INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY: APPLIED BUSINESS AND EDUCATION RESEARCH
2026, Vol. 7, No. 1, 180 – 199
http://dx.doi.org/10.11594/ijmaber.07.01.17

Research Article

Exploring Health Workers' Perspectives on Barriers to Family Planning Service Delivery: A Study in Health Center of District 2, Marikina City

Rodina P. Fernandez[1]*, Ma. Kryssie G. Fernandez[2], Jervie C. Dual[3], Leprex L. Padre[4], Claudine F. Payacag[5]

[1]Nurse PPO designate/ Midwife 11, Quezon City Health Department
[2]Police Officer, Philippine National Police
[3]Administrative Aide VI/Accounting Clerk II, Office of the Municipal Accountant, Local Government Unit of Makilala
[4]Registration Officer III, LCR Office-LGU Guimba
[5]Administrative Officer I, DPWH Camarines Sur 4th DEO

Article history:
Submission 02 December 2025
Revised 30 December 2025
Accepted 23 January 2026

**Corresponding author:*
E-mail:
fernandeznarda17@gmail.com

ABSTRACT

This study examined the barriers to family planning (FP) service delivery as perceived by health workers in selected health centers in District 2, Marikina City. The study is anchored on the WHO Health Systems Framework (WHO, 2007) and the Socio-Ecological Model (Bronfenbrenner, 1979), which explain how systemic, organizational, and socio-cultural factors interact to influence health service delivery. Specifically, it identified organizational, technical, resource-related, and socio-cultural factors that influence the implementation of FP programs and explored strategies to improve service delivery. A descriptive quantitative research design was employed, utilizing a structured self-administered questionnaire distributed to health workers involved in FP service provision. Data were analyzed using descriptive statistics, including frequency, percentage, and weighted mean, with limited qualitative inputs from respondents' perspectives used to support interpretation of the results.

Findings revealed that organizational challenges such as staffing shortages, high workload, and policy-related issues significantly affected FP service delivery. Technical and resource-related barriers included inconsistent supply of contraceptives, limited training opportunities, and inadequate infrastructure. Socio-cultural factors, particularly misconceptions about FP methods, cultural beliefs, and religious influences, were also perceived as major barriers to FP utilization among clients. Despite these challenges, health workers identified capacity-building activities, improved supply chain management, strengthened community education, and sustained policy support as key strategies for enhancing FP service delivery.

How to cite:
Fernandez, R. P., Fernandez, M. K. G., Dual, J. C., Padre, L. L., & Payacag, C. F. (2026). Exploring Health Workers' Perspectives on Barriers to Family Planning Service Delivery: A Study in Health Center of District 2, Marikina City. *International Journal of Multidisciplinary: Applied Business and Education Research*. *7*(1), 180 – 199. doi: 10.11594/ijmaber.07.01.17

The study concludes that barriers to FP service delivery are multi-dimensional and require coordinated interventions at the health system, community, and policy levels. Addressing these barriers through strengthened health systems, continuous training of health workers, and culturally sensitive community engagement may improve the effectiveness and accessibility of family planning services. The findings of this study may serve as a basis for local health administrators and policymakers in developing targeted strategies to strengthen FP programs.

Keywords: *Family Planning, Health Workers, Health Centers, Responsible Parenthood and Reproductive Health (RPRH) Law of 2012 (Republic Act No. 10354)*

Introduction

Family planning (FP) is an essential part of reproductive health. It is acknowledged worldwide as one of the main strategies to decrease the rates of maternal and infant morbidity and mortality, to prevent unintended pregnancies, and to promote social and economic progress (World Health Organization [WHO], 2019; United Nations Population Fund [UNFPA] Philippines, n.d.).

FP through the provision of voluntary and responsible decisions on the number and intervals of children, contributes to the realization of sustainable development goals related to health, gender equality, and poverty alleviation.

In the Philippines, the Parenthood and Reproductive Health (PRH) Law of 2012 (Republic Act No. 10354) was the instrument that formalized the government's commitment to providing universal access to reproductive health services, education, and contraceptives. The law emphasizes the right of every Filipino to make reproductive choices based on information and it provides that the integration of FP programs in the public health sector of the country is mandatory (Department of Health [DOH], 2018). However, in spite of this advanced legal framework, a number of obstacles have been identified in the supply of FP services nationwide.

Based on the 2017 National Demographic and Health Survey (NDHS) data, nearly 1 out of 6 currently married women had an unmet need for family planning, with only 57% of the total demand being met by modern methods (Philippine Statistics Authority [PSA] & ICF, 2018). The existing difference between supply and demand is a vivid illustration of the difficulties that are still faced, namely access issues, the problems of supply chain, the lack of and insufficiently trained medical and paramedical staff, cultural factors, and low level of health-related literacy of clients (David & Alano, 2020; Perez, 2022). Executive Order No. 12, s. 2017 was issued to eliminate family planning unmet needs through the promotion of RPRH Law implementation by the local government and system-level partnerships (Philippine Commission on Women [PCW], 2017).

