict between the adolescent and, occasionally, between the adolescents and facilitators. A program facilitator noted that the clashing of ideas had negatively impacted the participation of the adolescent participants. This led to the discouragement of participants top openly express and share their ideas or experiences:

> *"Kay si maam [name withheld] kay parent na biya, ako dili pa so ako mo adjust ko sa ilaha. But then siyempre mo comment gyud na mga participants na "kuan man gud si mama… kay ing-ani si mama". Unya si maam [name] mama biya siya "dili!". Ayay ka patay ta ani diring dapita. Kuan siya "dili wala gyud ginikanan ang naay ka lagot sa ilang anak ha…ing-ani gud ni ha, ing-ani gyud ni" ana ba. So, in return dili nato mo tingog, di nato ganahan mo share kay na kuan siya diretso ba, naay mga conflict sa mga ideas ba. [Since Maam [name withheld] is a parent and I'm not so I will have to adjust to them. But of course, the participants will share their comments on their own mothers' behavior "My mother is like this… like that… So Maam [name withheld] who is a mother said: "No! [I panicked] there is no parent who holds grudges towards his or her child. This is like this…" So, in return, the child no longer wants to share because of their conflicting ideas.]"*
>
> *(Nurse facilitator 2, female, 33 years old)*

The challenges described under **logistics** were with coordinating the program with program co-facilitators and managing participants. The most common issues described by all groups of adolescent participants and program facilitators were regarding the attendance or tardiness of the adolescent participants. While common challenges experienced by program facilitators related to inviting the adolescent participants and managing their time and workload.

Recruiting participants was particularly a challenge among health-centered based program facilitators. This was described as due to multiple factors including a lack of time, the wide geographical scope of barangays, using a poor mobilization strategy, and the availability of adolescent participants. According to one facilitator, most potential participants in her community were in school. Thus, they resorted to inviting older participants:

> *"Para sa akoa nag lisod ko ato kay kana ba gi ingon ko nga kana lang mga duol duol, unya ang nahitabo ana kay naa man guy ALS. Oo di sila kaapil kay naa silay klase. Mao toh nakakuha mi kani nang mga dagko-dagko na gani tog edad 20 na kapin. Oo kay tungod lagi… naay teenage gud pero skwela pa sila. Estudyante pa. [For me, I really had a hard time [looking for participants] and then it just so happened that there are ALS students but they can't join because*

they also have classes. We just recruited those aged 20 and above. Most of the teenagers here are still in school.]"

(Midwife facilitator 4, female, 61 years old)

Meanwhile for school-based models, ***compelling the students to join*** was the difficult part. According to program facilitators, because they had not facilitated the program they had challenges describing it to the students. Though there were many potential participants among the Eighth-Grade students, relatively few expressed interest to join the first program implemented at the school.

Attendance issues and tardiness by adolescent participants was also commonly described. Facilitators shared that sometimes the adolescents missed sessions due to household responsibilities or school assignments. After missing a session, one adolescent participant expressed feeling 'behind' her fellow participants on the topic:

"Naay sometimes nga maka absent man mi ana. Kanang maawahi na ba. Labi na daghan pa buhaton sa balay unya dili mi maka apil sa 'A Healthy Me'. Wa mi kahibaw sa na topic ana. Usahay ma kuan sa uban. Medyo naay ing-ana na pang huna-huna pero kay mura ra kag kuan, unsay tawag ani? Di man sa ingon nga mauwaw pero mura kag wala naka kahibaw unsa na ang topic ba. [There are times when we miss a session especially if there are a lot of household chores to finish and we cannot join 'A Healthy Me'. We don't know the topic anymore. We feel left out because we don't know where we are in terms of the discussion.]"

(School-based adolescent 3, 14 years old)

The challenges faced by the adolescent participants' in attending the sessions were understood and more accepted by the school-based program facilitators. However, the health center-based program facilitators expressed more frustration about this with some adolescent participants being very inconsistent with their attendance. Others attended but were very late. Waiting for the adolescents to confirm their attendance felt like a waste of time for some health center-based program facilitators. One health center-based program facilitator described having to repeat content for late attendees:

"Maayo na lang gani ang among participants naay motu… naa gyuy ni straight gyud, unya naa say mo tunga ang dinha unya ma late gani daghan, unya maghulat. Usahay among balikon ang topic. Unya dayon kuan na gyud toh murag gamay gamay ra gyud toh at least naa gyud nakahuman. [It's good that our participants really come for the sessions. Some participants had straight [complete] attendance. While some come in late and we have to wait until they arrive. At times, we have to get back to some content of the topic that they missed... At least, some of them have really finished the program.]"

(Midwife facilitator 3, female, 49 years old)

It was observed by the research assistants that some of the attendance issues were caused by poor selection of candidates. During program training, facilitators are strongly cautioned against inviting adolescents who are heavily pregnant or have young children without childcare support. However, because these adolescents are readily accessible to health center staff, they are often observed to be invited but are more likely to have attendance issues.

To improve the adolescent participants' attendance, program facilitators exerted effort by fetching them at their homes or from their classrooms. This required ***extra time and effort from the program facilitators***.

> *"Ang problema lang gyud dapat ang facilitator naa gyud time, unya ang usa sad sa naproblema nako ato noh kay dugay kaayo mangabot. Naay mo abot nga sayo naa say mo abot dugay sad kaayo kinahanglan pa gyud nimong adtoon ba. [The problem is that the facilitator should have time. Also, one of our problems is when participants arrive late. There are some who come early and there are some who come in late that you really need to go to their residence.]"*
>
> *(Midwife facilitator 8, female, 45 years old)*

> *"Then usa pod kay ang mga bata kinahanglan gyud nako silang kuanon, kana galing adtoon sa classroom, unya usahay kay mo absent unya, actually I have a goal na every session there should always a perfect attendance, so that's why apason gyud nako sa classroom. [One of the challenges was I really have to fetch the students from their classrooms. Some were absent too. Actually, I have a goal of having perfect attendance every session that's why I really go to their classrooms.]"*
>
> *(Teacher facilitator 2, male, 26 years old)*

In connection to extra time and effort, program facilitators expressed challenges ***managing their time and workload*** because of the additional responsibilities related to 'A Healthy Me'. However, despite the challenge of balancing their workload, many regarded the program positively. A school-based program facilitator highlighted that he didn't treat the program as additional work but perceived it as an opportunity to address important issues:

> *"Unya as facilitating team sad kay kanang kuan sad its a challenge for me kay I handled 5 classes, and then I also have works, and then this one but still as validator and overall, generally I am so thankful, I never treat this as an additional burden, but I treated this kind of program as a great opportunity that as guidance facilitator or guidance coordinator in the school, I already had this*

program that is really relevant to the current issues sa school. [As a facilitating team, it was challenging for me to handle 5 classes because I also have other tasks. But overall, generally as a validator [facilitator], I am so thankful. I never treated this as an additional burden, but I treated this kind of program as a great opportunity as a guidance facilitator and coordinator in school. This program is really relevant to the current issues in school.]"

(Teacher facilitator 2, male, 26 years old)

To help reduce the workload related to implementing 'A Healthy Me', two or more facilitators are usually trained per location to share program-related responsibilities and facilitation. However, sometimes the workload was not shared equally by the facilitators, particularly in the health-center setting. This was typically related to the hesitations of some senior community midwives about implementing the program, leading them to delegate most of the responsibilities to the younger health staff who were unable to negotiate other arrangements. One of these program facilitators expressed feeling stressed because of the program when all of the workload related to the program fell to her rather than being shared with other staff:

"Murag ikaw pod ma stress ba kay gikan sa sinugdanan ikaw hangtod sa katapusan ikaw pa. Unya honestly ang midwife kay "ikaw day..." mo ana biya na "Ikaw day unsa man imong kuan" [CT] Mangayo ta og kuan "okay ra ba nimo maam ani". Pero humana ang planning. Murag ang approval na lang ba. Murag usa na siya sa challenge kay dili ra biya pod…atong time ni ana na gyud ko kapoya aning 'A Healthy Me' kay dili ra biya unta ni among trabaho. Murag ma focus na lang ko aning 'A Healthy Me' ba sa kadaghan sa buhaton… Unya usa sa challenge gyud nako is ang kalisod bitaw sa schedule… Kanang mo ingon bitaw "day di nako ka session ron kay kuan. Unya ikaw pod ba balibaran pod ka sa usa ka midwife nga dili ko ka kuan. [You will also be stressed out because you manage the program from beginning to end. Honestly, the midwife is not very committed. When I consult something about the program, she would reply "How about you? What do you think about it?"... The planning has been done, they just give the approval. It's also one of the challenges, one time I got tired of implementing 'A Healthy Me' because this is not my only responsibility. I invested so much time in 'A Healthy Me' when I also have a lot of things to do... My challenge also is the difficulty in setting the schedule. Sometimes they would say, "I cannot have my session today because…" then another midwife will contact you because she cannot do her session too.]"

(Nurse facilitator 1, female, 26 years old)

Interpersonal challenges and conflicting beliefs and values between the older midwives and younger nurses were not uncommon. Younger program facilitators tried to avoid conflict by carefully choosing

their words during the sessions. One of the younger program facilitators described the 'clashing ideas' between herself and the older midwife and how she deferred to her colleague's perspective:

> *"Basin offensive sa ilaha ba [giving of information]. Naa man gud na sila mga beliefs nga ilaha. For example, like kami ni clash gyud mi kausa ni maam [name]. Kay si maam [name] kay parent na biya, ako dili pa so ako mo adjust ko sa ilaha. [Maybe giving of information is offensive for them. They have their own beliefs. For example, there was a time when Maam and I had a clash of ideas. Maam [the midwife] was a parent and I'm not, so I always adjust to her.]"*
>
> *(Nurse facilitator 2, female 33 years old)*

Younger health staff described feeling intimidated when facilitating in the presence of an older midwife and were more comfortable facilitating on their own:

> *"Kay kung naa man gud midwife mura pod kag ma sita… Naa tay idea nga dili mao unya sila mas nakahibaw, mas dugay biya sila namo. Mga ing-ana ba. Unya basig sayop ta, ingon ana ba. [If the midwife is around, you will also feel intimidated. We're afraid of sharing the wrong information or ideas with them around. They are more experienced than we are, and we're worried what if we make mistakes.]"*
>
> *(Nurse facilitator 4, female, 32 years old)*

Program facilitators also shared the challenge of having ***insufficient time to prepare and review the topic prior to the session***. Both groups of program facilitators admitted that they are unable to thoroughly read the topic in advance. This results in a feeling of 'suspense' while they unravel what the contents of the topic are during sessions as expressed by a health center-based program facilitator:

> *"Basta para nako suspense siya pirmi kay ngano di biya nimo maka open kung unsay among topic. Kahibaw mi na kani mao ni among topic karon o inigka ugma. Pero sila ug kami wala gyud ingon nakabasa nga amo gi susi daan kung unsay among topic. Wala gyud so ang akoang ang amoang mga kabatan-onan hasta ako dungan ra mi nakahibaw nga mao na diay toh nga ani na diay ni siya. [For me, it adds to the feeling of suspense since we can't open the journal and read the topic ahead of time. We just know that this will be the topic for today or tomorrow. We were really unable to read and examine our topics deeply. So, during sessions, the participants and I go through the journal and together learn what the topic is about, that it is like this.]"*
>
> *(Midwife facilitator 5, female, 48 years old)*

However, because this lack of preparation is anticipated in design of the program through use of the 'learning journal', the research assistants observed that most facilitators were able to achieve a good quality of implementation and maintain adequate fidelity to 'A Healthy Me's' content and methodology.

Regarding the duration of the sessions, the one and a half hour allocated per session was deemed insufficient by most program facilitators. They argued that some of the individual and group activities in the journal can be time consuming sometimes. According to a school-based program facilitator, the session time is limited to process the activities and the participant's responses especially when they are very engaged in the session.

> *"Pero kanang kuan lang gyud time consuming lang gyud tungod sa kadaghan sa activities. Ni kuan gani ko ato ni overtime supposedly pila to ang pinaka dugay, Miss? One hour and thirty? Oo nadugay because of the processing, because of the answers sa mga bata, dinha man gyud ka murag mu kuan. Niya naa pa diay, naa pa diay activity abi nako ug humana, last nato… Daghan activities at the same time ang mga bata maka relate man gyud. [It's really time consuming because there are a lot of activities. I even went over the allocated time supposedly instead of one hour and 30 minutes. Processing the answers of the adolescents takes too long. There are also a lot of activities that the participants can relate to.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

However, in some instances, some program facilitators also had to limit their session time due to their work and other personal circumstances. As a result, sessions are cut short by limiting the number of participants who can share their answers. One program facilitator described having a challenge with facilitating the small group session when he exceeded that recommended number of participants, including 17 participants rather than the maximum suggested of 14. This meant that the program facilitator needed to limit opportunities for the adolescents to share:

> *"All the participants were not able to share. yeah, because it's only me and I have 17 and then I should stop within this time because I will be left, oo so mabiyaan gyud ko sa pumpboat. [Not all participants were able to share. It was only me and I had 17 participants. I should stop when it was time because I might not catch my boat back to the island.]"*
>
> *(Teacher facilitator 2, male, 26 years old)*

Moreover, it was strongly recommended that female facilitators lead the program. In one situation where this was not possible, the male facilitator described experiencing challenges in related to what was being shared:

"Wala, siguro, all the activities ganahan gyud kay ko pero naa gyud activities nga sensitive kay most especially, ako man gyud lalaki unya ang akong mga bata puro mga babaye. I just kuan siguro nga murag naka ingon ko nga murag mas effective man siguro noh kung babaye gyud ang facilitator ba, I have that kind of realization. Unya its better gyud diay nga girl gyud ang mo faci kay the girl can give more information because that is based on herself makarelate gyud siya unya mga babaye pod iyaha. [I liked all the activities but there were activities that were really sensitive. I'm a male and my participants are all female. I just realized that maybe it's more effective if the facilitator is also female. It's better because they can give more information that is based on her personal experience. The female participants can easily relate to her.]"

(Teacher facilitator 2, male, 26 years old)

Furthermore, during the validation, program facilitators shared a challenge on the influence of the teacher-student relationship during the earlier sessions. Though program facilitators have set expectations for the adolescent participants that they are not acting as teachers during the program, adolescent participants had difficulty accepting that. In the first few sessions, it was shared that there were adolescent participants who were hesitant to openly express themselves and the facilitators felt this was because of fear that it may affect their grades or because they are uncomfortable conversing with their teachers.

