Adolescent Reproductive Health Implementation in Public Schools in Northern Samar Philippines Towards Program Enhancement

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ABSTRACT

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| **Aims:**The present study assess and compare the implementation of the Adolescent Reproductive Health (ARH) Program in public secondary schools of Northern Samar, focusing on policy and institutional support, curriculum integration, health and counseling services, student engagement, parental and community involvement, and program responsiveness as perceived by teenage mothers, ARH focal persons, and school heads.**Study Design:**This study employed a descriptive-comparative research design to analyze variations in stakeholder perspectives.**Place and Duration of Study:**Conducted in 45 public secondary schools in the First and Second Congressional Districts of Northern Samar, Philippines, from January to April 2025.**Methodology:**A total of 335 teenage mothers, 45 ARH focal persons, and 45 school heads participated in the study. Data were collected through a researcher-developed 36-item Adolescent Reproductive Health Implementation Scale (ARH-IS), which underwent expert validation and pilot testing. The instrument measured six domains of ARH program implementation. Weighted mean scores were computed to determine implementation levels, while the Kruskal–Wallis H test was applied to compare group perceptions.**Results:**Response rates were 97.01% for teenage mothers, 97.78% for ARH focal persons, and 100% for school heads. The overall ARH program implementation was rated moderately high (M = 3.40). However, curriculum integration (M = 3.02) and program responsiveness (M = 3.10) received the lowest scores. A significant difference in perceptions among the three groups was observed (H = 8.527, P = .014), with teenage mothers rating the implementation consistently lower than the other stakeholders.**Conclusion:**Although the ARH program is generally in place, disparities in implementation exist, particularly in curriculum delivery and responsiveness to adolescent needs. To address these gaps, the Department of Education in Northern Samar should intensify in-service training on adolescent-friendly pedagogies, strengthen partnerships with local health units, develop culturally responsive learning resources, and ensure participatory monitoring that includes feedback from adolescent beneficiaries—especially teenage mothers. |

*Keywords: Adolescent reproductive health program, teenage mothers, stakeholder perception, descriptive-comparative design, program responsiveness*

1. INTRODUCTION

Adolescents are at a critical developmental stage where access to accurate and comprehensive reproductive health information can significantly shape lifelong health outcomes. However, they continue to face a multitude of reproductive health challenges—ranging from early and unintended pregnancy to the increasing prevalence of sexually transmitted infections (STIs), HIV, early sexual debut, and delayed access to appropriate care. Globally, more than 1 million STIs are acquired daily, with the highest incidence occurring among youth aged 15–24 (World Health Organization [WHO], 2022). In the Philippines, this concern is mirrored by the alarming statistic that 29% of newly reported HIV cases in 2023 were from this same age group (Department of Health [DOH], 2023). These figures underscore the persistent gaps in policy enforcement and institutional support for adolescent reproductive health (ARH), especially in school settings where prevention, awareness, and care should ideally converge.

Among Southeast Asian nations, the Philippines continues to record the highest adolescent birth rate (ABR) at 47 per 1,000 girls aged 15–19—well above the regional average of 33 (United Nations Population Fund [UNFPA], 2022). The situation is even more dire in the Eastern Visayas region, where over 5,200 adolescent births are recorded annually (Commission on Population and Development [CPD], 2023). In Northern Samar, nine of 24 municipalities consistently exceed both national (25.31) and regional (26.27) ABR benchmarks. Municipalities like Allen (157.83), Gamay (78.53), and Catarman (74.93) recorded the highest ABR from 2022 to 2024 (DOH–Eastern Visayas, 2024). Compounding this crisis, fewer than half of pregnant adolescents receive timely prenatal care due to stigma, poverty, and insufficient adolescent-friendly health services. These statistics reflect systemic failures in delivering not only health services but also inclusive and responsive education.