Nevertheless, there is still a great deal of variance in service delivery across local health facilities. Even in an urban area like Marikina City, characterized as having a well-functioning health system, there are still differences in the use of FP. District 2, with its socio-economically diverse population, creates an intriguing environment for research into differences in health behaviors in general, and in FP in particular. Within this district, the Barangay Tumana Health Center, Barangay Malanday Health Center, and Barangay Fortune Health Center are instrumental in the implementation of reproductive health and family planning programs under the supervision of the City Health Office. Lacking the full implementation of these services, local reports and field observations reveal that issues such as staff shortage, lack of resources, and community attitudes towards family planning have led to suboptimal program implementation (Marikina City Health Office, 2023).

Health workers are directly involved in these programs; they are the primary people who implement policies and educate clients. Their viewpoints give us a deep insight into the

framework and surroundings that not only hinder FP service delivery but also affect the system as a whole. Research conducted in different localities have reported that shortage of training, long working hours, lack of supplies and conflict of values among health providers were the main reasons for the difficulties faced in these sectors (Jimenez et al., 2019; Dela Cruz & Ramirez, 2021). Nevertheless, few studies have emphasized the health workers' perspective in the Marikina City Health District 2, especially in Tumana, Malanday and Fortune Health Centers.

This is why the present research intends to delve into the viewpoints of medical staff in these three health centers to figure out the obstacles in providing family planning services. Their experiences and challenges will give valuable insights to local policymakers and program managers in crafting interventions that are not only effective but also targeted and sensitive to local conditions thereby ensuring the accessibility and quality of reproductive health services. In the end, this paper is about helping the RPRH framework of Marikina City to become more solid and the setting of the gasification of the goals outlined in the RPRH Law and Executive Order No. 12.

Research Methodology

Research Design

The study employed a descriptive quantitative research design to examine the difficulties that health workers face in providing family planning (FP) services. The design was intended to depict the situations, ideas, and challenges which the respondents had experienced. Information was gathered via a structured online survey developed with Google Forms, which facilitated the data collection process from health workers of the chosen health centers.

Research Locale

The study was based in Marikina City's District 2, that includes the Tumana, Malanday, and Fortune Health Centers. These establishments are the first health care units to offer services to mothers, children, and reproductive health along with family planning as a program. The centers are managed by the Marikina City Health Department, which is the body responsible for the execution of health care plans both of local and national levels within the city.

Respondents and Sampling Technique

The study respondents were the medical personnel that were directly engaged in giving family planning services. These doctors, nurses, midwives, and barangay health workers attached to the selected health centers were among the respondents. To choose the participants, a total enumeration sampling technique was used to get all the health workers in Tumana, Malanday, and Fortune Health Centers who met the criteria and were willing to take part. The research only involved those who gave their consent to participate voluntarily.

Research Instrument

The main instrument used for gathering information directly from the respondents was a structured questionnaire which was created by the researcher and it included the following parts: demographic and professional profile (age, sex, designation, years in service, and FP-related training); organizational barriers (administrative, policy, financial, and staffing issues); technical and capacity-related barriers (training adequacy, access to updated FP methods, and data management); and client-related and socio-cultural barriers (community misconceptions, privacy concerns, and religious influences).

Data Gathering Procedure

Before going out and doing the data-gathering, the researcher had to get permission from the City Health Officer of the Marikina City Health Department. The City Health Officer gave the green light to the administration of the survey to health workers from Tumana, Malanday, and Fortune Health Centers.

The questionnaire was designed in a Google Form and included an introduction, an informed consent, and structured questions. The survey link was sent out through official communication channels like email or messaging platforms. Everyone's answers were automatically saved in the Google Form database, and the organizer had limited access to this data to

ensure that the information remained confidential.

Data Analysis

Information collected from the survey were converted to figures, arranged, and analyzed by descriptive statistical methods to present a systematic summary of the respondent's profiles and their perceptions of barriers to the family planning (FP) service delivery. Descriptive statistics are numerical methods that describe, summarize, and interpret data in a meaningful way (Creswell & Creswell, 2018).

The study utilized the following statistical tools: frequency, which shows the number of times a particular response or observation occurs within a dataset and was used to determine the number of respondents that had the same characteristics or perceptions; percentage, which shows the frequency in relation to the total number of respondents and enables the comparison between categories; mean or average, which was derived to find the central point of the responses, especially to get the general perception of health workers toward different barriers; and standard deviation that indicates the fluctuation or spread of responses from the average, thus reflecting how the respondents' views were in agreement or differed with the items. Answers for the open-ended questions of the questionnaire were handled through a straightforward thematic analysis. This qualitative approach involved sorting and interpreting the themes and patterns of the participants' written statements to corroborate the quantitative findings. Together, these approaches gave a fuller picture of the measurable trends while still taking into account the contextual experiences of health workers.