In one municipality, it was decided by the senior health officer that the barangay offices would provide the venue and shoulder the costs of snacks provided for participants during the sessions. However, there were different levels of support provided by the barangays. For those who were not well supported, the facilitators used their own resources to buy snacks and utilize the health center as a venue as shared by a program facilitator:

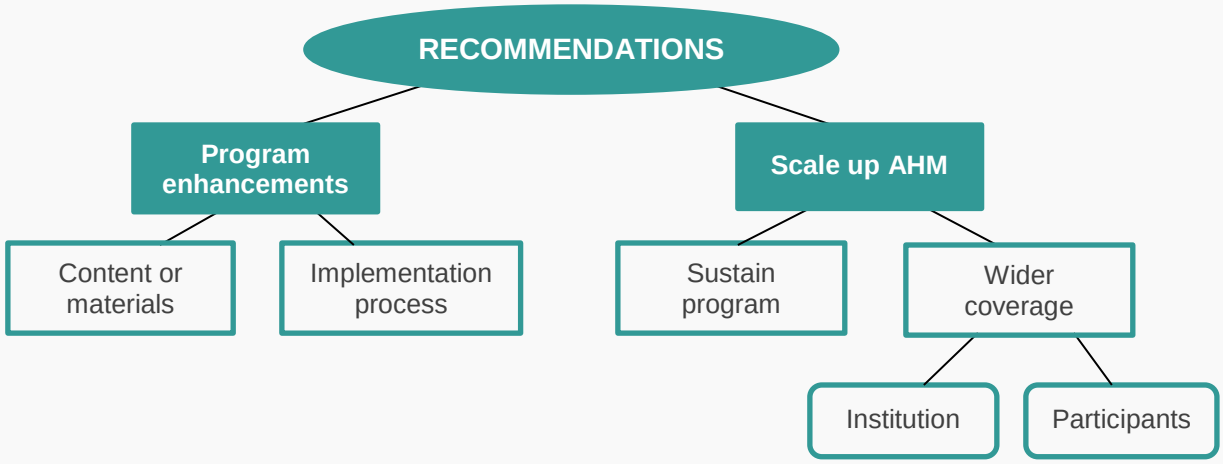
"Pero mao lagi murag di pa sad mi kaayo biya gyud ready ato kay ang amo sad sa barangay murag lahi lahi gyud nga mo naa gyud bitaw, financial lang muhatag og snacks. Usahay mag libog pa ta, tagaan ba ta or dili. Labi na ma timingan nga ang among treasurer ato is naga-seminar. Unya di mi maka gamit sa room. Ari na lang mi tawon sa health center. [We were also not ready that time. Our barangay is different from the others who provide snacks. Sometimes, we get confused whether they will provide or not especially if our treasurer is out on a seminar and we cannot use the room. We will just have the session here in our health center.]"

(Midwife facilitator 6, female, 43 years old)

Evidently, the holistic experience of 'A Healthy Me' had led to positive outcomes for both adolescent participants, program facilitators, and even parents of adolescent girls. The gained knowledge, changed attitudes, acquired skills or behaviors, and strengthened relationships are indicators of its success in achieving its goals. However, it is duly noted that there are aspects that can still be improved to address the implementation challenges encountered. Some of hese challenges were provided with solutions by the research participants during the FGDs.

6.3 FINDING: RECOMMENDATIONS FOR 'A HEALTHY ME'

FIGURE 4. THEMATIC MAP OF RECOMMENDATIONS FOR 'A HEALTHY ME'



Having experienced both the benefits and challenges of participating in 'A Healthy Me', the research respondents made recommendations about what they would like to see happen with the program in the future. Their responses centered around two themes: (1) opportunities for program enhancement and (2) recommendations to scale-up 'A Healthy Me'. In terms of content, the majority of research participants were positive about the topics and educational methodology employed and suggested no changes. However, all groups mentioned the need to improve participant selection. Program facilitators identified far more opportunities for program enhancements with the most common being improving facilitator selection, having appropriate venues, and scheduling the program at times which were most convenient for partners. All research groups shared that 'A Healthy Me' should be not only sustained but have wider coverage and include more participants overall and participants who are younger.

THEME 9. THERE ARE OPPORTUNITIES FOR PROGRAM ENHANCEMENT

Program improvements are integral to strengthen the methodology and further enhance program impact and effectiveness. To address the implementation challenges mentioned by the adolescent participants and program facilitators, they recommended the following changes in (1) content or materials and (2) implementation process.

Content or materials related to the topics covered and educational material used in the sessions. There was a consistent contentment with the existing topics covered in 'A Healthy Me', with only

twelve research participants across the different groups suggesting the addition of particular topics. However, there was no consistency in the topics suggested and hence may reflect individual interests and preferences rather deficiencies in the program content.

TABLE 6. ADDITIONAL TOPICS SUGGESTED FOR INCLUSION IN 'A HEALTHY ME'

Adolescent participants' suggestions		Program facilitators' suggestions	
		Topics for girls:	*Topics for boys:*
• No change/complete • Waste disposal • Family communication • How to avoid sex (at school) • Cutting classes	• Depression • Drugs • Self-improvement • Teenage pregnancy • Partying	• No change/complete • Family communication • Values • Infant care (importance of immunization)	• Women's worth • Reproductive health • Sense of responsibility

Regarding changes in the educational materials used, there was also consistently positive feedback about the 'learning journal' used in the program. Only one facilitator had a very strong preference for ***including a flip tarp*** rather than a journal, although this became a subject for significant debate during both the FGD and validation meeting. She further added to discuss all topics in one day:

> *"Kato ako gi suggest ganina maam usahon siya og session. Kung kami mo facilitate nindot kaayo toh siya kay ka usa ra gani i-flip tarp style ba di siya libro then usa ka adlaw nga session. Ana ba [I suggested to fuse the sessions into one. We can use a flip tarp style, not a journal, and we can facilitate that. We can do one session per day.]"*
>
> *(Nurse facilitator 4, female, 32 years old)*

Another program facilitator disagreed with her idea, explaining that this would lead to the participants losing interest:

> *"Di siguro 1 session. Kung imo sad i-whole day ma bored na sila. [Maybe not 1 session. If you do it in a whole day, participants might get bored.]"*
>
> *(Nurse facilitator 3, female, 25 years old)*

The program facilitator then dropped the idea of a one-day program but pushed for the use of flip tarp with limited information, allowing the facilitators to choose what and how much to share:

"Aw pwede ra dili whole day basta i-flip tarp na gyud siya. Unya kanang ang pinaka main ideas na lang gyud. Kita na lang mo expound ba. Ang facilitator na lang ang mo expound sad sa mga samples. [Maybe not the whole day but it should be placed in a flip tarp style. Only the main ideas will be included and we will be the one to expound it. The facilitators will be the ones to expound on the examples.]"

(Nurse facilitator 4, female, 32 years old)

During the validation meeting the flip tarp recommendation was discussed further. More program facilitators strongly opposed the idea, highlighting that it contradicts the purpose of the educational methodology; to enable adolescent participants to be the 'holders of knowledge'. Another program facilitator also claimed that flip tarp is a very classroom-type approach means the sessions would not be participatory and would result in the adolescents becoming disinterested and disengaged.

One adolescent participant also suggested ***including educational videos*** during the discussion of STIs and HIV. However, it is noted that most government school and health center do not have access to the internet or large screens for viewing videos. She felt it would convey the messages more quickly and allow greater self-reflection:

"Sa akoa kay, mag add on og mga videos nga murag maka igo gani sa ilaha, for example, pariha atong sa renewsiya kay nag topic mi atong about mga STD, mga HIV, so patan-awon mig video. Like sa PYAP kay gipakita mi atog video nga while naa sila sa school kay nangadto silag CR, boarding house kay para mag buhat og in ato. So at least makabalo mi ba nga while doing ato nga butang, unsay mga consequence nga among makuha. Oo, kay maka ingon ko, murag i-reflect, while nag watch ko og video kay mag reflect man sad ko, "ay ing-ani diay akong makuan ing-ana." [Add videos that the adolescents can relate to. Just like with Renewsiya, we had a topic about STD and HIV, we were made to watch a video. In PYAP, they also showed us a video - while the students are in school, they went to the comfort room of the boarding house to [have sex]. At least, we will know the consequences of our wrong acts. I can also reflect while watching the videos.]"

(Health center-based adolescent 5, 17 years old)

Suggestions related to the program's **implementation process** were more common, predominately by the facilitators which arose from the challenges they experienced during the program. Implementation process refers to how the program was being executed from the beginning until the end – that is program training of facilitators, inviting adolescent participants, adolescent sessions, parent sessions, and graduation. The recommendations included strategies and procedures to improve both program preparation by improving selection of adolescents and facilitators, and

session implementation. The latter involved proposed changes on the schedule of implementation, session duration and attendance.

Adolescent participants focused on ***strengthening promotion of the program and invitation process.*** School-based adolescent participants felt that the invitation should be expanded to all female students who could then participate via self-selection. She recalled an experience of a poor selection, stating that they have a classmate who was unable to attend due to volleyball training:

> *"Kanang before mo-kuan Mam ba, ang program. Ipakuan sa tanan mga babaye, ipakuan sa tanan girls, aron ganahan sad sila mo-apil. I-explain kung unsay buhaton ana ba. Before mo-kuan sa program kay para daghan pud ang maka-apil. Kay pareha sa among classmate Mam ba ng ani-undang, one day ra siya nakasulod. Timing sad to kay pirmi sila training sa ilang volleyball. [Before you run the program, you should explain it to all girls so they will also be encouraged to join. You should explain what they will be doing during the program so many will be interested to join. One of my classmates stopped attending the program, she only joined one session. It also happened that they were training for volleyball.]"*
>
> *(School-based adolescent 2, 14 years old)*

Meanwhile health center-based adolescent participants believed that involving higher barangay official to invite adolescent girls would encourage greater participation:

> *"Mag-announce nga ingon ana para daghan sad willing ba. Silbi si Kap nalang siguro mismo ang mo-kuan para naa gani mo-participate. Kay kung taw ra sa barangay murag dili man siguro mukuan ang mga taw. Kay naa man guy uban na "ah bahala mo diha oy". Daghan kaayo ug storya ba, maayo nang i-announce sa usa sa dako dako gyud. [They should announce so many will be willing to join. Our barangay captain should be the one to encourage the adolescents to participants. Because if it's only one of the personnel of the barangay, it's not very convincing. There really are others who disregard the announcement. That's why I think it's better if it comes from the mouth of a higher-ranking barangay official.]"*
>
> *(Health-center based adolescent 2, 22 years old)*

A further suggestion made by one adolescent participant to encourage participation was to enhance promotion of the program to the parents of adolescent girls. According to one adolescent participant, orienting the parents about the program will encourage more participation because of greater parental support:

"Kuan, sa mga parents, para if ilang mga anak kay dili mo-apil sa 'A Healthy Me', pwede rasad silay mo sulti sa ilang mga anak nga dapat mo apil mog 'A Healthy Me' kay more nag blessings para ninyo, silay murag mo guide nalang sa ilang anak ba para mo apil og 'A Healthy Me'. [The parents can also encourage their children to join 'A Healthy Me' because it can mean more blessings for them. They can serve as a guide for their children to join 'A Healthy Me'.]"

(Health center-based adolescent 7, 15 years old)

During validation, school-based program facilitators came up with an idea to further enhance the promotion. They suggested using a video presentation that they could easily show to the possible participants. They added that this could also help avoid misconceptions about the program.

The second most common recommendation for program implementation made by all groups was to ***improve the selection of adolescent participants***. It was recommended that adolescent girls be assessed regarding whether they were motivated to join the program and had time to attend the sessions. As expressed by one adolescent participant, not all girls are motivated to learn and wasted the opportunity of participating in 'A Healthy Me':

"Pero dili tanan man gud babaye, dili sila eager nga makahibaw ba, mao nang kanang gisayangan nila ang opportunity nga makat-on paagi ninyo. [Not all girls are eager to learn. They wasted the opportunity to learn through the program.]"

(Health center-based adolescent 5, 17 years old)

The program facilitators supported this recommendation and took note of things to consider when selecting participants. School-based facilitators believed that including classmates and friends would improve rapport early in the program and that discussions would be enhanced if the adolescent had a similar academic standing, as she described below:

"Mas ganahan ko kong classmate lang or mga friends ang mga bata rather than they come from different sections kay ang ilahang relationship and rapport nila build na daan kaysa naa man gyud mga bata na na-belong ug laing section ato dili kaayo ka take-off,dili kaayo ka kuan kay mahawngan pod sa lain nga kuan especially ang dominant ato mga pilot class, mga bright na bata so ang uban naghilom hilom ragyud. Tingali mas maayo pare-parehog level, they come from one class, nga magkuha ta sa usa ka class niya another class kay more or less kaila na sila. [I prefer to group together classmates or friends rather than randomly from different sections because their relationship and rapport is already built. If we group together those from different sections, you can't easily take off because some students may be too dominant or smart and it can affect

others who are silent. It's better if we group together students of the same level and I prefer if they come from the same class.]"

(Teacher facilitator 1, female, 39 years old)

In comparison, health center-based program facilitators mentioned their general difficulty in identifying potential participants, proposing to tap schools to select potential candidates:

"Mo tap pod ta sa school ana maam kay kasagaran gyud teenagers kay naa sa school, public schools gani. [We also tap the school Maam because most teenagers are in public schools.]"

(Nurse facilitator 3, female, 33 years old)

Having experienced challenges with facilitation, including co-facilitating with health-center colleagues, most program facilitators suggested ***improvements in facilitator selection***, emphasizing that the effectiveness of the program relied on the motivation and skill of the facilitator. A few facilitators felt that Renewsiya's officer should facilitate the program. The program facilitators suggested that facilitators should be committed, understand the program, and support the program's goals. One teacher felt that the success of the program was strongly linked the facilitator's level of concern for the wellbeing of adolescents and belief in the effectiveness of the program:

"Another thing pod kanang mo matter gyud pod ang teacher, ang facilitator, it should be a personal commitment rather than pilion lang siya sa principal or estoryahan gyud siya nga dapat ingon ani. If you don't have the commitment dili gyud siya ingnana ka effective kay you could not give what you do not have, if you do not have the heart nga mo spend time, kay mo study baya mo lingkod baya gyud ka and be there with the students kanang lahi ra gyud ang impact, so first and foremost ang facilitator must be convinced of the effectiveness of the program niya dapat nakakita siya, niya naa siyay heart, niya ang goal niya is one with the program, nga mo help out gyud dili lang kay napugos lang siya or just for the sake of implementing, bungkag kaayo, empty gyud kaayo siya dapat. work with kato rang mga willing nga teachers nga mo personally commit gyud sa pag implement sa program. Dili gyud siya basta basta nga kanang mo pinpoint lang ta og person kay ang atoang personal biases ang atong mga kuan mo come in gyud. Dili ka open, dili ka welcoming dili gyud siya effective bisag unsa paka nindot sa program kung ang nag facilitate wala siyay kuan. It must be selfless giving of time gyud and being with the students nga nag-struggle og ingon ana. [Another thing that matters is the teacher or the facilitator should be personally committed to doing the program rather than just being hand-picked by the principal or be appointed to do it. If you don't have the commitment, it will not be very effective. You could not give what you do not have. If you do

not have the heart to spend time, because you will really have to be there with the students, the impact will be different. First and foremost, the facilitator must be convinced of the effectiveness of the program, has the heart, and her goal should be one with the program - to help out the adolescents not just being forced for the sake of implementing it. It shouldn't happen that they only pinpoint who will facilitate the program because our personal biases will come in. If the facilitator is not open and not welcoming, it will never be effective no matter how good the program is. It must be selfless giving of time and being with the students who are struggling.]"

(Teacher facilitator 1, female, 39 years old)

In addition, other health center-based facilitators pointed out that a facilitator should be well trained and understand or relate with adolescent girls:

"So mao na toh maam noh kinahanglan gyud kanang ang mo facilitate ana kanang trained gyud maam noh. [The facilitator should be trained to do it.]"

(Midwife facilitator 6, female, 43 years old)

"Unya ang speaker maayo gani kanang kasabot gyud ang mga kabatan-onan. [The speaker [facilitator] should be good and someone who really understands the youth.]"

(Midwife facilitator 3, female, 49 years old)

Similarly, it was validated by teacher facilitators that truly a skill training is needed for program facilitators. Despite years of training as teachers, they felt inadequate facilitating the sessions to some of the vulnerable girls. During the validation, they stressed that the program facilitators should be equipped with the necessary knowledge and skills on the effective way to facilitate the program. That is achieved by conducting a whole day facilitators' training. Some of the key training topics mentioned include how to conduct oneself, how to ask questions, what are the facilitating gestures, and how to deal with participants' sensitive experiences which might be shared during sessions. With this, the facilitator will gain confidence and will be prepared to take on the responsibility of a facilitator.

Lastly, a health center-based program facilitator suggested selecting a facilitator who has extra time and can focus on the program implementation with fewer other work responsibilities.