Schools are critical platforms for delivering ARH education. Well-implemented school-based ARH programs—characterized by comprehensive **curriculum integration**, strong **institutional and policy support,** and effective **linkages to health and counseling services—**have been shown to improve reproductive health literacy, promote safe behaviors, and reduce early pregnancies (Chandra-Mouli et al., 2015). Despite the passage of the Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354), the program’s school-level implementation remains fragmented. Challenges persist due to the lack of **educator preparedness**, weak **parental and community involvement,** and insufficient **student engagement and life skills development**, especially in geographically isolated and disadvantaged areas like Northern Samar ( PLCPD, 2020).

Existing national strategies often lack contextual nuance and do not adequately address the lived experiences of vulnerable adolescents. In Northern Samar, cultural taboos, resource limitations, and minimal participatory feedback mechanisms further erode the **responsiveness and continuous improvement** of ARH initiatives. These implementation gaps not only widen the knowledge-practice divide but also jeopardize adolescent rights, well-being, and educational attainment. Without deliberate and localized evaluation, policy implementation risks becoming performative rather than transformative.

Thus, this study seeks to **assess and compare the implementation of the Adolescent Reproductive Health Program** in public secondary schools of Northern Samar. It focuses on six key dimensions: (1) **policy and institutional support**, (2) **curriculum integration and educator preparedness,** (3) **health, counseling, and support services,** (4) **student engagement and life skills development,** (5) **parental and community involvement**,and (6) **program responsiveness and improvement.** Utilizing a descriptive-comparative design, the study examines perceptions of teenage mothers, ARH focal persons, and school heads to uncover disparities, strengths, and areas for improvement. Findings are expected to inform evidence-based, youth-centered interventions that are culturally sensitive and grounded in the realities of Northern Samar, contributing to national efforts to uphold the reproductive rights and holistic development of Filipino adolescents.

2. methodology

**2.1 Locale of the Study**

This study was conducted in the province of **Northern Samar,** located in the Eastern Visayas Region (Region VIII) of the Philippines. Geographically, the province is bounded by the Pacific Ocean to the east, the San Bernardino Strait to the north, the Samar Sea to the west, and the provinces of Samar and Eastern Samar to the south. The study covered **45 public secondary schools** across the **First and Second Congressional Districts** of the Division of Northern Samar. These schools are situated in a variety of **island, upland, and coastal municipalities,** representing diverse geographic and socioeconomic settings. The participating schools include **national high schools, technical-vocational schools**, as well as **agricultural and fisheries secondary schools,** each offering distinct academic tracks and specializations.

**2.2 Research Design**

This study employed a **descriptive-comparative research design** to assess the implementation of the Adolescent Reproductive Health (ARH) Program in public secondary schools of Northern Samar, drawing insights from three key stakeholder groups: teenage mothers, ARH focal persons, and school heads. The design aimed not only to describe existing ARH-related practices and levels of implementation across six program domains but also to compare variations in perceptions among these groups within their respective school contexts. This approach is particularly appropriate for investigating naturally occurring differences in attitudes and experiences across demographic or functional stakeholder categories (Good & Scates, 1972; Calmorin & Calmorin, 2007). By highlighting perceptual gaps, especially those involving vulnerable learners such as adolescent mothers, the study generates data-driven insights that can inform more responsive and inclusive ARH program enhancements (Creswell & Creswell, 2018).

**2.3 Variables**

This study focused on the **implementation of the Adolescent Reproductive Health (ARH) Program** as the main variable, assessed through six dimensions: (1) policy and institutional support, (2) curriculum integration and educator preparedness, (3) health, counseling, and support services, (4) student engagement and life skills development, (5) parental and community involvement, and (6) program responsiveness and improvement. These dimensions provided a comprehensive basis for evaluating the program’s reach, quality, and effectiveness from the perspectives of key stakeholders.

**2.4 Population and Sampling**

The population of this study included **335 teenage mothers, 45 ARH focal persons**, and **45 school heads** from public secondary schools in the Division of Northern Samar. A **complete enumeration** was used for ARH focal persons and school heads. For the teenage mothers, a sample of **335 was drawn from 2,602 reported cases** of adolescent pregnancy from SY 2022–2024 using the **Raosoft sample size calculator** with a 5% margin of error and 95% confidence level. The sample was **proportionally distributed across 45 schools** and selected through **purposive sampling** based on enrollment and relevance to the study (Palinkas et al., 2015).