"Asa man kaha ato angay usbon ha? Kay og para nako ang program okay raman. Ang kuan ra gyud noh ang facilitator kay kinahanglan gyud mo mangita og facilitator kanang mo focus gyud sa program nga dili lang gyud kuan ba kay pareho sa amoa daghan man kay mig gidala nga program pa gyud. [What else

do we need to change? For me, the program is already okay. I think my only [suggestion] is to look for a facilitator that can focus on implementing the program. It shouldn't be like us who are also handling a lot of other programs on the side.]"

(Midwife facilitator 8, female, 45 years old)

Although, time and workload had been a prominent challenge mentioned by program facilitators. Based on the observational data during the site visits of the program monitoring team, the interest and attitude of facilitators to implement the program plays a significant role in the way they accept and perceive program facilitation. Thus, whether they have time or not, facilitators can allocate a time within their working schedule if they find the program relevant. A program facilitator recommended attempting to enhance the motivation of facilitators to enable them to view it, not as an additional workload, but as important work:

"Kuan sad kanang nindot unta if mas para lang mas matagaan ni siya og priority di siya priority, matagaan siya'g gibug-aton ba rather than just a mere additional trabaho. [It would be better if it will be given a priority, if it will be given much more weight and importance, not just a mere addition to our workload.]"

(Nurse facilitator 2, female, 33 years old)

Additionally, with the health center-based model, program facilitators believed that ***improving the inter-facilitator coordination*** will help reduce the demands on the facilitators' time. A program facilitator cited her successful strategy to address facilitation concerns by creating a schedule and delegating the sessions to the either the midwife, barangay health workers, or herself:

"So ang akong gibuhat kay sige ha mag set ko og kanang katong pareha kang maam [name] schedule. Unya ako sah ang mo initiate sa first nga session. Akong ihatag, di ba naa man toy BHW nga na apil nato pag orientation bitaw, ako silang gipa apil. Ako sila gihatagan og role on areas nga or katong mga chapters nga dili kaayo medically kuan kaayo. So pareho atong isa kato bitawng sample didto nga love your body. So ako na gihatag nila. [What I did was to set a specific schedule. I also initiated the first session. I let the BHW join the orientation. I gave each one a role to facilitate [chapters] that did not need much medical explanation. Example, that chapter on loving your body, I gave that to them to facilitate.]"

(Nurse facilitator 1, female, 26 years old)

Following on from this, facilitators strongly recommended ***identifying the most convenient schedule*** for program implementation for both the adolescent participants and the program facilitators themselves. The health center-based facilitators identified the school break as the most convenient

period for implementation both because of the students' availability and the lighter workloads during this period:

> *"Unya also ang time ana is kanang summer. Fit gyud siya sa mga batan-on. [We can also implement the program during summer. It's fit for adolescent girls.]"*
>
> *(Midwife facilitator 4, female, 48 years old)*

Meanwhile for school-based program facilitators, the start of the school year (the months of June to July) were the least busy for both students and teachers and considered ideal for program implementation:

> *"Tingali siya Miss naay certain time of the year nga murag adto nato i-kuan, dili kay siya madungan sa ting buhat sa kanang naa man gyud clearance, nay mga compliance nga kinahanglan i-kuan tingali mga…June, July siguro, mga beginning pa sa kuan nga wala pa gyud kaayo…August man gud quarterly, inig ka November na pod, October. Niya naa man gyud nay set of kuan a kinahanglan i-submit para makagrado naka, so kana sigurong mga time nga June, July dili kaayo na siya kuan, kay kung magka-end of the year na pod daghan gyud pod kaayo i-comply ang mga bata. [It [program implementation] may be during a certain time of the year that is not too busy. For example, June or July is not so busy. August is a busy month because of the quarterly [reports]. November and October too because we need to submit reports for the grades. So, I think the best time is June or July because the end of the year is also very busy.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Moreover, the ideal time to conduct a session was also considered. For students, this was suggested to be immediately after their classes. If sessions were done before their class, students were thought to rush their assignments and have more difficulty attending or focusing during the sessions. This was outlined by one teacher-facilitator:

> *"Nindot to siya nga ang mga bata mo…mas maayo siguro noh nga morning niya ang klase, then ang afternoon murag free na sila naay 1 hour and a half, dili siya before class, kay kung murag before class, daghan pa silag ipang comply nga mga assignments for the afternoon classes nila. So kung after class hours na murag humana sila sa mga assignments, sa mga kuan, then naa pa silay time in the afternoon, then kung 1 hour and a half lang siya naa pa silay time para mo practice ug mo perform sa ilahang…mao raman siguro na akong nakit-an. [It's better if the sessions will be in the morning then they can have their classes, and in the afternoon, they have free time around 1 hour and 30 minutes. It should not be before class because if we have it before class, they still need to*

comply with a lot of assignments for the afternoon classes. If we have it after class hours when they are done with their assignments and they still have time in the afternoon, they will still have time to practice.]"

(Teacher facilitator 1, female, 39 years old)

This has been proven effective in one of the school-based model implementations. After-class sessions resulted in better attendance of adolescent participants compared to before-class sessions. Program facilitators also stressed the need to consider their time and other responsibilities when scheduling the sessions:

"Unya sa ako sang part kung kuan ba convenient ba sa akong time. Nindot unta na siya. [I think it's better if it will be convenient on my part [it fits my schedule].]"

(Teacher facilitator 3, female, 46 years old)

Despite the pressure on the program facilitators' time, the majority recommended ***increasing the duration of sessions***. Program facilitators suggest that adolescent sessions can be extended from 1 ½ to 2 hours. As shared by a program facilitator, time should not be limited when participants are highly engaged in the session:

"Pero para nako kato nga overtime okay raman to allowable lang, murag two hours, up to two hours siguro ang session especially when mabantayan nimo nga engrossed ang mga bata pero kung bored na sila that's the time to cut short the session pero while naa pa silay energy, sustained pa ilahang kuan, I think it's better to go with the kuan gyud. Not necessarily i-limit lang gyud siya to one and a half, I think it's forgivable to extend kung naa gyud need. [I'm fine with the overtime but up to 2 hours only. You can extend to 2 hours when you notice that the adolescents are really engrossed with the session. If they are bored, that's the time to cut short the session but while they can still sustain their energy, it's better to [proceed]. We should not necessarily limit it to one hour and a half, I think it's forgivable to extend it if there is really a need.]"

(Teacher facilitator 1, female, 39 years old)

Likewise, program facilitators from the health center-based model hoped to extend the time for parent sessions as well. A program facilitator recalled that they needed more time for the parent session:

"Kato bitawng pa apil na ang parents kato nga lecture with parents. Kulang ra gyud kaayo og time para sa mga parents ba. Kay kadyot ra gyud toh. Pila ra toh ka kuan kuwang ra kaayo ang kuan sa parents ba ang time, kuwang ra gyud.

[The one when we had the parent session. There wasn't enough time for the parents because the session was really quick and short.]"

(Midwife facilitator 4, female, 61 years old)

Program facilitators highlighted the importance of ***ensuring that the parents of adolescent participants attended the parenting session*** because of their role in supporting and guiding their children:

"Even the session with the parents, nindot gyud siya kong ang parents atong mga bataa mao gyud ni undergo pod sa kuan kay they can help also niya especially if positive kaayo sila then ma reinforce nila ang ilahang mga bata. The sessions will be reinforced by the parents at home, so na ganahan ko niya. [For the parent session, it would be better if the parents will really attend that because they can also help reinforce the learnings to their children. The sessions will be reinforced by the parents at home, that is what I really like about it.]"

(Teacher facilitator 1, female, 39 years old)

"Pero katong mga sessions nato nakahibaw na atong participants nga ingon ana pero if wala gyuy guidance sa parents maam, wala gyud toh, nothing gyud toh maam. Kinahanglan gyud toh siya og kuan sa mga ginikanan. So nindot toh siya maam gi atubang ang mga parents ing-ana pero og wala gihapon guidance sa iya parents maam useless lang toh nakat-onanan. [When we did our sessions, the participants were already aware of the [issues] but if they do not have guidance from their parents, all whose knowledge will go to waste. It's a must that parents reinforce the learning to their children. It was a good idea to have a parent session but again, if parents fail to guide their children, all the learnings will be useless.]"

(Midwife facilitator 6, female, 43 years old)

Some program facilitators went as far as suggesting that parents should be incentivized to attend through the provision of 'give-aways':

"Unya kana para sad mo duol sad maam ba ganahan pod sad sila mo adto kanang bitawng naay, di mana sila mo duol maam, kung wala mga ihatag sad sa ila. Labi na gyud naghisgot ta sa mag ginikanan. Di gyud na mo duol og basta kanang wala kay ihatag. [They will not really join if they are not given anything. Most especially if we talk about parents, they will never join if they wouldn't get anything from it.]"

(Midwife facilitator 6, female 43 years old)

The adolescent participant also agreed that their parent would benefit from participation, recognizing their role in providing ongoing education about SRH issues:

> *"Same sad sa atong gi buhat sa renewsiya miss ba. May 28 kay graduation namo, dayon pag after ana kay gipatawag pod ang mga parents, sila sad gipang istorya. So ganahan sad mig ing-ato kay while, wala nami ato, among mama nalang. Unya pagkauli namo kay naa man jud nay time nga makakita ta sa TV, then naay mga ing-ana kay sila nay mo explain ba nga ing-ana na siya, Bisan wala na ang Renewsiya kay nag continue pa gani gihapon ang knowledge, di ma stuck ra ba. [Same with what we did with Renewsiya, our graduation was last May 28, after that, they called the parents for the parent session. We liked that they talked to our parents while we were not around. When we watch television at home, there really are times when you see [sexual acts] on TV, we are assured that are parents our there to explain that to us. Even if our sessions with Renewsiya are done, we still continue to gain knowledge.]"*
>
> *(Health center-based adolescent 5, 17 years old)*

Facilitators also mentioned the ***importance of having a private, conducive venue*** for the sessions to enable participants to feel safe sharing their experiences:

> *"Kuan pod maam ang usa pod kay ang privacy sa matag usa kay dili sila ka open up kung kuan gyud siguro kung kanang dapat siguro kung session, session naa ra gyud, exclusive ra gyud ba. Oo kay makapagawas gyud sila. [Also, one concern that I have is of the privacy of the adolescents because sometimes they cannot openly share their concerns. Maybe it's better if we have an exclusive session so that they can freely share.]"*
>
> *(Midwife facilitator 5, female, 48 years old)*

THEME 10. SCALING UP 'A HEALTHY ME' IS RECOMMENDED

Even whilst making recommendations for program enhancement, the research participants remained highly positive about the program, the ongoing need for it, and its potential impact in improving the health and wellbeing of adolescent girls. All groups strongly recommended expanding 'A Healthy Me' to new locations and populations, and aiming for sustainability through stronger government partnerships and institutionalization of 'A Healthy Me'. There are two recommendations that all groups suggested: (1) sustaining the program and (2) widening program coverage. Research participants recommended many specific strategies which could help 'A Healthy Me' to be scaled up.

Sustaining the program pertains to ensuring that the program becomes sustainable or is maintained in the communities where it was implemented and other potential venues. The strategies

suggested were to strengthen the support of government institutions and to maintain the engagement of former program graduates. Adolescent participants in both models saw their role as ***graduates to continue to share their learning with their peers***, as described below by one graduate:

> *"Silbi ikay mudala sa ilaha, muhandle bahin anang sa mga ni-ana nga pangkuan Maam ba sa 'A Healthy Me', itudlo pud sa ilaha. Dayon kato napud sila didto napud sila sa pikas, sila napud motudlo. [You can also handle and share the knowledge you gained from 'A Healthy Me' to others. With this, they can also share what they learned from us to their other peers.]"*
>
> *(School-based adolescent 5, 16 years old)*

Other adolescent participants saw themselves supporting future programs by helping to invite other adolescent girls:

> *"As ning-graduate ko miss, ako pud nga agnihon sila miss ba nga nindot kaayo sa feeling nga maka-apil ka kay daghan ka og makat-onan. [As a graduate of the 'A Healthy Me' program, I will encourage other adolescents to join. It felt good that I was able to join and I also learned a lot.]"*
>
> *(Health center-based adolescent 2, 22 years old)*

A school-based facilitator suggested that there should be ***post-program follow-up of the adolescent girls*** who graduated from 'A Healthy Me' as a one way of assessing and reinforcing the impact of the program:

> *"So for me ang usa lang siguro, it's the regular monitoring. So when we say regular monitoring, from time to time we are going to follow up those participants who just graduated and then kumusta na ang ilang life status sa kinabuhi, the healthy living, if they really applied sa ilahang tinoud na kinabuhi and then para progressing gyud siya, progressive ang atong program. [For me, it's the regular monitoring. When we say regular monitoring, from time to time we are going to follow-up those participants who just graduated and ask about their life status, healthy living, and if they really applied their learnings to their own personal lives. This must be done so that the program will be progressive.]"*
>
> *(Teacher facilitator 2, maale, 26 years old)*

To address the need for government support and to ensure the sustainability of 'A Healthy Me', both program facilitators and adolescent participants recommend three strategies. First, to ***create community partnerships with the local government units*** both at the barangay (community) level and at the city or municipal level. Second, they recommended involving the Sangguniang Kabataan (SK or the youth council). All groups identified the involvement of the barangay officials as one of the

requirements for program sustainability. According to the research respondents, the barangay office has the manpower and the influence to invite adolescent participants together with resources such as venues and funding, which are vital to sustain and expand program implementation. Facilitators suggested that the program should have a budget allocation from the barangay:

> *"Oo, unya kanang kuan sad maam kanang dili kanang mag gikan sa atoang barangay maam lahi man gud maam. Kanang gikan gyud sa kanang kinahanglan gyud og budget gyud maam ba. Dili lang ang health, apil lang pod ang bisag kapitan. Ma invite gyud sila maam ba. Ma apil sa ila budget. [There has to be a separate budget allocated for the program implementation alone and not from the existing funds of the barangay. Not only the health staff but even the barangay captain has to be involved. They must be proactive in inviting adolescents to participate in the program.]"*
>
> *(Midwife facilitator 6, female, 43 years old)*

Program facilitators also identified gaining the support of the SK, both financially and for program implementation:

> *"Coordination sa barangay maam sa SK. Para makatabang pod. [There should be coordination between the barangay and Sangguniang Kabataan. They can also help [with the implementation of the program].]"*
>
> *(Midwife facilitator 1, female, 42 years old)*

To achieve sustainability, research participants identified the need to train and fully orientate more government community partners to prevent challenges with partnering during program implementation:

> *"I-seminar gyud sila [LGU] maam para makahibaw sila. Maglisod man ka kung storya lang maam. Kay at least makahibaw sila unsay kuan kaysa i-storya lang namo maam…. Sila [LGU] gyud mo tagad namo ba. Kung mag sige lang mi og agad nila, negative kaayo sila. [The local government unit should have a seminar so they will also be oriented on the program. It's hard if we only talk about it casually. If we do a seminar or training for them, they will know more about the program. The LGU should work with us on this. If we keep on depending on them, they become too negative.]"*
>
> *(Midwife facilitator 1, female, 42 years old)*

Facilitators, specifically from the health center-based model, strongly suggested that local government leaders or staff should join the program training to understand the importance of the program and their potential role in supporting the implementation:

"Kuan maam mo train mo og mo facilitate gani. Mas maayo kung barangay ka magkuha og people gani. Kay kung kami, once mag… makahuna-huna sila nga nurses ang na train, sa amoa man gud ipasok tanan. Unya dili ra biya kana among buhatonon. So maayo na gikan sa barangay para sila jud mismo kaila sila sa ilang taw. Sila nay mangita. [If you train people to facilitate the program, it's better if you include people from the barangay. Because if you only train nurses like us, they will end up dumping all the work for us to do. But this is not the only work that we have. I think it's better if you include people from the barangay because they themselves know their people better. They can better invite participants.]"

(Nurse facilitator 1, female, 26 years old)

"Oo [budgettan sa munisipyo or brgy] ana maam ba kay wala pa man gyud ni siya na kuan gyud maam napahibaw gyud nila ba kung unsa ni ang 'A Healthy Me'. Wa pa gyud sila kahibaw. Kinahanglan sad sila unta una sad sila ma kuan maam e murag i-seminar lang maam bisag gamay lang ba kanang bisag kanang kuan lang kanang orientation. Unsa ni ka importante kay dako ang barangay maam dili mo lihok kung wala sila ani maam. [Yes, they [barangay officials or staff can solicit for funding from the municipality or barangay. But the thing is, they are not really aware of what 'A Healthy Me' is. I think it should be mandatory for them to be included in a seminar or orientation about the program. Through this, they will know how important this program is.]"

(Midwife facilitator 6, female, 43 years old)

Lastly, ***institutionalizing the program in government institutions*** was also a strong recommendation given by many facilitators to secure long-term support and prioritization from the government. Institutionalizing the program entails its inclusion in the priority programs of institutions such as schools and government agencies, and is annually budgeted. However, they had varying suggestions about which government agency should institutionalize 'A Healthy Me'. Health center-based facilitators asserted that the program could be institutionalized through a local ordinance:

"Ang involvement pod sa barangay officials ug sa SK maam. Ma ordinance ba. Mga ingon ana. [The involvement of barangay and SK officials [is very important], They can set a local ordinance [for the implementation of the program].]"

(Midwife facilitator 5, female, 48 years old)

Other facilitators suggested that the program could be institutionalized under the Gender and Development (GAD) program of barangays:

"Oo sa GAD, ana man gyud na siya mabutang sa GAD so pwede siya magamit og mag kuan ka og mga adolescents unsa lecture? Unsa man? Pwede ra. Oo kay og naay mga adolescents kanang activity pwede pero taas man sad gyud ang topics noh? Dili man gyud mahog og usa ra ka adlaw mao sad nay problema niya kay kinahanglan gyud siyag time. Kay adto mana siya didto na belong. [The program can also be placed under the Gender and Development arm of the barangay. The only problem is that the topics are really long and we cannot fit all of it in just a day. The implementation of the program really needs adequate time. [It may be institutionalized under GAD] because that's where the program belongs.]"

(Midwife facilitator 8, female, 45 years old)

Institutionalizing the program at a national level through the Department of Social Welfare and Development (DSWD) was also suggested. One program facilitator mentioned that this might help address the issue of violence against women:

"Sa DSWD. Kuan sa DSWD kay i-address gyud bitaw niya ang violence against women kanang uban nga abuse teenage. So if ma adopt ba ang tawag ana. Ma adopt na sa DSWD mas okay na mas… [It can also be institutionalized under] DSWD. In DSWD, they address issues such as violence against women and teenage abuse. If DSWD can adapt the 'A Healthy Me' program, it could [better address these issues].]"

(Nurse facilitator 2, female, 33 years old)

The same program facilitator believed that the program should be incorporated with the programs of the Department of Health (DOH) to address the lack of adolescent health programs. This would ensure funding and mandatory implementation:

"Ma incorporate gyud na siya as DOH program... Ma fundan sa government kay pareha gud sa nutrition. Wala bitaw kaayo program sa Adolescents noh? Kuan aside from ma fundan siya ma implement gyud siya. Ma mandatory gyud siya ma implement ba and maapil siya kay kasagaran wala man gyud. Wala kaayo. Wala gyud programs for adolescent health and to think biya kanang mga adolescent kinsa man… matiguwang mana puro sila. Diha gyud mag sugod ba. [It can be incorporated as a program under DOH. The government can allocate funds for the implementation of the program. I just realized that there aren't many programs for adolescents. If we incorporate 'A Healthy Me' as a program of DOH, it will be funded and implemented. It's better if the implementation of the program will be mandated by the government. There aren't any programs for adolescent health to think that it's better if we start with the adolescents.]"

(Nurse facilitator 2, female, 33 years old)

Meanwhile, one of the school-based facilitators added that being part of the Child's Rights Protection Unit of the municipality would be a great opportunity to gain full support on the program:

> *"Kung had it been nga nakakuan mog support sa LGU, then naka sitdown mo sa Child's Rights Protection unit nga meeting kanang mas dako ang support nga mahatag ninyo, mas nindot siya nga ma kuan sa lain nga areas. [If you gained the support of the local government unit and sat down with the Child's Rights Protection unit, you could have gained stronger support [for the program implementation]. It's also better if we conduct it in all the other areas [of the municipality].]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Widening coverage was described as expanding the program to new locations, including within (a*) institutions* such as schools and puroks (household clusters), and to (b) *participants* with different demographic profiles, including younger age groups, adolescent boys, and grade levels.

All of the adolescent participants and program facilitators saw the need to ***invite more adolescent girls*** because of the perceived benefit of program participation. They specifically suggested ***inviting younger age groups***. One of the school-based adolescent participants highlighted that girls as young as 12 years old in Grades 7 or 8 should be invited so enable them to prepare for the changes of adolescence:

> *"Sa kuan kay 14 raman ang gipakuan dri sa 'A Healthy Me'. Unya sa among naapil diri kay 13 years old ba. Mas angayan gyud siya nga 12 or 13, kanang makasabot siya ba, in advance. Grade 7 or Grade 8. [Only adolescent girls aged 14 years old and above were invited to join 'A Healthy Me'. In our group, the youngest is only 13 years old. I think it's better if we included girls as young as 12-13 years old who are in Grade 7 or 8. It's better if they understand about adolescent health in advance.]"*
>
> *(School-based adolescent 3, 14 years old)*

Health center-based adolescent participants shared similar sentiments. One adolescent participant described that adolescent girls aged 15 below were more vulnerable as they are already exposed to different issues:

> *"Like sa giingon ni [name] kanang mag-invite ta og mga batan-on. Pwede ra pod mang-imvite tag 15 below pud siya kay kasagaran man gud nga mga kuan karon mao na sila nga edad, diha sila nagsugod gani. Kay kasagaran man gud*

ingon ana nga edad diha sila daghan na og na expose ana nga problema gani. [Like what she said, you should invite younger adolescent girls. You can also invite adolescent girls aged 15 and below because these girls already started to be exposed to [adolescent health issues]. Younger adolescent girls usually are more vulnerable and exposed to problems related to their health.]"

(Health center-based adolescent 3, 21 years old)

These recommendations were supported by both groups of program facilitators. Program facilitators firmly believed that it is better to start providing SRH education to younger adolescent girls. They said that the earlier they are educated the more they are likely to prevent negative outcomes as described by the following program facilitators:

"Daghan pa gyud kaayo ang kinahanglan i-reach ug i-touch especially kato pa tawn grade 7, mga grade 8 nga mga inosente pa niya makakita na nga naay kuan, ing-ana ba. Sila gyud to ang dapat i-reach para dili sila maabot ana na point. [There are many we need to educate [in terms of sexual and reproductive health]. Those in Grade 7 or 8 are still innocent about these things. They are the ones we need to reach out to so we can prevent negative outcomes.]"

(Teacher facilitator 1, female, 39 years old)

"Didto sa school sad kuan kay as early as grade 7 if masulod nila sa grade 7 mas sayo, mas better. [Also, in schools, we can include adolescents in Grade 7. The earlier [we educate them], the better.]"

(Nurse facilitator 2, female, 33 years old)

However, during the validation, school-based program facilitators suggested to include lower grade levels such as adolescent girls in the 5th to 6th grade. They argued that recent statistics show an increase of teenage pregnancy cases among early adolescence, girls aged 10-14.

Inclusion of adolescent boys in the program was also recommended by health center-based adolescent participants and both groups of program facilitators. Both groups of research participants believed that it was important to educate adolescent boys to enhance the impact of the program. One adolescent participant said that adolescent boys should also learn about the issues affecting adolescent girls and to help them make better choices:

"Dapat naa jud ang mga lalaki para ma aware sila ba nga kung unsay mga buhat sa babaye, nga maka apply nila sa ilang kaugalingon nga dili sila makahimog dautan ba nga naa sad silay ma learn sa 'A Healthy Me' kay sa akong opinion. [Adolescent boys should also be invited to the program so they will also be aware of what girls are going through [in terms of sexual and reproductive

health]. They can also apply what they learned in the program so they won't be persuaded to do bad things. In my opinion, boys can also learn a lot from 'A Healthy Me'.]"

(School-based adolescent 7, 15 years old)

A program facilitator further elaborated that adolescent boys should learn about the value of women as well as about their own sexual reproductive health to address the issue of teenage pregnancy.

"Kuan maam pwede ang 'A Healthy Me' maam kay naay session para sa men sad? Kay naa may… dili man gud kanang di ba naa man mi gi ingon diri nga ang babae mamabdos for 9 months pero ang lalaki makamabdos labaw pa sa siyam ka babae sa usa ka adlaw. More likely pod ba at least sila pod makabalo sila sa worth pod sa babae. Dili para mabdosan lang ing-ana gani kay ang kana biyang just sexual reproductive dili ra biya na para sa babae lang ang affected ana. Ang lalaki pod biya. Pair man gyud na ang mo commit sa crime. Crime gyud. Mao na maayo pod naay program for boys. [Is it possible if you could also conduct 'A Healthy Me' sessions for adolescent boys? There is a thought that goes, "A woman may be pregnant for 9 months but a man can impregnate more than 9 women in just one day". [If they can participate in the program], they [boys] will also know the worth of women - that women don't exist just to be impregnated by them. Sexual reproductive health is not a topic for women alone, men also have that. Both boys and girls commit to the same "crime" [having sex]. It's better if there is also a program for boys.]"

(Nurse facilitator 1, female, 26 years old)

Another program facilitator briefly commented that including boys would impart a greater sense of responsibility:

"Aware pod...Sense of responsibility. [Boys will be aware and have sense of responsibility.]"

(Nurse facilitator 4, female 32 years old)

With the hope of institutionally expanding 'A Healthy Me' to empower and equip more adolescent girls and possibly even boys, adolescent participants and program facilitators also recommended ***expansion to new schools and other communities***. Health center-based program facilitators and adolescent participants suggested that implementing the program in schools as part of the educational curriculum would achieve better participation and attendance. One of the adolescent participants suggested that it could be included as one of the special subjects taught in schools like Catechism:

"Akoa kay ganahan ko nga maapil siya sa during class days namo. Murag pariha gani sa catechism mura ganig e apil siya kay mas nindot man gud sa school kay mas daghan pa ang maka hibaw ba. Para ma share, then makat-on sila unsa na siya nga butang. [I prefer if we include the program as part of our class [curriculum]. Same as catechism, we can incorporate ['A Healthy Me' program] in our school because it's better if many will learn from it. Other students will also learn about [sexual and reproductive health].]"

(Health center-based adolescent 6, 15 years old)

This suggestion was also supported by a health center-based program facilitator. She cited that their barangay has plans of implementing sexuality education within the school and personally she thought the program could be a subject:

"Naay subject ba og focus ra gyud ana. Mo apil biya ang mga teachers ana maam kato diay sa [school withheld] kay mao gyud toh naay plan ang barangay nga magpahigayon didto og Reproductive Health awareness, teenage pregnancy, unya mga symposium nila HIV/AIDS. Kanang ang barangay maoy mo provide sa logistics sa ilahang snacks. Unya ang ilang participants ang mga estudyante. [There could be a subject that focuses on sexual and reproductive health. The teachers could also be involved in that like in [school withheld]. The barangay had a plan to conduct Reproductive Health Awareness, including symposium on teenage pregnancy and HIV/AIDS. The barangay will arrange the logistics and provide the snacks. The participants of the symposium are the students.]"

(Nurse facilitator 4, female, 32 years old)

In general, health center-based program facilitators suggested implementing 'A Healthy Me' primarily in schools. Similarly, school-based facilitators proposed to implement in other schools, including both public and private high schools, and in elementary schools:

"Only dili lang kaayo siya murag ma kuan sa elementary, niya ang kuan diri usa raman ka highschool pero mas maayo pod nga mo kuan siya sa private schools pod kay naa man poy mga taga community nga mga bata didto, ma tap sila. [It's also better if we implement the program in private schools because there are also adolescents from the community who study there. We can tap them for the implementation.]"

(Teacher facilitator 1, female, 39 years old)

However, school-based program facilitators also recognized the importance of implementing in the community, particularly at the purok level (household clusters), to ensure that higher risk out-of-school youth are still reached:

> *"Nindot pod siya sa community pod man Miss kay naa man pod daghan out of school didto na mga young people pod. So not only in schools but also in the community centers, kay naa man Purok centers noh, mas maayo pod to na ma-touch didto, especially sa island, kay mao gyud toy pinaka-need nila. So I look forward nga ang 'A Healthy Me' will not be school based lang pero it would be supported by kanang kuan, dili lang to kay last nato siya na kuan namo but naa pay lain. [It's also good if we implement it in the community because there are a lot of out of school youth there. You can implement the program, not only in schools, but also in the community centers. There are purok centers and it's good if you also include them, especially in the island because this is what they need the most. I look forward to widening the implementation of 'A Healthy Me', not only as a school-based program. And I also look forward to more [programs like this] in the future.]"*
>
> *(Teacher facilitator 1, female, 39 years old)*

Overall, there was a strong recommendation to sustain the program and expand its coverage while considering improvements in some elements of its implementation. Being a unique program, its benefits and impact were recognized by the adolescent participants and program facilitators. With this, they were hopeful that 'A Healthy Me' would conintue, as expressed by the following facilitator:

> *"Kani siya nindot biya ni siya maam kaning NGO kaning inyoha ipadayon lang maam ba. Kanang mas nindot man gyud siya maam nga mapalapdan pa gyud para makita gyud nato unsa ka epektibo ang usang epekto sa atoang community, ma apply ba. So nindot gyud siya maam nga ipadayon unya kani siya wala mani siya sa atoang programa. Oo, so nagpasalamat biya mi maam nga nisod mo NGO unya wala biya ni sa amoa, wala ni sa among barangay, wala ni sa amoa diri sa amoang LGU. So nindot biya gyud. [This program by your NGO is great and should be sustained. It will be better maam if we are able to expand the program so we can perceive how effective the effects [impact] will be in our community – learning will be applied. So, it will be really good to continue the program as we don't have this kind of program yet. Also, we are grateful to your NGO for coming in with this unique program. We don't have a similar program here in our barangay, neither in our LGU. This is really a good program.]"*
>
> *(Midwife facilitator 6, female, 43 years old)*

7. DISCUSSION

'A Healthy Me' was developed to provide Filipina adolescents with greater access to comprehensive SRH health education to help protect them against the serious SRH issues affecting them. Given the magnitude and potential impact of these issues, together with a lack of rigorous program evaluations from the Philippines, this research was undertaken to demonstrate program effectiveness, understand the characteristics of the program which were important in achieving this effect, and identify further opportunities for program enhancement.

Overall, the research findings reinforce much of the existing research both about the nature of the issues affecting adolescent girls globally and in the Philippines, and the elements of effective programs. The research adds a richer understanding of the importance of the facilitator-adolescent relationship and breaking down barriers that reduce access to comprehensive SRH education and government health services for adolescent girls.