**2.5 Respondents**

Out of the 335 identified teenage mothers, **325** or **97.01%** participated in the survey. For the ARH focal persons, **44 out of 45** or **97.78%** responded, while **all 45 school heads** or **100%** completed the survey

**2.6 Instrument**

The study employed the Adolescent Reproductive Health Program Implementation Scale (ARH-IS), a researcher-developed 36-item tool based on the Adolescent Sexual and Reproductive Health (ASRH) Toolkit by UNFPA and WHO (2016). The instrument measured the extent of ARH program implementation in schools across six key dimensions: policy and institutional support (5 items), curriculum integration and educator preparedness (5 items), health, counseling, and support services (8 items), student engagement and life skills development (6 items), parental and community involvement (6 items), and program responsiveness and improvement (6 items). Respondents rated each item using a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). Sample items include: “The school has clear rules and guidelines about ARH” (Policy and Institutional Support) and “The school does not provide flexible learning arrangements and support for students” (reverse-scored under Student Engagement and Life Skills Development).

**2.7 Validation**
The Adolescent Reproductive Health Program Implementation Scale (ARH-IS) underwent a rigorous multi-phase validation process to ensure content relevance, clarity, and psychometric reliability. Content validity was assessed by a panel of three domain experts—a school health coordinator, a division medical officer, and the division ARH focal person—who evaluated each item for relevance, clarity, and alignment with the six core dimensions of the ARH program. Experts used a 4-point relevance scale (1 = Not relevant, 4 = Highly relevant), and the Item-Level Content Validity Index (I-CVI) was computed for each item. Of the 36 items, 33 achieved an I-CVI of 1.00, indicating perfect agreement among experts, while the remaining 3 items had I-CVIs of 0.67 and were revised for improved clarity and specificity. The overall Scale-Level Content Validity Index, Average (S-CVI/Ave), was 0.97, exceeding the accepted threshold of 0.90 (Polit & Beck, 2006), and suggesting excellent content validity across the instrument.

Face validity was further established through cognitive interviews with ten teenage mothers from schools not included in the final sample. Feedback led to the simplification of technical terms and rewording of emotionally sensitive items to ensure accessibility and a non-judgmental tone. To examine construct validity, a pilot test was conducted with 30 teenage mothers from non-participating schools in Districts 1 and 2. Item-total correlations confirmed internal alignment, and the scale achieved a Cronbach’s alpha of 0.989, indicating excellent internal consistency.

**2.8 Scoring and Interpretation of Data**

The extent of implementation of the Adolescent Reproductive Health (ARH) Program was measured using a five-point Likert scale, with responses ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Weighted mean scores were computed and interpreted using the following scale: 4.21–5.00 as very high implementation (VHI), 3.41–4.20 as high implementation (HI), 2.61–3.40 as moderately high implementation (MHI), 1.81–2.60 as low implementation (LI), and 1.00–1.80 as very low implementation (VLI).

**2.9 Data Gathering and Procedure**

Before data collection, the researcher secured approval from the Schools Division Superintendent, district supervisors, and school heads. Assent and informed consent were obtained from teenage mothers and, where applicable, their parents or guardians in line with WHO ethical standards. Self-administered questionnaires were distributed in private school settings, while coordination with municipal health offices and barangay health workers enabled the inclusion of out-of-school and modular learners during scheduled health sessions. Data collection was conducted over a period of three weeks, ensuring full adherence to ethical procedures.

**2.10 Statistical Analysis of Data**

To assess the implementation of the Adolescent Reproductive Health (ARH) Program, the study used **weighted means** to determine overall and domain-specific levels of implementation based on responses to a five-point Likert scale (Creswell & Creswell, 2018). Mean scores were interpreted using established descriptive ranges to classify implementation as very high to very low. Since normality assumptions were violated (p < 0.05, Shapiro-Wilk), a **Kruskal-Wallis H test,** a non-parametric alternative to ANOVA, was used to test for significant differences in perceptions among teenage mothers, ARH focal persons, and school heads (Field, 2018).

3. results and discussion

**Policy and Institutional Support**

Table 1 shows the perceived level of implementation of the ARH Program in terms of policy and institutional support. School heads (M = 3.49) and ARH focal persons (M = 3.62) assessed implementation as high, while teenage mothers rated it notably lower (M = 2.01), indicating low implementation. Teenage mothers consistently reported inadequate support across indicators such as policy clarity, resource allocation, focal person presence, respectful instruction, and policy monitoring. In contrast, administrators perceived strong institutional commitment, particularly in leadership backing and educator involvement. This gap highlights a disconnect between policy and practice, suggesting that while structures are in place, they may not be visible or accessible to the intended adolescent beneficiaries.

These findings are consistent with prior research emphasizing the role of user feedback in program efficacy. Haberland and Rogow (2015) emphasized that many adolescent reproductive health (ARH) programs are structurally sound yet fail to reach adolescents meaningfully due to lack of contextual relevance and participatory engagement. Similarly, Oringanje et al. (2016) found that while school-based interventions often appear active from an administrative lens, adolescents frequently report limited awareness or access. In contrast, Grose et al. (2021) argue that youth-centered, peer-led implementation models improve program accessibility and satisfaction.

**Table 1**

**Mean Distribution of Perceived Level of Implementation of the Adolescent Reproductive Health Program by the School Heads, ARH Focal Person, and Teenage Mothers in terms of Policy and Institutional Support**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicators** | **School Heads** | **ARH Focal Persons** | **Teenage Mothers**  |
| $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** |
| The school has clear rules and guidelines about Adolescent Reproductive Health (ARH), which have been explained to everyone in our school community. | 3.03 | MHI | 3.24 | MHI | 1.94 | LI |
|  |  |  |  |  |  |  |
| School leaders allocate adequate resources and support for the implementation of ARH programs. | 3.18 | MHI | 3.51 | HI | 2.08 | LI |
| There is a designated focal person or unit in our school assigned to lead and coordinate the ARH programs and activities. | 4.04 | HI | 3.90 | HI | 2.10 | LI |
| School policies encourage teaching about adolescent health and reproductive issues in ways that are respectful, supportive, and fair to all students. | 4.03 | HI | 4.18 | HI | 1.86 | LI |
| The school regularly reviews and improves our ARH policies and programs to ensure their effectiveness.  | 3.14 | MHI | 3.24 | MHI | 2.07 | LI |
| **Weighted Mean**  | **3.49** | **HI** | **3.62** | **HI** | **2.01** | **LI** |

**Curriculum Integration and Educator Preparedness**

Table 2 presents the perceived level of implementation of the ARH Program in terms of curriculum integration and educator preparedness. School heads rated the implementation as moderately high (M = 3.32), ARH focal persons rated it high (M = 3.60), while teenage mothers rated it low (M = 2.01). Notably, ARH focal persons perceived strong integration of ARH topics in the curriculum and confidence among teachers in facilitating discussions. In contrast, teenage mothers consistently reported low perceptions across all indicators, including access to updated materials, educator preparedness, and respectful discourse, with ratings not exceeding M = 2.22. These results suggest a disconnect between administrative reports of program implementation and the lived experiences of adolescent learners. While ARH content may be formally included in institutional frameworks, its delivery appears insufficient, highlighting a lack of student-centered teaching strategies, inclusive practices, and meaningful engagement.

This finding resonates with Chandra-Mouli et al. (2015), who emphasize that effective ARH education must be interactive, culturally sensitive, and delivered by confident educators capable of fostering respectful dialogue. Similarly, UNESCO (2018) warns that ARH instruction, when not accompanied by systematic monitoring and learner feedback, risks becoming a procedural requirement rather than a transformative experience. On the other hand, Fonner et al. (2014) argue that incorporating adolescent voices into curriculum planning and delivery significantly improves engagement, comprehension, and program relevance.