7.1 PROBLEM DESCRIPTION

The research findings are consistent with existing data about the common issues affecting adolescent girls in the Philippines. Given the long standing, widespread, and highly visible nature of teenage pregnancies, it is not surprising that much of the concern focused on this. The problems of commercial sexual exploitation, including online sexual exploitation, were also recognized as being significant as reflected in the relevant literature (NSO & ILO, 2011, p. vxii; Terres de Hommes, 2013, p. 5, UNICEF, 2016, p. 6). However, an emerging concern was the increasing commercial sexual exploitation of adolescent boys also, particularly with the MSM population. Concern was not only expressed for these adolescent boys but also for the adolescent girls who are their usual sexual partners, particularly in view of escalating rates of HIV/AID and other STIs (UNAIDS, 2018, p. 2; Vista, 2018). In the Philippines, HIV rates have been rising most rapidly among the MSM population with recent data showing 68% were due to male-male sex (DOH HIV/AIDS & Art Registry Philippines, 2019). In east and southeast Asian regions, data show that the prostitution of boys is occurring despite being less common than among girls and women, but it is largely undocumented due to the stigma against homosexuality (ECPAT, 2016, p.14). However, it is known that young males involved in transactional same-sex relationships are considered at higher risk of experiencing violence (Tan, 2001; Hernandez & Imperial, 2009; Holmes, 2015). There is thus an increasing call to amend relevant policies and accelerate efforts among government institutions to address this emerging issue (Conde, 2016).

The complex social determinants from which these problems arose were recognized in the findings, similar to that described by Chandra-Mouli et al. (2015) as a "complex web of interrelated factors that operate at different levels". These are also consistent with literature from the Philippines (Melgar et al, 2018: UNICEF, 2016, p.12) where conservative beliefs and myths about SRH, poverty, family breakdown and dysfunction, lack of access to comprehensive SRH services and education have been identified as determinants together with the normal adolescent behaviors of curiosity, risk taking, and peer influence. 'A Healthy Me's' previous quantitative research also demonstrated very low pre-program SRH knowledge scores among both in and out-of-school youth. Furthermore, adolescents who had not already begun children had very access to the government health center prior to 'A Healthy Me' (see Appendix A). These longstanding influences appear to be converging with more recent societal factors such as the increasing sexual activity of young people and access to cheap devices and technology, to drive the issues of commercial sexual exploitation and OSEC. A further influence strongly expressed in one research location known to be a 'hot spot' for commercial sexual exploitation, including OSCE, was the cultural norm of adolescent girls being encouraged to seek relationships with foreign men, which they can now do online. Research confirms that a desire to improve their economic situation is a common reason behind this behavior (Sassler & Joyner, 2011) along with a 'colonial mentality' that people with white ancestry have more favorable physical characteristics (Nadal 2004; Gaston, 2003; Revilla, 1997; Root, 1997b). With the proliferation of internet cafes and easy access of internet, some Filipino girls and women spend enormous time, effort, and money online to seek potential romantic relationships with foreign men in the hope of financially gain (Bulloch & Fabinyi, 2009). Filipino women who achieved a relationship with a foreign man were then described as being 'lucky' by their peers in the community and that a foreign partner was preferred over a Filipino man because of the perceived financial benefits for the household. However, research also demonstrates negative outcomes for many girls and women who pursue foreign men. One study of adolescent girls and young women living in residential aftercare facilities who were rescued as sex trafficking victims, found that the majority entered the club scene with high expectations of marrying a foreigner (Artadi et al., 2010).

7.2 EVALUATION OF PROGRAM EXPERIENCES

The research documented the experiences of program facilitators and adolescent participants during and after 'A Healthy Me'. These findings are useful in evaluating whether the program has been successful in achieving the program's goals. A Healthy Me' has four program goals which are to:

1. Provide comprehensive health education, including SRH education
2. Develop supportive relationships between the adolescent participants and key adults, including parents, teachers, and community health staff
3. Create greater access to youth-friendly government health services
4. Enhance parent-child communication about SRH issues to support their children to make healthier choices and to protect them against abuse and sexual exploitation

7.2.1 PROVIDING COMPREHENSIVE HEALTH EDUCATION

The effect of 'A Healthy Me' in providing comprehensive SRH education is consistent with international research about the benefits of comprehensive SRH and characteristics of effective programs. Both the previous quantitative research and and current qualitative research demonstrate that adolescent participants achieve significant SRH-related knowledge gains as results of program participation. Knowledge gains extended to broader issues such as emotions, social media, and body image. However, knowledge alone is considered to be a relatively weak determinant of health choices (Kirby et al., 2011), and thus effective programs must strengthen protective factors such as relevant attitudes, self-confidence, agency, strong communication skills, and personal aspirations (Chandra-Mouli et al., 2015, Pound et al., 2016). These changes were also observed among 'A Healthy Me' participants, in particular improvements in their self-worth and self-confidence, how they appreciate their bodies and sex, their values about what is 'right and wrong' and, among out-of-school youth, their aspirations. Health-related skills which were observed to have been strengthened included moderating alcohol and social media use, risk avoidance, refusal skills, emotional regulation, and the ability to manage contraceptive use.

The educational tools used in 'A Healthy Me' were experienced as novel and innovative by both the facilitators and adolescents, which is not surprising given that their previous experiences appeared typically limited to more traditional, facilitator-directed approaches. The program facilitators believed that the participatory, activity-based learning to be more relevant and effective than the traditional approaches they had experienced, which is supported by a large body of research (UNESCOa 2018, p. 12; Lopez et al. in UNESCOb, 2018, p. 19; UNESCOb, 2018, p. 95).

The group activities and discussions were also seen as critical in creating a fun, engaging, two-way learning experience. This environment also created a context where participants felt safe sharing their experiences and feelings which experts consider to be an important part of effective programs (Pound et al., 2017; Pound et al., 2016, p. 4). Although not mentioned during the research, the presence of girls only in the sessions may have contributed toward their feelings of safety and confidence participating during the sessions (Pound et al., 2016).

7.2.2 CREATING SUPPORTIVE RELATIONSHIPS WITH KEY ADULTS

It was well established in the findings that meaningful connections were created by those participating in the program, both between the adolescent participants and the facilitators and adolescents. The interactive, discussion-based educational methodology enabled the facilitators and adolescents to share their ideas and experiences which led to a greater understanding, acceptance, and openness towards each other. The development of these safe, supportive adult relationships appeared to be a key factor in whether the adolescents chose to disclose their experiences of abuse and exploitation. It was noted that the adolescents did not disclose these experiences to the research assistants, with whom they were unfamiliar, during the FGDs. Whilst the facilitators described being

better able to communicate and relate with adolescent after the program, including with their own children, they appeared to be inadequately prepared to respond to disclosures, as none mentioned they had taken any action upon hearing of the abuse during the sessions.

The need for facilitators to be competent and motivated (Kontula, 2010) and to create an environment where adolescents feel safe and comfortable participating (Pound et al., 2017; Pound et al., 2016, p. 4) in comprehensive SRH programs has been recognized. However, the importance of creating strong, meaningful connections between facilitators and adolescents from vulnerable households where the parents or guardians may be neglectful or disengaged, as described in the findings, has not been strongly emphasized as having an influence on the effect of the program. The depth of these relationships appears to go well beyond what is described under the term "youth friendly" by the World Health Organization (2012, p7) where services should be are accessible, acceptable, equitable, appropriate, and effective for young people. It instead recognized that children and young people need at least one supportive, nurturing adult relationship to be successful (Cohen, 2017; Singer et al., 2013; Scales & Leffert, 1999) and our findings suggest that these relationships could be formed through 'A Healthy Me'.

The research adds important insights about the benefits of the program to facilitators, not only in the understanding of adolescents and adolescent issues but also in their ability to build relationships and facilitate education. Whilst this finding had been observed during site visitations and through informal feedback, the degree to which facilitators experience a personal benefit from the program to both their work and personal lives (including their own children) was surprising. Teacher facilitators who described themselves as already in the role 'substitute parent' for many students felt better able to relate with them after the program. Similarly, whilst nurse and midwife facilitators were presumed to have participated in the Philippine Department of Health's widely implemented adolescent health training programs (DOH, 2018), this was not sufficient to impart the necessary skills to overcome their prejudices and develop meaningful relationship with adolescents. However, they expressed being able to do so more following 'A Healthy Me'.

This finding supports the need to move beyond the one-off or limited training models for adults working with adolescents and potentially engaging with them about their SRH, to including more experiential and two-way learning methodologies. This will inevitably involve more time, effort, and challenges with schedules, but will produce a greater impact on the capacity of the facilitators and hence the lives of both the adolescents they work with.

7.2.3 IMPROVING ACCESS TO YOUTH-FRIENDLY HEALTH SERVICES

The barriers experienced by Filipino adolescents in accessing comprehensive SRH education and health services were described in findings as including community and parental values and stigma, the attitudes of health service providers toward adolescents and about SRH providing education and services to this population, and the perceptions of adolescents about the health staff and services. Overcoming these barriers thus requires more than just ensuring services are affordable, friendly and welcoming, and that adolescents are knowledgeable of the services and how to use them. as suggested in relevant guidelines and research (ICRW, 2014, p. 8a, Chandra-Mouli et al., 2015). Far more must be done to address sociocultural norms, stereotypes, misinformation, and fear.

Both the quantitative and qualitative research investigating 'A Healthy Me' confirms that the program helps reduce the barriers experienced by adolescents and program facilitators. The quantitative data demonstrated small but significant improvements in how the adolescents and health facilitators perceived each other together with greater awareness among the adolescents of their rights to SRH education and services and confidence in accessing these. During the FGDs, health facilitators expressed more willingness to provide SRH education and services to sexually active adolescents which was also reflected in the quantitative survey with significant changes in the responses to questions, "I am okay with providing contraceptives to young people" ($z = 2.104$, $p = 0.035$) and "Adolescents should be given contraceptive counselling before they even become sexually active" ($z = 2.119$, $p = 0.034$).

The research confirms that this result was not merely achieved by providing comprehensive health education, but by providing a context where the facilitators' and adolescents' negative perceptions and stereotypes about not only SRH education and services but also about each other could be challenged and changed. The connections that were thus formed and, in many cases, sustained after the end of the program were a key in helping the adolescent continue to access health advice and care.

7.2.4 ENHANCING PARENT-CHILD COMMUNICATION ABOUT SRH

Parent-child communication (PCC) has a significant long-term impact on the health and wellbeing of their children (Kirby et al., 2011). Research confirms PCC influences outcomes among children and adolescents such as tobacco use, depression, eating disorders, academic achievement, and SRH outcomes such as unintended pregnancy and STIs. (Lezin et al. 2004). Research suggests that the impact of PCC about SRH depends greatly on factors such as the characteristics of parents (e.g. parenting style, time availability, norms), the quality of the relationship with their children (e.g. closeness and connectedness), and their communication style (e.g. open and two-way) (Kirby et al., 2011). Many of these characteristics of effective PCC were confirmed by a study of Arguilla and Habitan (2014) in the Philippines which investigated factors influencing parents' attitudes towards discussing sex-related topics with their children. Poor knowledge about SRH, feelings of discomfort

and anxiety about SRH topics, the family's conservatism, and a lack of closeness in the parent-child relationship were drivers of poor PCC.

Although the experiences and responses of the parents participating in 'A Healthy Me's' parent session was not directly explored in this research, their experiences were described by the program facilitators and these observations were supported through observational data collected by the research assistants and the results of a small pilot conducted during the development of the parents' session (see Appendix E). These findings suggest that parents gain awareness, knowledge, confidence, and skills which may help improve the quality and content of their communication with their children about SRH. Research involving multiple programs aimed at improving PCC about SRH have demonstrated a positive effect on at least one short-term outcome, and many found a long-term impact on the reduction of the sexual risk behaviors of adolescents (Gavin et al, 2015). Many of these programs were only limited one-off interventions of relatively short duration, similar to 'A Healthy Me's program.

However, despite the possible benefit of the session, the facilitators described difficulties in encouraging parents to attend. Overall attendance of parents at the parent session across the three program models was 82% of those enrolled. However only 36% were parents of the adolescent 'A Healthy Me' participants. The challenges described in achieving higher attendance levels were not explored during the FDGs, but program feedback and observation data suggested that parents are unable to attend due to their availability (e.g. work and household commitments), lack of interest, and the absence of parents in the family home. These observations were similar to those identified in a pilot study in India (Jejeebhoy et al., 2014) where barriers experienced in promoting parent-child interaction and communication included the lack of availability of the parents due to work or household responsibilities and the parents' skepticism about the benefits of the program. The latter is thought to be a barrier among many parents in Asia who perceive SRH education as promoting promiscuous behavior among adolescents and do not understand the risk of not providing information and support (RHIYA, 2006).

8. RECOMMENDATIONS

The following recommendations are aimed at addressing the gaps in the implementation of "A Healthy Me' to strengthen the program's impact and ensure sustainability. Although the research confirmed that the main goals of the program were met, there were clear opportunities identified for improving implementation, coverage, and sustainability. Many of the recommendations from adolescent and facilitator research participants were consistent with relevant best-practice guidelines and research and are explored below.

8.1 BROADEN THE PROFILE OF PARTICIPANTS INVITED

8.1.1 PARTICIPANTS AGED 11 - 13 YEARS

With teenage pregnancies and online sexual exploitatoin increasing among younger adolescent girls, it is important to equip them at an earlier age with the knowledge and skills to protect themselves. This recommendation is consistent with global research that "young people report that SRE was delivered too late and that starting it earlier might make it easier to discuss sex" (Pound et al., 2016). However, as the current program was designed for older adolescents this would require adaptation of the curriculum to the developmental stage of the age group as per expert guidelines (UNESCOb, 2018, p. 16) and hence the content would be modified accordingly.

8.1.2 CREATE A PROGRAM FOR ADOLESCENT BOYS

There is a need for more research about the issues affecting adolescent boys in the Philippines and effective interventions to address these. However, this research identified issues regarding the effect of adolescent boys' behavior on both the health and wellbeing of adolescent girls. Furthermore, the research found that adolescent boys also face significant threats to their SRH. There are no programs that were identified for adolescent boys in the Philippines. However, an international study by Svanemyr and colleagues (2015), identified a growing number of SRH programs that engage men and boys to address gender norms, inequality, and other harmful behaviors through different approaches such as participatory group education, mass media campaigns, and community mobilization activities. These types of approaches have been found to promote positive SRH outcomes including those related to HIV, maternal and child health, gender-based violence, and gender equitable norms and behaviors (Barker et al., 2007). However, despite promising outcomes and improvements, the growing body of evidence about the effects of these programs, significant

knowledge gaps remain. These include whether the positive effects are sustained over time, whether they are adaptable and effective across different settings and contexts, and the potential unintended consequences for the empowerment of girls and women (Svanemyr, 2015). However, existing research confirms that girls feel safer in and generally prefer single-sex education (Pound, 2016) and thus any session developed for adolescent boys would be as a separate session or program. Given the lack of research about SRH issues and interventions in this population, program development would need to start with a detailed needs assessment to understand the unique SRH challenges of Filipino adolescents and educational approaches likely to be the most acceptable and effective to form the basis on initial program pilots.

8.1.3 ACHIEVE GREATER PARENT PARTICIPATION IN THE PARENTING SESSION

Parents play a critical role in promoting the SRH and overall wellbeing of their children and, as discussed in the previous section, relatively short interventions aimed at improving their parenting and PCC skills can be effective. There was a strong emphasis on ensuring participants' parent attendance during the conduct of parent sessions given the perceived benefits of the program. Providing incentives, such as giveaways, was suggested as a possible means to encourage greater attendance. Other possible solutions including conducting the session in smaller household (purok) clusters or, with the school model, combining the session with meetings the parents are required to attend such as parent-teacher conferences. Greater attendance would also like be achieved if the barangay chairman or other senior officials advertized the session and encouraged participation from parents.

8.2 SCALE UP 'A HEALTHY ME'

It was strongly recommended to expand the reach and duration of 'A Healthy Me'. Scaling the program to more schools, health centers, and community venues, as well as maintaining programs with existing partners, will be important in achieving this recommendation. However, given the importance of maintaining program quality and fidelity (Chandra-Mouli et al., 2015; UNESCOb, 2018, p. 98) this would need to be done carefully, ensuring adequate training, supervision and monitoring, and evaluation. Given some of the challenges of implementing fully within a health-center, it appears most feasible to scale predominately within government high schools whilst still maintaining some sessions within the center as per the school-based model. The health-center only model could be predominately used to reach out-of-school youth who remain particularly vulnerable to poor health outcomes. Given the unique context of many communities, local government units (LGUs) could be supported to adapt 'A Healthy Me' to be implemented according to local needs. This approach was tested and shown to be effective in the purok-based model. This model could be used predominately during summer vacation to extend reach and program saturation within particular 'hot-spot' communities.