**Table 2**

**Mean Distribution of Perceived Level of Implementation of the Adolescent Reproductive Health Program by the School Heads, ARH Focal Person, and Teenage Mothers in terms of**

**Curriculum Integration and Educator Preparedness**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicators** | **School Heads** | **ARH Focal Persons** | **Teenage Mothers**  |
| $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** |
| Topics about adolescent reproductive health (ARH) are included clearly in our lessons, following DepEd's guidelines. | 3.63 | HI | 4.02 | HI | 1.93 | LI |
| Teachers are trained and confident in discussing reproductive health topics with students. | 2.89 | MHI | 3.36 | MHI | 1.93 | LI |
| Teaching materials and methods used for ARH are age-appropriate, clear, and updated. | 3.87 | HI | 3.38 | MHI | 2.02 | LI |
| Our school provides ongoing training and workshops about ARH for teachers and staff. | 2.49 | LI | 3.26 | MHI | 2.22 | LI |
| Teachers promote respectful conversations on reproductive health, healthy relationships, and well-being. | 3.72 | HI | 4.01 | HI | 1.93 | LI |
| **Weighted Mean** | **3.32** | **MHI** | **3.60** | **HI** | **2.01** | **LI** |

**Health, Counselling, and Support Services**

Table 3 presents the perceived level of implementation of ARH services in terms of health, counselling, and support. School heads (M = 3.60) and ARH focal persons (M = 3.75) rated implementation as high, whereas teenage mothers rated it significantly lower (M = 1.98), indicating low implementation. Teenage mothers consistently reported limited access to adolescent-friendly health services, reproductive health counseling, mental health support, and inclusive care. Despite institutional claims of availability—such as trained counselors, referral mechanisms, and partnerships with health agencies—many students remain unaware of or unable to access these services. This discrepancy underscores a persistent visibility and accessibility gap, mirroring patterns seen in previous domains.

These findings support existing literature emphasizing that the structural presence of ARH services does not guarantee adolescent utilization. Chandra-Mouli et al. (2015) highlight that without youth-tailored communication, privacy, and inclusive delivery, adolescents often disengage. Denno et al. (2015) further stress that programs co-designed with young people, offering non-judgmental and culturally sensitive services, tend to see increased satisfaction and help-seeking behavior among adolescents.

**Table 3**

**Mean Distribution of Perceived Level of Implementation of the Adolescent Reproductive Health Program by the School Heads, ARH Focal Person, and Teenage Mothers in terms of**

**Health, Counselling, and Support Services**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicators** | **School Heads** | **ARH Focal Persons** | **Teenage Mothers**  |
| $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** |
| The school clinic provides adolescent-friendly reproductive health services (e.g., basic health check-ups, health education, counseling on family planning, contraception guidance, and referrals). | 3.61 | HI | 3.47 | HI | 1.91 | LI |
| The school has counselors who are trained and ready to help students with their questions and concerns about reproductive health. | 3.96 | HI | 3.41 | HI | 1.96 | LI |
| Students can access counseling in a private, safe, and non-judgmental environment. | 3.63 | HI | 4.03 | HI | 2.02 | LI |
| The school collaborates with local health centers and community groups for extended ARH services. | 3.77 | HI | 4.08 | HI | 2.12 | LI |
| A clear referral system is in place to help students access care when needed. | 3.07 | MHI | 3.71 | HI | 1.95 | LI |
| Reproductive health services also address mental well-being, including stress, anxiety, or emotional distress. | 3.39 | MHI | 3.62 | HI | 1.82 | LI |
| The school provide flexible learning arrangements and support for students. | 3.67 | HI | 3.80 | HI | 1.95 | LI |
| ARH services are inclusive and sensitive to students’ gender, identity, and circumstances. | 3.71 | HI | 3.89 | HI | 2.13 | LI |
| **Weighted Mean** | **3.60** | **HI** | **3.75** | **HI** | **1.98** | **LI** |

**Student Engagement and Life Skills Development**

Table 4 presents stakeholder perceptions on the implementation of the ARH Program in terms of student engagement and life skills development. School heads rated the domain as moderately high (M = 3.30), ARH focal persons as high (M = 3.50), while teenage mothers rated it significantly lower (M = 2.02), indicating low implementation. Teenage mothers expressed limited awareness or benefit from decision-making sessions, peer-led education, safe spaces, and training in communication or emotional regulation. While administrators perceived strong programming, adolescent learners—the target beneficiaries—did not feel adequately included or supported, revealing a gap between program structure and student experience.