Increasing the duration of the program is consistent with high quality research confirming the 'dosage' is important in maximizing the impact of the program, including both intensity and duration (Chandra-Mouli et al., 2015). Renewsiya Foundation Inc. currently manages a growing online community to help sustain program messaging but further in-person strategies are needed. This might include progressive curriculums over several school years, after school peer-led support groups, or peer-led support groups managed within the barangay facilities with the help of the SK youth representatives. To be sustainable, this would need to be led by the partner organization but with ongoing support from Renewsiya Foundation Inc. However, it was evident that past graduates and teacher-facilitators were motivated to be involved.

8.3 IMPROVE TRAINING FOR FACILITATORS

It well established by existing research that facilitator attitudes and skills affect program outcomes (Kontula, 2010; Denno et al., 2015). This research also found that establishment of strong relationships was critical in achieving the program goals. Thus, ensuring that the facilitators are highly engaged and equipped is even more important. As facilitators are typically selected by the partnering organizations, more guidance could be provided to them about whom to select. During the FGDs, some program facilitators expressed the need for 'trained' facilitators but were not able to identify the qualities for selecting facilitators. Pound et al. (2016) outlined 11 qualities of a good educator from the perspective of the youth that they: (a) are knowledgeable; (b) have experience in sexual health; (c) are professional; (d) are specifically trained in SRH education; (e) are confident, unembarrassed, straightforward, approachable and unshockable, experienced at talking about sex, use everyday language; (f) are trustworthy, able to keep information confidential; (g) have experiential knowledge and feel comfortable with their own sexuality; (h) are good at working with young people; (i) have the ability to relate and accept young people and their autonomy, treat them as equals; and (k) have similar values to youth, provide balanced views and are non-judgmental.

However, for the health-center model, it is often necessary for most nurses and midwives to be involved and, even within the high schools, few of the teachers are available to take on additional responsibilities. Thus, it is unlikely that facilicators can be selected according to very specific criteria.

The effectiveness of the pre-program training in empowering and equipping facilitators is therefore very critical. Currently faciliators participate in a half-day, training activity prior to the program and receive site visitations and follow up calls with structured feedback during implementation. Although the training is limited and some facilicators expressed an initial lack of confidence in implementing 'A Healthy Me', most were able to achieve adequate implementation and fidelity to the educational methodology, acquiring the interpersonal and communication skills needed to make meaningful connections with the adolescent participants. This reflects a 'learning by doing' or experiential learning approach and, interestingly, the most powerful 'teachers' for the facilitators appears to be

the adolescents themselves. Extending the pre-program training would likely improve initial confidence. More training is also needed to equip facilitators with basic debriefing skills to manage adolescent participants who disclose abuse and to ensure referral to appropriate legal and support services. Facilitators may also need access to additional support to prevent secondary trauma. However, there is often limited time available for training prior to the program to conduct training and, if significantly extended, this would become a barrier to partners agreeing to implement the program. A solution is to make further, optional online training modules available where facilicators can select short electives which addressses their self-identified training needs.

It was evident in the findings that the facilitators, particularly those who were health center-based, had different attitudes to the program with some viewing it as an important opportunity and others as a burden. Although the program was designed to require minimal preparation by facilitators prior to each session, the challenges of juggling the program together with other responsibilities were recognized. More attention is needed during training and program preparation in helping facilitators schedule the sessions to accommodate their usual activities and to help resolve conflict between co-facilitators. Despite these challenges, program data demonstrated high attendance and graduation with an average turnout of 70% (see Appendix A, p. 167). However, it is not possible to avoid 'A Healthy Me' being seen as an additional workload on facilitators and thus strategies to improve the motivation of reluctant facilitators are important. This might include sharing personal testimonials from other facilitators, sharing evidence of the program's impact, and ensuring strong leadership and engagement from the senior health officials in each location.

8.4 ADDRESS ONGOING KNOWLEDGE GAPS

This research identifies many areas where further research is needed. This includes the following:

i. Sexual and reproductive health-related attitudes and behaviors of adolescent boys in the Philippines
ii. Effective SRH programs for adolescent boys both internationally and in the Philippines
iii. Effective capacity building programs for adults working with youth in the Philippines
iv. The effects of adolescent SRH programs on the personal lives of facilitators
v. Effective parent-child communication training the in the Philippines, including the impact of 'A Healthy Me's' parenting session
vi. The long-term effect, ideally including biological outcomes such as on unintended pregnancy, of 'A Healthy Me'

9. LIMITATIONS

The limitations of this research are recognized. These are outlined below.

i. Many of the attitude and behavioral changes outlined in the findings are self-reported and, as described by multiple authors (Althubaiti, 2016; Rosenman et al., 2011), these may not be accurate. However adolescent attitude and behavioral changes are triangulated both by the facilitator's observations of the adolescents and through the results of the quantitative program research, strengthening the probability that the changes are authentic.

ii. As is true of much of the research regarding adolescent SRH education, attitude and behavioral change is reported rather than 'hard' or biological outcomes such as the number of unintended pregnancies, new STI infections, or the number of individuals exiting abusive situations because of the expensive and complexity involved in conducting this research (Haberland and Rogow, 2015). Thus, the ability of the research to draw firm conclusions about the effect of the program is limited.

iii. The potential bias of the research assistants who also act as program officers is recognized. However, multiple methods of validation, with the inclusion of independent research supervisors, were included to minimize this influence. Although practitioner-led reseatch has been criticized as lacking academic strength or rigor (Punch, 2014), others highlight that academic-practitioner collaboration can foster a greater understanding of certain phenomena better than either academics or practitioners could have accomplished alone (e.g. Avenier et al., 2012, Amabile et al., 2001; Amabile et al., 2006; Bartunek et al., 2000). According to Klinken et al. (2007), this may in part be due to their different perspectives, with academics interested in 'truth' and practitioner more concerned about 'what works'. Thus, blending both research evidence and practice may generate more rigorous but usable knowledge (Lightowler et al., 2018).

iv. The research was not able to directly investigate the perspectives and experiences of parents participating in the program, nor the health-center facilitators involved in the limited sessions for the school-based model or the community volunteers for the purok-based model. Exploring these three populations could provide a wider and richer understanding for each program model.

v. During the FGDs and KIIs, the researchers observed factors that may have influenced what was shared by the research participants. Many of these are well recognized in research about qualitative methodologies (Althubaiti, 2016; Smithson, 2000). First, although questions were tested prior to the FGDs, participants interpreted some of the interview questions differently. This resulted in responses that diverged from the intended subject. Second, there was a tendency

for research participants in the FGD to influence one another in their responses potentially limiting the scope of the discussion. Although this was managed by repeating and rephrasing the questions to draw out other responses, there were still some instances when one or two research participants dominated the discussion. Third, adolescent participants, especially those who were younger, were hesitant about or unable to elaborate on their experiences. With this, researchers respected the participants' limitations and privacy and did not attempt to pressure them to share.

vi. The lack of previous localized program evaluation studies for similar adolescent SRH programs also weakens the foundation for understanding effective programs in the Philippine context.

10. CONCLUSION

This qualitative study involving facilitators and adolescents participating in 'A Healthy Me', a comprehensive adolescent SRH program in the Philippines, adds to both local and international research regarding effective approaches. This is important not only because of the lack of relevant research from the Philippines but, as described by (Catalano et al., 2012), it is ideal to have "enough effective interventions available worldwide so that adopters can select those that closely match their own population, needs, and resources, then faithfully replicate them".

Catalano et al. (2012) also emphasized the need to identify the core elements of effective interventions. The findings regarding 'A Healthy Me' support the significant body of research which demonstrates that effective SRH programs are comprehensive, participatory and activity-based, learner-center education and are implemented in safe, supportive environments by competent facilitators. However, the research also adds insights about the importance of experiential, two-way learning involving both program facilitators and adolescent participants to break down unhelpful stereotypes and relationional barriers between these groups. Removing these barriers enables mutual trust, openness, greater learning, and both improved access to health care services and safe, nurturing adults for the adolescents, the latter being particularly important given adolescents were often described as lacking these relationships with the caregivers in their home environments.

Whilst implementation challenges were experienced, particularly with the increased workload and scheduling around regular activities, much of this is unavoidable as effective programs must be comprehensive and of higher dose and duration for adolescents to gain the holistic knowledge, attitudes, and skills for a sustained impact. This is particularly true given, first, the complexity of the issues faced by adolescents described in the research and, second, the time needed to create a context where facilitators and adolescents can form meaningful relationships. Given that most of the adolescent SRH programs experienced by program partners prior to 'A Healthy Me' have been of limited scope and duration, embracing an alternative approach will take a change in mindset. However, this research shows that experiencing a different approach like 'A Healthy Me' can help program partners and facilitators make this transition.

The research also adds to the understanding of the significant threats to the health and wellbeing of both adolescent girls and boys in the Philippines. This points not only to the need to reach more girls with comprehensive SRH education and develop program for boys, but to capacitate the various adults in their lives to provide the guidence, support, and care that they need but often lack. The complex determinants of the issues affecting Filipina adolescents that were described reinforce the importance of multi-faceted and multi-sectoral approaches across the Philippines which penetrate deep into communities and households. These interventions also need to address dynamics such

poverty, labor migration and local employment options for guardians, use of social media, and cultural norms and attitudes about SRH and commercial sexual exploitation.

Adolescence is a time of rapid socio-emotional development and brain neuroplasticity, and thus represents a critical window where effective, evidence-based interventions can significantly alter long-term health and life outcomes. This will require significant effort, allocation of resources, and reorganization of existing responsibilities and responses in the Philippines. When compared against the significant vulnerabilities experienced by adolescent girls and the current adverse outcomes they suffer in increasing numbers, that these efforts would not be made is unthinkable.

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APPENDIX A.
OVERVIEW OF 'A HEALTHY ME' QUANTITATIVE RESEARCH

1. PARTICIPANTS AND DATA COLLECTION

There were two respondent groups in the research. The first were the adolescent girls who joined the 'A Healthy Me' sessions. They completed the surveys before the first and immediately after the last session. The second respondent group were the health midwives and nurses who facilitated the sessions. They completed the pre-survey at the training session and the post-survey immediately following program completion. Where possible, questions were sourced from existing and validated tools (e.g. Philippine National Demographic and Health Survey). However, in the absence of existing, validated tools for our context to test attitude, a new tool was developed and pre-tested, and aggregated into themes (e.g. attitude toward health service utilization, attitudes toward adolescents). The survey tools are included in at the end of Appendix A.

2. RESEARCH APPROVAL AND PARTNERS

Ethics review and approval from the University of the Visayas was obtained for both the survey. Voluntary participation in the research was assured with consent or assert obtained from all program partners and participants, and privacy and confidentiality protected through the research process. The research was undertaken in partnership with an independent, local academic (Mr. Rex Villavelez), who conducted the data analysis.

3. METHODOLOGY FOR QUANTITATIVE ANALYSIS

Descriptive and inferential statistics were used to analyze the data. Basic frequencies, means, and averages were used to describe the respondents' demographic data. Data was also disaggregated according to method of implementation, demographics, service provision, and etc. using independent samples t-test for statistical significance. Additionally, pre and post surveys were also matched to check if the change in knowledge and attitudes were statistically significant using paired samples t-test. Finally, one-way ANOVA was used for knowledge gains and changes in attitudes disaggregated by the method of implementation (health center based, school based, or purok based).

4. FINDINGS FOR ADOLESCENT PARTICIPANTS

DEMOGRAPHIC INFORMATION

Data was collected from 326 adolescents. The average age of the female participants was 18 years (range 11 – 24). 68% of participants were current students with the rest being out-of-school youth. Most participants were single (78%), with 18% living with a partner, and 25% having begun childbearing.

ACCESS TO HEALTH SERVICES AND SRH EDUCATION

Only 12% of participants had never previously visited the health center, although those who had begun childbearing had visited significant more times compared with those who were nulliparous with an average of 15 visits compared with three visits since the age of 13 years ($p = 0.000$).

Most participants had not received previous family planning education from the health center (82%), with parents and schools the most commonly stated sources of SRH information. In comparison, for information about sexual practices, peers and the internet were the most common sources.

PROGRAM ATTENDANCE AND GRADUATION

A minimum of 6 out of 9 sessions attendance is required to qualify as a graduate of the program. With this, an average of 70% graduation turnout was reported among adolescent participants across all program models. Parent session is an open invitation to parents in the community. Out of the 588 parents attending, only 36% were parents of adolescent girls.

TABLE 1. TURNOUT OF ATTENDANCE AND GRADUATION (ADOLESCENT GIRLS AND PARENTS)

Program model	Adolescent			Parent		
	Total no. attended	Total no. graduated	%	Total no. attended	Parents of adolescent participant	%
Health center-based	725	509	70%	533	179	34%
School-based	70	53	76%	39	21	54%
Purok-based	73	54	74%	16	11	69%
Overall	**877**	**616**	**70%**	**588**	**211**	**36%**

PROGRAM RATING

The adolescent participants rated the program very highly (see Table 2), both in terms of how much they learnt and whether this learning would influence subsequent health choices. Informal feedback confirmed the high value that the participants placed on being able to participate in the program.

TABLE 2. PARTICIPANT'S FEEDBACK ABOUT 'A HEALTHY ME'

Feedback question	Score (1 – 5)	Rating
How much did you learn from 'A Healthy Me'?	4.64	Very high rating
In your opinion, will the learning from 'A Healthy Me' affect your future health choices?	4.53	Very high rating
How would you rate the 'A Healthy Me' program overall?	4.77	Very high rating
Would you recommend 'A Healthy Me' to your friends or relatives?	4.57	Very high rating

KNOWLEDGE CHANGE

The pre-survey demonstrated low knowledge of SRH issues, including about HIV/AIDS and methods to protect against pregnancy and sexually transmitted infections. The post program survey demonstrated a 56% knowledge increase across all questions. (see Tables 3 and 4) with each significant improvement demonstrated for each question (see Appendix A). Out-of-school youth had slightly higher knowledge gains compared with in-school youth ($p = 0.000$).

TABLE 3. PRE AND POST SURVEY PARTICIPANT KNOWLEDGE AND ATTITUDE SCORES

		Mean	N	Std. Deviation	Std. Error Mean
Knowledge score	K Pre	5.18	326	2.698	0.149
	K Post	8.08	326	3.515	0.195
Attitude scale 1 (-/20)	A1 Pre	16.29	326	5.393	0.299
	A1 Post	17.38	326	3.651	0.202
Attitude scale 2 (-/20)	A2 Pre	14.45	326	5.997	0.332
	A2 Post	16.40	326	4.748	0.263

TABLE 4: PAIRED SAMPLE TEST FOR ADOLESCENT PRE AND POST KNOWLEDGE AND ATTITUDE SCORES

Domain	Paired Differences					t	df	Sig.
	Mean	Std. Dev	Std. Error Mean	95% CI				
				Lower	Upper			
Knowledge	-2.896	3.660	0.203	-3.295	-2.497	-14.284	325	0.000
Attitude Scale 1	-1.089	6.327	0.350	-1.778	-0.400	-3.108	325	0.002
Attitude Scale 2	-1.945	7.247	0.401	-2.734	-1.155	-4.846	325	0.000

ATTITUDE CHANGE

The survey also tested attitude change across two domains; attitudes toward health workers (Scale 1) and attitudes regarding SRH services and education (Scale 2).

As seen in Table 3, the survey demonstrated a small but statistically significant improvement for both scales of 1.01 and 1.95 out of 20 respectively, reflecting the participants felt more open and trusting of health staff after the program and more aware of the need and right to access comprehensive SRH education. Each individual question showed a positive change, with most being significant (see Table 5).

TABLE 5. ATTITUDE CHANGES PER QUESTION

Question	Z score	P value
Attitude Scale 1. Attitudes to health workers		
I am comfortable when interacting with the health workers in the community.	-1.501	0.133
I feel that health workers don't respect my privacy when I visit the health center due to sexual and reproductive concerns (reverse coded)	-3.143	0.002
Most health workers are youth-friendly.	-2.386	0.017
I believe that health staff will always treat me with respect.	-1.554	0.120

Attitude Scale 2. Attitudes about SRH services and education		
Adolescents have the right to learn about SRH services.	-1.575	0.115
Young people should know about their bodies through SRH education.	-1.125	0.261
Young people have the right to use contraceptives so that they can protect themselves against early pregnancy and diseases	-3.369	0.001
Most young people are comfortable acquiring SRH services and contraceptives from barangay health centers.	-3.150	0.002

Pre-program scores are relatively high, including for participants who had previously limited contact with health staff (e.g. no previous pregnancy), which may reflect social desirability bias. Thus, it is likely that the magnitude of the attitude change is under-estimated.

5. FINDINGS FOR PROGRAM FACILITATORS

DEMOGRAPHIC DATA

Nurse and midwives only (no. 31) and were evaluated due to the survey's focus on health service provision. The facilitators were government nurses or midwives of whom 91% were female and had been working in community health for an average of 12 years. Most identified their religion as being Roman Catholic.

PROGRAM RATING

Facilitators rated the program very highly and strongly recommended further programs both within and outside of their own municipality (Table 6). This finding was affirmed during informal discussions, where facilitators and municipal officers were also able to share specific challenges regarding implementation to enable Renewsiya to improve the implementation strategy in future programs.

TABLE 6. FACILITATOR FEEDBACK ABOUT 'A HEALTHY ME'

Question	Score (1-5)	Rating
How would you rate the 'A Healthy Me' program overall?	4.48	Very high rating
Would you recommend 'A Healthy Me' to another municipality?	4.65	Very high rating
Would you recommend implementing 'A Healthy Me' within your municipality again?	4.54	Very high rating

ACCESS TO HEALTH SERVICES AND HEALTH EDUCATION

On average, facilitators provided services to 10 adolescent girls in the health center per month. 74% of these girls were in a live-in or marriage partnership and 64% had begun child bearing. Although the facilitators commonly provided family planning education or contraceptive to adolescent girls, the vast majority of these girls (94-100%) had already begun child bearing. This confirms the need for programs which improve access for adolescent girls to affordable health services to prevent early pregnancy.

KNOWLEDGE CHANGE

Most of the knowledge questions were the same questions given to the adolescents and pre-survey scores were uniformly high. Hence there was no significant pre and post knowledge change which was expected.

ATTITUDE CHANGE

As seen in Table 7, the survey demonstrated a small positive attitude change by the facilitators in the first group of questions which assessed general beliefs and perceptions of adolescents (t_{30} = -2.82, p = 0.008). There is a trend toward a positive change in the second group of questions which assessed the facilitators' attitude toward providing SRH services to adolescents (t_{30} = -1.68, p = 1.03). Although the aggregated scale wasn't significant, specific questions were, such as "I am okay with providing contraceptives to young people".

TABLE 7. PRE-POST KNOWLEDGE AND ATTITUDE CHANGE AMONG FACILITATORS

Domain	Paired Differences					t	df	Sig.
	Mean	Std. Dev	Std. Error Mean	95% CI				
				Lower	Upper			
Knowledge Score	0.097	1.106	0.199	-0.309	0.503	0.487	30	0.630
Attitude 1 Score	3.032	5.980	1.074	-5.226	-0.839	2.823	30	0.008
Attitude 2 Score	4.645	15.394	2.765	-10.292	1.001	1.680	30	0.103

The questions demonstrating significant change were:

- I believe that adults (myself or parents) have a significant role in influencing adolescents to make healthy choices in their lives. (z = 2.26. p = 0.024)

- Adolescents should be given contraceptive counselling before they even become sexually active. ($z = 2.119$, $p = 0.034$)
- I feel that teenagers need to know the risks and consequences of unprotected sex and STIs ($z = 3.156$, $p = 0.002$)
- Providing contraceptives and condoms to teenagers and young people does not necessarily reflect my personal values about sex ($z = 2.389$, $p = 0.017$)
- I can positively impact the lives of adolescents by providing SRH services to them even when they are still young. ($z = 2.724$, $p = 0.006$)
- I am okay with providing contraceptives to young people. ($z = 2.104$, $p = 0.035$)
- I feel that it is vital to provide SRH services to teenagers and young adults who are sexually active. ($z = 2.668$, $p = 0.008$)

Although the attitudes changes were small, the ability of a quantitative survey to detect changes is relatively weak, especially with the small sample size. Thus, this finding may underestimate the true influence of the program on the facilitators. To better understand the experience of the facilitators during and after 'A Healthy Me', focus groups were planned.

APPENDIX B.
CONSENT FORMS

I. ASSENT FORM FOR PARTICIPANTS (aged 14-17 yrs.)

ENGLISH VERSION

Dear Participant,

First of all, we would like to thank you for your participation in the A Healthy Me program. We at Renewsiya Foundation are conducting a qualitative research to gather information about your experiences and perceptions after participating in 'A Healthy Me'. This information will help us improve the program so that it can be better utilized by future participants.

For this research, we will invite you to participate in a Focus Group Discussion, wherein you will be asked to share your experiences, ideas and perceptions with other research participants. This is like what you did during your 'A Healthy Me' sessions. We are inviting you to be part of this research because you are an adolescent girl within the age range of 14-24 and have graduated from the A Healthy Me program.

We don't think that any big problems will happen to you as part of this study, but you may feel a little bit of discomfort when answering questions in the presence of other people. The focus group discussion or group sharing may last for one (1) hour and 30 minutes. A research assistant will do the group interview and it will be audio and video recorded. We will be providing lunch and a token of appreciation for your participation in the study/FGD.

Rest assured that we will keep all your answers private and will not show them to anyone. Only people from Renewsiya Foundation on the study will see them. We will be writing a research article out of the responses that you will give us. We may be using some quotes or lines from your answers. However, your names and all your private information will not be revealed in this document. The results form this research may be shared to other organizations interested in the evaluation of the program.

This research is funded by Renewsiya Foundation under a grant from The Counsuelo Foundation, Philippines. The University of the Visayas - IRB Ethics Review Panel has reviews and approved this study. If you have a question about this research and of your rights as a research participant, you can contact UV-IRB through *(inserted phone number)* or *(inserted email).*

You should know that:

- You do not have to participate in the study if you do not want to. You won't get into any trouble with anyone if you say no.
- You may stop being in the study at any time.
- Your parent(s)/guardian(s) were asked if it is OK for you to be in this study. Even if they say it's OK, it is still your choice if you want to participate or not.
- You can ask any questions you have, now or later. If you think of a question later, you or your parents can contact us at (*inserted phone number*)

<u>Sign this form only if you:</u>

- have understood what you will be doing for this study,
- have had all your questions answered,
- have talked to your parent(s)/legal guardian about this project, and
- agree to take part in this research

Thank you very much!

Assent Reply Form for Participants 14-17 y.o. A Healthy Me Qualitative Research 2019		
Please write your name, signature and date when this form was signed. Please return this form to Renewsiya after you and your parent has signed. *This form certifies that I understood what this research is about, and I know what I am going to do in it. I am expressing my voluntary participation in this research/my consent for my child to participant in this research, through dis document:*		
Adolescent's Name:	Signature:	Date:
Name of Parent(s) or Legal Guardian(s):	Signature:	Date:
Name of Researcher:	Signature:	Date:
(Renewsiya's copy)		

BISAYA VERSION

Dear Participant,

Una sa tanan, magpasalamat kami sa imong pag-apil sa A Healthy Me program. Kami sa Renewsiya Foundation nag himo ug usa ka qualitative research aron mag kuha ug impormansyon bahin sa imong mga experiences ug panghuna-huna human sa imong pag-apil sa A Healthy Me. Ang kani nga mga impormasyon makatabang aron ma improve ang programa ug magamit pa kini sa mayo nga paagi para sa mga future participants.

Para sa kani nga research, imbitahon ka namo nga mu-apil sa usa ka ***Focus Group Discussion***, diin pangutan-on ka nga mu-share bahin sa imong mga experiences ug panghuna-huna kauban ang lain pa nga mga participants. Parehos ra kini sa imong gibuhat sa A Healthy Me nga sessions. Gi-imbita ka namo aron ma-apil ani nga research kay usa ka ka batan-on nga babaye sa pangidaron nga 14-24 ug kay ni-graduate ka sa A Healthy Me program.

Sa among tan-aw, walay dakong problema nga mahitabo tungod sa imong pag-apil ani nga research, pero pwede nga maka-feel ka ug kiwaw o kauwaw kung mu-tubag kag pangutana sa atubangan sa uban taw. Ang kani nga group sharing mahimo nga mu-abot ug usa ug tunga ka oras (1 hr. & 30 mins.). Naay research assistant nga mubuhat sa group interview ug ang tibuok interview kay e-record sa audio ug video. Maghatag kami ug pani-udto ug give-away alang sa imong pag-apil sa research/FGD. Among e-schedule ang FGD sa oras nga pwede para nimo. Kontakon ka namo o ang imong ginikanan sa dihang mu-sugot ka nga mu-apil ani nga research. Ang FGD pwedeng mahitabo inig _____.

Ayaw kabalaka kay ang imong mga tubag private ug dili ipakita ni bisan kinsa. Ang mga taga Renewsiya nga nagtrabaho ani nga Research lang ang makakita ani. Magsuwat mi ug research article gikan sa tubag nga imong i-share namo. Mahimo mi nga mugamit ug mga quote o linya gikan sa inyong mga tubag. Pero, ang imong pangalan ug uban pa nga private information dili ipakita sa bisag unsa nga document. Ang resulta ani nga research mahimo nga i-share sa ubang organization nga interesado sa evaluation ug ka-epektibo sa programa.

Ang kani nga research funded sa Renewsiya Foundation pina-agi usab sa tabang sa Consuelo Foundation, Philippines. Gi-review ug gi-approbahan kani nga research sa University of the Visayas – IRB Ethics Review Panel. Kung naa kay mga pangutana bahin ani nga research ug sa imong mga katungod isip usa ka research participant, mahimo ka mo-kontak sa UV-IRB gamit ani nga numero *(insert phone number)* o sa *(insert email address).*

Kinahanglan makahibaw ka nga:

- Di ka pugson mu-apil ani nga study kung dili ka ganahan. Wala'y masuko nimo nga bisan kinsa kung mu-sulti ka nga dili ka mu-apil.
- Pwede ka nga mu-hunong sa pag-apil sa research bisag kanus-a.
- Ang imong parent(s)/guardian(s) gipangutana kung OK raba nila nga mu-apil ka ani nga research. Bisan pa nga mu-OK sila, depdende ra gihapon na nimo kung mu sugot ka nga mu-apil sa research o dili.
- Pwede ka mangutana sa mga researchers karon o unya. Kung naa kay mga pangutana sa umaabot nga panahon, mahimo ka o imong parents nga mu-kontak sa Renewsiya Foundation pinaagi ani nga numero *(insert phone number).*

Pirma ani nga form ONLY kung:

- Nakasabot ka unsa imong buhaton ani nga research,
- Natubag imong mga pangutana,
- Nakig-estorya ka sa imong ginikanan/legal guardian bahin ani,
- Nisugot ka nga mu-apil ani nga research

Thank you very much!

Assent Reply Form for Participants 14-17 y.o.
A Healthy Me Qualitative Research 2019

Palihug isuwat imong pangalan, pirma, ug date kung kanus-a ni gipirmahan nga form. Palihug i-balik kani nga form sa Renewsiya human ka o imong parent maka-sign.

Kani nagpamatuod nga nakasabot ko kung unsa bahin kani nga research ug kahibaw ko unsa akong buhaton ani. Akong gipahayag akong boluntaryo nga pag-apil ani nga research / akong paghatag ug pagsugot sa akong anak nga mu-apil ani nga research, pina-agi ani nga dokumento:

Adolescent's Name:	Signature:	Date:
Name of Parent(s) or Legal Guardian(s):	Signature:	Date:
Name of Researcher:	Signature:	Date:

(Renewsiya's copy)

II. INFORMED CONSENT FORM FOR FACILITATORS AND PARTICIPANTS (Aged 18-24 yrs.)

ENGLISH VERSION

Dear Participant,

We are inviting you to participate in a study to explore on your experiences with the A Healthy Me program.

What is A Healthy Me and what is the goal of this research?

We at Renewsiya Foundation have partnered with your Municipal/City Health Office in implementing a program called 'A Healthy Me' in your barangay health centers, which is a holistic health and education program for adolescent girls. We are conducting a qualitative research to gather information on your experiences and perceptions after participating in 'A Healthy me' and to explore on topics such as health and wellbeing, sexual and reproductive health, and how the program helped participants protect themselves against negative outcomes including abuse and exploitation.

Why are you invited to this Focus Group Discussion?

We are asking you to be part of this Focus Group Discussion because you are:

1. an adolescent girl within aged 18 above and have graduated from the 'A Healthy Me' sessions in your barangay
2. facilitated the A Healthy Me in your barangay health center.

What are your rights as a participant?

You have the right to decline from participating in this study. You do not have to say "yes" if you don't want to participate. Your eligibility to receive health services in your barangay health center (adolescent) will not be affected whether you say "yes" or "no" to this research. In the same manner, declining from participating in this study does not affect your position as a health staff in your community (facilitator). If you decide to participate, you have the right to withhold private information during the research and may quit at any time that you want.

What will happen to you during this Focus Group Discussion?

This research is expected to be safe and will cause very minimal discomfort for you. You will be asked to join a Focus Group Discussion (FGD) to answer some interview questions from the researchers. You will be joining other participants during the group discussion. This will be the same with what you do during your 'A Healthy Me' sessions. The researcher will ask you some questions and you may answer if you are comfortable to answer. The FGD will be video recorded and then transcribed for data analysis. All the information that you share with us will be kept confidential. Once again, your participation in the research is voluntary. You may choose to withdraw from the research at any time.

What information will be gathered during the Focus Group Discussion?

This research is qualitative and will use Focus Group Discussion to collect data from you through an interview. The interview questions are about your experiences and perceptions after joining the A Healthy Me program.

When, how long, and where will Focus Group Discussion happen?

The interview will take about approximately 1 hour and 30 minutes and the venue will be at the Barangay Health Center/Barangay Session Hall/Guidance office. You will only attend 1 FGD. We will contact you or your parent to inform you of the final FGD schedule.

What will happen to the information that you will share with us?

The results from this research may be shared to other organizations interested in the evaluation of the program and might be published in a scientific paper. Your participation in this study is useful in creating knowledge and understanding about adolescents' experiences of adolescent health programs and how programs will help participants avoid negative health outcomes. The information that you provide to us will help us provide rigorous data for different stakeholders who will be able to promote the rights and protection of children. Your answers will be kept confidential. Your name and information will not be revealed in any documents.

What will you receive after participating in this Focus Group Discussion?

There is no monetary compensation or stipend for your participation in the Focus Group Discussion. However, we will be providing lunch and giving tokens of appreciation for your participation in the research.

Who are behind this program and research?

This research is funded by Renewsiya Foundation under a grant from The Consuelo Foundation, Philippines. The University of the Visayas – IRB Ethics Review Panel has approved this study. If you have a question about this research and of your rights as a participant, you can contact UV-IRB through *(inserted phone number)* or *(inserted email address)*. You may also contact Renewsiya Foundation at *(inserted phone number)* if you have further questions. Thank you very much.