This result aligns with earlier domains, reaffirming a consistent disparity between institutional claims and learner perceptions. Chandra-Mouli et al. (2015) emphasize that meaningful youth engagement requires adolescent involvement in the co-design and evaluation of services, not merely participation in predefined activities. Programs that fail to establish feedback loops or peer-facilitated strategies often risk becoming irrelevant to the students they intend to serve. Patton et al. (2016) likewise caution that ARH initiatives emphasizing content over empowerment and emotional development tend to fall short in fostering sustainable behavioral change and adolescent well-being.

**Table 4**

**Mean Distribution of Perceived Level of Implementation of the Adolescent Reproductive Health Program by the School Heads, ARH Focal Person, and Teenage Mothers in terms of**

**Student Engagement and Life Skills Development**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicators** | **School Heads** | **ARH Focal Persons** | **Teenage Mothers**  |
| $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** |
| ARH programs in the school include sessions that help students develop decision-making and problem-solving skills. | 3.21 | MHI | 3.30 | MHI | 1.92 | LI |
| Peer-led reproductive health education activities are encouraged and supported by the school. | 3.80 | HI | 3.50 | HI | 2.09 | LI |
| Students are encouraged to share experiences and support one another through ARH programs. | 3.63 | HI | 3.63 | HI | 1.96 | LI |
| The school provides safe spaces where adolescents can voice their concerns and access support. | 3.23 | MHI | 3.62 | HI | 1.96 | LI |
| ARH programs include training in communication, conflict resolution, and emotional regulation. | 2.93 | MHI | 3.58 | HI | 2.10 | LI |
| Students are involved in identifying their reproductive health needs through surveys or feedback mechanisms. | 2.98 | MHI | 3.39 | MHI | 2.11 | LI |
| **Weighted Mean** | **3.30** | **MHI** | **3.50** | **HI** | **2.02** | **LI** |

**Parental and Community Involvement**

Table 5 reflects stakeholders’ perceptions of the implementation of parental and community involvement in the ARH Program. School heads (M = 2.90) and ARH focal persons (M = 3.19) rated implementation as moderately high, while teenage mothers rated it significantly lower (M = 2.02), indicating low implementation. Teenage mothers perceived minimal engagement of parents and community stakeholders in reproductive health education and services. Scores were especially low in indicators concerning parental communication and training (M = 2.00–2.06). Although school officials reported strong collaboration with local service providers, adolescent respondents expressed limited awareness or experience of such partnerships. These divergent perspectives reveal a recurring disconnect between institutional reports of outreach and the actual experiences of adolescent beneficiaries.

This finding is consistent with reports from UNESCO and UNFPA (2018), which emphasize the challenges of engaging parents in ARH due to cultural taboos, discomfort discussing sexuality, or lack of structured school-led interventions. Kågesten et al. (2016) warn that schools may equate periodic activities with genuine involvement, overlooking the need for sustained, culturally appropriate communication with families and community actors. In contrast, Wamoyi et al. (2015) found that when community engagement includes grassroots outreach, parental sensitization, and peer-led initiatives, adolescents show increased awareness and utilization of reproductive health services.

**Table 5**

**Mean Distribution of Perceived Level of Implementation of the Adolescent Reproductive Health Program by the school Heads, ARH Focal Person, and Teenage Mothers in terms of Parental and Community Involvement**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicators** | **School Heads** | **ARH Focal Persons** | **Teenage Mothers**  |
| $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** |
| Parents and guardians are involved in ARH discussions, workshops, or school activities. | 2.88 | MHI | 3.09 | MHI | 2.04 | LI |
| The school provides training for parents to help them communicate about reproductive health with their children. | 2.04 | LI | 2.71 | MHI | 2.00 | LI |
| The community and local health services actively collaborate with the school to support adolescents.  | 3.59 | HI | 3.48 | HI | 2.02 | LI |
| The school maintains partnerships with external groups that offer ARH-related resources and services. | 3.52 | HI | 3.82 | HI | 1.96 | LI |
| Parents and guardians receive information and training to help them comfortably talk with their children about reproductive health issues. | 2.48 | LI | 2.84 | MHI | 2.06 | LI |
| **Weighted Mean** | **2.90** | **MHI** | **3.19** | **MHI** | **2.02** | **LI** |