Yours sincerely,

Informed Consent Form Reply for Facilitators and Adolescents above 18 A Healthy Me Qualitative Research 2019		
Palihug isuwat imong pangalan, pirma, ug date kung kanus-a ni gipirmahan nga form. Palihug i-balik kani nga form sa Renewsiya human ka maka-sign. *Kani nagpamatuod nga nakasabot ko kung unsa bahin kani nga research ug kahibaw ko unsa akong buhaton ani. Akong gipahayag akong boluntaryo nga pag-apil ani nga research, pina-agi ani nga dokumento:*		
Patticipant's Name:	Signature:	Date:
Name of Researcher:	Signature:	Date:
(Renewsiya's copy)		

BISAYA VERSION

Dear Participant,

Giimbita ka namo nga mo-participate sa usa ka research aron hisgutan ang inyong mga experiences sa A Healthy Me program.

Unsa man ang goal ani nga research?

Una sa tanan, magpasalamat kami sa imong pag-apil sa A Healthy Me program. Kami sa Renewsiya Foundation nag himo ug usa ka qualitative research aron mag kuha ug impormansyon bahin sa imong mga experiences ug panghuna-huna human sa imong pag-apil sa A Healthy Me. Ang kani nga mga impormasyon makatabang aron ma improve ang programa ug magamit pa kini sa maayo nga paagi para sa mga future participants.

Nganong gi-imbita man ko ani nga research?

Gi-imbita ka namo nga mu-apil ani nga research kay:
1. usa ka kabantan-on nga babaye nga nagpangidaron ug 18 pataas ug naka-graduate ka sa A Healthy Me program sa inyong barangay
2. usa ka sa ning facilitate sa A Healthy Me program sa inyong barangay

Unsa man akong buhaton ani nga research?

Ang research safe ra ug dili maka-daot kanimo. Pero pwede ka maka-feel ug kiwaw o kauwaw kung mutubag kag pangutana sa atubangan sa uban nga participants. Imbitahon ka namo nga muapil sa usa ka Focus Group Discussion

(FGD). Ang FGD mura ra sad ug group interview, o pareha ra sa inyong A Healthy Me session. Ang mga pangutana kabahin sa inyong mga experiences ug panghuna-huna human sa inyong pag-apil sa A Healthy Me program. Mahimo ka nga mupili nga mutubag o dili mutubag sa mga pangutana sa researcher. Ang FGD i-video ug audio record aron pag-kolekta sa mga data. Ang inyong mga tubag hubaron sa mga researcher ug i-analyze. Ang tanang impormasyon nga inyong i-share kanamo kay confidential.

Unsa man ang akong mga katungod isip usa ka participant ani nga research?
Naa kay katungod nga mu-balibad sa pag-apil ani nga study. Dili ka kinahanglan mu-apil kung dili ka ganahan ani. Ang imong katungod nga makadawat ug mga health services sa health center o skwelahan dili ma-apektahan sa imong pagbalibad ani nga research. Kung mu-apil ka sa research, duna kay katungod nga dili mu-share ug mga information nga personal. Pwede sad ka nga mu-undang sa pag-apil sa research sa bisag unsa nga oras nga imong ganahan.

Kanus-a, unsa kadugay, ug asa man buhaton ang FGD?
Ang interview mu-dagan ug 1 hour and 30 minutes. Ang venue kay sa Barangay Health Center/Barangay Session Hall/Guidance office. Mu-attend raka ug 1 ka FGD. Kontakon ka namo o ang imong ginikanan kung naa nay FGD schedule. (Siguro inig October)

Unsa may mahitabo sa mga information nga akong i-share?
Ang resulta ani nga research pwede nga i-share sa uban na mga organizations nga interesado sa evaluation sa programa ug mahimo nga i-apil sa mga scientific paper. Ang imong participasyon ani nga research dako ug tabang alang sa pagpuno sa kaalam ug pagsabot bahin sa experiences sa mga batan-on aning mga adolescent health programs, ug gi-unsa pagtabang sa programa nga maka-likay ang mga batan-on sa mga bati nga panghitabo sama sa pag-abuso ug exploitation. Ang mga impormasyon nga inyong ihatag kanamo kay makatabang aron makatigom ang mga hingtungdan nga maoy maka-promote sa mga katungod ug proteksyon sa mga kabatan-onan. Ang imong mga tubag confidential. Imong pangalan ug mga impormasyon dili ipakita sa bisag unsa nga dokumento.

Unsa man akong madawat sa akong pag-apil ani nga research?
Wala kami ihatag nga bayad para sa inyong pag-apil sa Focus Group Discussion. Pero maghatag mi ug snacks or/and lunch ug give-aways para pasalamat sa inyong pag-apil sa research.

Kinsa man ang nagsuporta ani nga research?
Ang kani nga research gipundohan sa Renewsiya Foundation pinaagi sa Consuelo Foundation, Philippines . Gihatagan kini ug approval sa UV – IRB Ethics Review Panel Kung naa kay mga pangutana bahin sa research ug sa imong mga katungod isip participant, mahimo ka nga mu-contact sa UV-IRB sa *(inserted phone number)* or *(inserted email address)*.. Mahimo ka nga mo kontak sa Renewsiya Foundation *(inserted phone number)* kung naa pa kay mga pangutana. Daghang Salamat.

Yours sincerely,

Informed Consent Form Reply for Facilitators and Adolescents above 18
A Healthy Me Qualitative Research 2019

Palihug isuwat imong pangalan, pirma, ug date kung kanus-a ni gipirmahan nga form. Palihug i-balik kani nga form sa Renewsiya human ka maka-sign.

Kani nagpamatuod nga nakasabot ko kung unsa bahin kani nga research ug kahibaw ko unsa akong buhaton ani. Akong gipahayag akong boluntaryo nga pag-apil ani nga research, pina-agi ani nga dokumento:

Patticipant's Name:	Signature:	Date:
Name of Researcher:	Signature:	Date:

(Renewsiya's copy)

APPENDIX C.
EMERGENCY RESPONSE PROTOCOL

WHEN TO INITIATE EMERGENCY RESPONSE:

- Participant discloses abuse*[1]
- Participant discloses that she is in immediate danger
- Participant seeks help
- Participant is emotionally distressed

SIGNS OF EMOTIONAL DISTRESS ARE:

- Tearful, cannot stop crying
- Anger
- Shaking
- Staring blank
- Disorientation
- Hyperventilation
- Looking very sad

DISTRESS/EMERGENCY RESPONSE IS OUTLINED AS:

- Stop the interview
- Ask the respondent is she is all right
- Offer tissue is she is crying
- Do not touch the participant physically
- Give her some time to gather herself
- Ask “Is there anything you would like to tell me?”
- Wait for the answer for a few minutes. Silence is Ok.
- Ask “Would you like to continue?”
- If respondent is crying and could not seem to stop or is getting hysterical
- Offer a drink of water
- Tell her to breathe deeply and then exhale slowly
- Ask, “Would you like to talk to a counselor by phone?”

REFERRAL TO CARE:

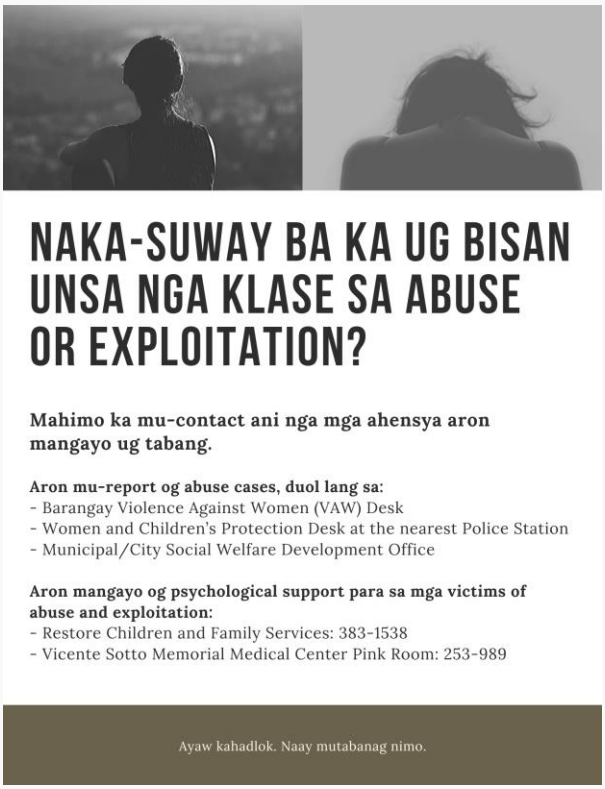
A counselor from Renewsiya Foundation was on standby to immediately speak with a research participant if this was requested. This counselor staff is a licensed Psychometrician, trained in crisis intervention and multiple other therapeutic approaches. Renewsiya Foundation also partnered with Restore Children and Family Services, an NGO which provides tailored wellness plans, and high-quality intervention and treatment for trauma victims and their families, to provide long term counseling if this was requested.

[1] In the event that any participant in the FGD discloses abuse experience, RAs will take note of this participant and approach her after the FGD. The participant who disclosed may continue the FGD if no signs of distress are detected. However, if significant signs of discomfort or distress are noticed, the RA will need to pause the FGD and have that participant proceed to a separate room so that the RA can conduct distress/emergency response.

All research participants, including those who disclosed abuse, were provided with written information about how to report abuse and agencies and organizations providing services for victims.

COPY OF BROCHURE

Bisaya version



NAKA-SUWAY BA KA UG BISAN UNSA NGA KLASE SA ABUSE OR EXPLOITATION?

Mahimo ka mu-contact ani nga mga ahensya aron mangayo ug tabang.

Aron mu-report og abuse cases, duol lang sa:
- Barangay Violence Against Women (VAW) Desk
- Women and Children's Protection Desk at the nearest Police Station
- Municipal/City Social Welfare Development Office

Aron mangayo og psychological support para sa mga victims of abuse and exploitation:
- Restore Children and Family Services: 383-1538
- Vicente Sotto Memorial Medical Center Pink Room: 253-989

Ayaw kahadlok. Naay mutabang nimo.

English version

HAVE YOU EXPERIENCED ANY FORM OF ABUSE OR EXPLOITATION?

You may contact the following agencies to ask for assistance.

To report abuse cases, go to your:
- Barangay Violence Against Women (VAW) Desk
- Women and Children's Protection Desk at the nearest Police Station
- Municipal/City Social Welfare Development Office

To seek psychological support for victims of abuse and exploitation:
- Restore Children and Family Services: 383-1538
- Vicente Sotto Memorial Medical Center Pink Room: 253-989

Do not be afraid. Help is available.

APPENDIX D.
DEMOGRAPHIC PROFILE OF RESEARCH PARTICIPANTS

I. ADOLESCENT PARTICIPANTS

Research participant code	Age	Education status	Civil status	Has child
Health center-based model				
Health center-based adolescent 1	21	High school graduate	Single	No
Health center-based adolescent 2	22	Junior high school	Live-in	No
Health center-based adolescent 3	21	College	Single	No
Health center-based adolescent 4	17	Primary school	Single	Yes
Health center-based adolescent 5	17	Grace 12	Single	No
Health center-based adolescent 6	15	Grade 10	Single	No
Health center-based adolescent 7	15	Grade 10	Single	No
Health center-based adolescent 8	24	Technical / Vocational	Live-in	Yes
Health center-based adolescent 9	22	Junior high school	Live-in	Yes
Health center-based adolescent 10	23	Primary school	Married	Yes
Purok based model				
Purok-based adolescent 1	13	Grade 8	Single	No
Purok-based adolescent 2	13	Grade 7	Single	No
Purok-based adolescent 3	13	Grade 7	Single	No
Purok-based adolescent 4	14	Grade 7	Single	No
Purok-based adolescent 5	17	Grade 11	Single	No
Purok-based adolescent 6	16	Grade 10	Single	No
Purok-based adolescent 7	13	Grade 7	Single	No
School-based model				
School-based adolescent 1	13	Grade 8	Single	No
School-based adolescent 2	14	Grade 8	Single	No
School-based adolescent 3	14	Grade 8	Single	No
School-based adolescent 4	13	Grade 8	Single	No
School-based adolescent 5	16	Grade 8	Single	No

II. PROGRAM FACILITATORS

Research participant code	Age	Sex	Years of service	Religion
Health center-based model				
Midwife facilitator 1	42	F	18	Roman Catholic
Midwife facilitator 2	44	F	9	Roman Catholic
Midwife facilitator 3	49	F	9	Roman Catholic
Midwife facilitator 4	61	F	38	Roman Catholic
Midwife facilitator 5	48	F	11	Roman Catholic
Midwife facilitator 6	43	F	17	Roman Catholic
Midwife facilitator 7	32	F	4	Roman Catholic
Midwife facilitator 8	45	F	6	Roman Catholic
Nurse facilitator 1	26	F	2	Roman Catholic
Nurse facilitator 2	33	F	5	Roman Catholic
Nurse facilitator 3	25	F	1	Roman Catholic
Nurse facilitator 4	32	F	8	Roman Catholic
Nurse facilitator 5	27	F	5	Roman Catholic
School-based model				
Teacher facilitator 1	39	F	14	Roman Catholic
Teacher facilitator 2	26	M	6	Roman Catholic
Teacher facilitator 3	46	F	17	Roman Catholic

APPENDIX E.

PARENT SESSION PILOT EVALUATION

The project involved developing, piloting, and incorporating an educational session for parents into 'A Healthy Me'. Three successive iterations of the parent session where facilitated by Renewsiya's program officers and observational data and formal and informal feedback collected from participants and community assistants to enable program enhancement.

Twenty-eight (28) parents participated in the three pilot sessions. Evaluation of the pilot demonstrated a 153% increase in SRH knowledge across six questions (Table 1) and a 286% increase in confidence in talking with their children about SRH topics across eight different questions (Table 2). 90% of participants reported that they would change their communication with their children following the education session and 100% recommended the program to other parents.

TABLE 1. CHANGE IN PARENT'S KNOWLEDGE PRE AND POST EDUCATION SESSION (% WITH CORRECT ANSWER)

Question	Pre-session		Post-session	
	N	% correct	N	% correct
Is a teenager's body adequately developed to have babies?	23	78%	10	50%
Is contraception only allowed for married couples?	23	26%	10	90%
Do you think that teenagers should use condom when having sex?	23	35%	10	100%
Is it okay for teenagers to use the contraceptive pills, IUD, injections and implants?	23	17%	10	100%
Can people reduce the chance of getting HIV by having just one uninfected sex partner who has had 0 other sex partners?	23	74%	10	90%
Can a person reduce their chance of getting HIV by using condom every time they have sex?	23	78%	10	90%

TABLE 2. CHANGE IN PARENTS' CONFIDENCE LEVELS PRE AND POST EDUCATION SESSION (0 - 10)

Statement	Pre-session			Post-session		
	N	Mean	Std. Dev	N	Mean	Std. Dev
Confidence to talk with my child about values and beliefs about body and sex	23	4.3	3.5	10	8.0	3.8
Confidence to talk with my child about romantic relationships	23	4.9	3.9	9	7.7	3.6
Confidence to talk with my child about sex	23	2.1	3.2	10	6.7	4.5
Confidence to talk with my child about pregnancy	23	4.1	3.9	9	8.3	3.3
Confidence to talk with my child about sexually transmitted infections & HIV/AIDS	23	2.9	4.0	10	7.7	3.7
Confidence to talk with my child about condom	23	.5	1.5	10	8.5	2.8
Confidence to talk with my child about how to refuse physical contact, including unwanted sex	23	5.9	3.9	9	8.1	3.8
Confidence to talk with my child about online safety and how to protect themselves from SEC (e.g., Facebook)	23	5.8	3.9	10	6.9	4.0