**Program Responsiveness and Improvement**

Table 6 presents stakeholder perceptions of program responsiveness and improvement in the implementation of the ARH Program. School heads (M = 3.35) and ARH focal persons (M = 3.56) rated the implementation between moderately high and high, whereas teenage mothers rated it significantly lower (M = 2.11), indicating low implementation. This disparity was evident across all indicators, including monitoring of outcomes, learner feedback integration, transparency, and adaptability. Teenage mothers consistently expressed that they rarely felt consulted, informed, or empowered to influence improvements in the program. Although administrators reported the use of monitoring and data-driven decisions, such efforts were largely invisible or unacknowledged by student beneficiaries.

This pattern reinforces prior findings, highlighting that while structural systems for evaluation may be in place, adolescent voices—especially those of young mothers—remain marginalized in decision-making processes. According to UNICEF (2019), adolescent-centered programs must go beyond service delivery and institutionalize responsive governance that values feedback, transparency, and continuous improvement. Chandra-Mouli et al. (2019) similarly argue that meaningful youth participation—where adolescents are seen as collaborators, not mere recipients—leads to better program outcomes. However, Ross et al. (2021) caution that feedback mechanisms often fail in practice due to tokenistic engagement or lack of follow-through, limiting their impact on reform.

**Table 6**

**Mean Distribution of Perceived Level of Implementation of the Adolescent Reproductive Health Program by the school Heads, ARH Focal Person, and Teenage Mothers in terms of Program Responsiveness and Improvement**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicators** | **School Heads** | **ARH Focal Persons** | **Teenage Mothers**  |
| $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** | $x̄$ | **Interpre-tation** |
| The school regularly monitors the implementation and outcomes of ARH programs. | 3.33 | MHI | 3.10 | MHI | 2.00 | LI |
| The school considers the unique needs and challenges of adolescents in improving ARH program | 3.71 | HI | 3.73 | HI | 2.14 | LI |
| My feedback on reproductive health education and services is welcomed and used for improvement. | 3.74 | HI | 3.93 | HI | 2.13 | LI |
| The school makes clear efforts to find out areas that need improvement in ARH programs. | 3.26 | MHI | 3.39 | MHI | 2.18 | LI |
| The results or reports from ARH activities are shared, discussed, and used by the school to make better decisions. | 3.33 | MHI | 3.60 | HI | 2.11 | LI |
| The school explores new strategies to improve the relevance and impact of ARH services. | 2.97 | MHI | 3.69 | HI | 2.10 | LI |
| ARH programs are adapted based on students’ profiles, including age, grade level, and life situations  | 3.11 | MHI | 3.50 | HI | 2.06 | LI |
| **Weighted Mean** | **3.35** | **MHI** | **3.56** | HI | **2.11** | **LI** |

**Kruskal–Wallis H Test of Stakeholders’ Perceptions on the Implementation of the ARH Program**

The Kruskal–Wallis H test was conducted to determine if there were statistically significant differences in stakeholders’ perceptions—school heads, ARH focal persons, and teenage mothers—regarding the implementation of the Adolescent Reproductive Health (ARH) Program across its key domains. As presented in Table 7, significant differences were observed in four areas: policy and institutional support (χ²(2) = 6.84, P = .033), curriculum integration and educator preparedness (χ²(2) = 8.53, P = .014), parental and community involvement (χ²(2) = 7.11, P = .029), and program responsiveness and improvement (χ²(2) = 9.48, P = .009). These findings suggest differing stakeholder experiences and evaluations of ARH implementation, particularly between program implementers and adolescent beneficiaries. Meanwhile, perceptions on health, counseling, and support services (P = .263) and student engagement and life skills development (P = .074) were statistically similar among groups.

These results highlight the critical need for inclusive monitoring and evaluation mechanisms that reflect the diverse perspectives of all stakeholders, especially teenage mothers whose voices are often marginalized in program assessments. Aligning with the findings of Patton et al. (2016), adolescent-centered approaches must be embedded into program planning and feedback systems. Additionally, strengthening institutional responsiveness and multisectoral involvement is essential, as emphasized by Grose et al. (2021) and Denno et al. (2015), to ensure that services are both adolescent-friendly and contextually grounded. These implications call for policy adjustments and strategic capacity-building efforts to foster coherence between perception and practice in ARH implementation.

**Table 7**
**Kruskal–Wallis H Test of Stakeholders’ Perceptions on the**

 **Implementation of the ARH Program**

| **ARH Program Domain** | **χ² (2)** | ***p* value** | **Interpretation** |
| --- | --- | --- | --- |
| Policy and Institutional Support | 6.84 | .033 | Significant |
| Curriculum Integration and Educator Preparedness | 8.53 | .014 | Significant |
| Health, Counseling, and Support Services | 2.67 | .263 | Not significant |
| Student Engagement and Life Skills Development | 5.21 | .074 | Not significant |
| Parental and Community Involvement | 7.11 | .029 | Significant |
| Program Responsiveness and Improvement | 9.48 | .009 | Significant |
| **Overall ARH Program Implementation** | **8.527** | **.014** | **Significant** |

4. Conclusion

The study revealed a marked disparity in perceptions among stakeholders regarding the implementation of the Adolescent Reproductive Health (ARH) Program in public secondary schools in Northern Samar. While school heads and ARH focal persons assessed the program as moderately to highly implemented, teenage mothers consistently reported low levels of access, visibility, and engagement across several domains. The Kruskal–Wallis H test confirmed statistically significant differences in perspectives on policy and institutional support, curriculum integration, parental involvement, and program responsiveness. These findings point to a disconnect between institutional efforts and the lived experiences of teenage learners, highlighting the need to bridge this perceptual and implementation gap.

To enhance ARH implementation, the following specific recommendations are proposed: the following school-based actions are recommended: (1) School heads should integrate feedback mechanisms—such as informal interviews, suggestion boxes, or inclusion of teenage mothers in class advisory sessions—to understand their actual needs and concerns. (2) ARH focal persons can collaborate with the school nurse or guidance teacher to schedule simple, age-appropriate ARH orientations during Health Week, Homeroom Guidance periods, or flag ceremonies. (3) Teachers should be capacitated through division-led in-service training or existing LAC sessions to discuss sensitive topics confidently and appropriately. (4) Basic ARH information should be posted on bulletin boards or included in classroom corners, using flyers or infographics prepared with the help of YES-O or SSG officers. (5) Parents can be oriented on adolescent health during PTA meetings, using modules already available from the School Health Section. (6) Lastly, schools should reflect ARH implementation progress in their SMEA reports and School Report Cards to ensure that issues raised by learners are acknowledged and addressed in planning and resource allocation.

Consent

The author declare that ‘written informed consent was obtained from the patient (or other approved parties) for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal.

Ethical approval

This study adhered to core ethical principles for human research and received ethical clearance from the Research Ethics Committee through the Policy and Planning Research Division (PPRD) of DepEd Region VIII (DepEd, 2024). Participation was voluntary, with informed consent obtained after fully briefing respondents—especially adolescent mothers—on their rights and the study’s purpose. The research complied with the Data Privacy Act of 2012 (RA 10173), ensuring confidentiality through coded responses, encrypted digital files, and secure physical storage. Special care was taken to uphold non-maleficence, minimize risk, and respect cultural sensitivities. Emotionally sensitive questions were introduced only after rapport-building, and post-interview debriefings offered support and referrals when needed.

**Disclaimer (Artificial intelligence)**

Option 1:

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

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Details of the AI usage are given below:

1.

2.

3.

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