Data were collected using a structured, self-administered questionnaire distributed to health workers assigned in selected health centers in District 2, Marikina City. The instrument consisted of three main sections: (1) demographic profile, (2) perceived barriers to FP service delivery measured using a five-point Likert scale, and (3) a checklist of recommended strategies to improve FP services.

The questionnaire was developed based on existing literature on family planning service delivery barriers and was reviewed by subject-matter experts to ensure content validity. Prior to actual data collection, the instrument underwent pilot testing to assess clarity and reliability. Data collection was conducted during scheduled work hours with permission from health center administrators to ensure minimal disruption of services.

Ethical Considerations

The study conformed to the ethical standards of research. Participation in the study was voluntary, and an informed consent was given electronically before taking the survey. Participants were guaranteed anonymity and confidentiality, and no personal identifiers were recorded. Getting the go-signal from the City Health Officer of the Marikina City Health Department was the factor that made the study meet the requirements of the ethical protocols at the institution. All the information was kept in a safe place and was only for academic use.

Ethical approval was secured prior to data collection. Participation in the study was voluntary, and respondents were informed of the purpose, procedures, risks, and benefits of the research through an informed consent form. Respondents were assured that they could withdraw at any point without penalty.

To protect confidentiality and anonymity, no personally identifiable information was collected. Data were encoded and stored securely, accessible only to the researchers. Aggregated results were reported to prevent identification of individual respondents or specific health centers. The study adhered to the ethical principles of respect for persons, beneficence, and justice.

The study adhered to the principles of the Declaration of Helsinki.

Presentation, Analysis, and Interpretation of Data

This part features the analysis and interpretation of the information collected for the research titled, "Exploring Health Workers' Perspectives on Barriers to Family Planning Service Delivery: A Study in Health Center of District 2, Marikina City." Descriptive statistical techniques were employed to analyze the responses and to recognize the dominant

patterns, perceptions, and challenges which the respondents had experienced. A five-point Likert scale was used in this research to measure the level of agreement of the participants with the given indicators. The results of this analysis serve as a solid foundation for the objectives of the study and pave the way for the valuable insights into the impediments that affect the implementation of family planning services in the area health center.

This study is anchored on the WHO Health Systems Framework and the Socio-Ecological Model, which together provide a comprehensive lens for examining multi-level barriers to family planning service delivery. Organizational, technical, and resource-related barriers reflect systemic weaknesses within the health system, while socio-cultural and religious barriers operate at the community and individual levels. Using these frameworks allows for a holistic interpretation of findings and supports the development of targeted, multi-sectoral interventions.

A. Demographic Profile of Respondents

Table 1: Likert Scale Legend and Verbal Interpretation

SCALE	RANGE OF MEAN SCORES	VERBAL INTERPRETATION
5	4.21 – 5.00	STRONGLY AGREE
4	3.41 – 4.20	AGREE
3	2.61 – 3.40	MODERATELY AGREE
2	1.81 – 2.60	DISAGREE
1	1.00 – 1.80	STRONGLY DISAGREE

The Likert Scale is an instrument that is most frequently utilized in Quantitative Research to quantify the attitude, opinion, or perception of the respondents towards the specific subject matter. It usually contains a set of statements along with the response options for each statement, where such options indicate the extent of agreement or disagreement with the statement (e.g. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree). To each response, a number is allocated that enables the researchers to measure subjective views numerically and to conduct statistical analysis on such data. Using this scale, different degrees of agreement or disagreement can be combined to disclose general trends, patterns, and the predominant sentiment of respondents concerning the variables presented.

Table 2: Age Group of Classification of Respondents

AGE BRACKET (IN YEARS)	FREQUENCY	PERCENTAGE (%)
22-29	12	22%
30-37	17	31%
38-45	13	24%
46-51	9	16%
52-56	4	7%
TOTAL	55	100%

The figures reveal the dominant age group of the respondents as the 30-37 years bracket that made up 31% of the total participants. This means that most of the survey participants are in their early to mid-adult life, which is generally considered a time of stable career experience and active community participation. On the other hand, a lesser number of people are aged between 52 and 56 years old, making 7% of the total respondents, thus indicating that a small fraction of the respondents is close to the later stage of their professional practice. The age distribution, therefore, indicates a staff capable of being both youthful and seasoned at the same time, which is an excellent combination for the provision of quality family planning and health services in the community.

Table 3: Sex-Based Classification of Respondents

SEX	FREQUENCY	PERCENTAGE (%)
MALE	10	18%
FEMALE	27	49%
PREFER NOT TO SAY	18	33%
TOTAL	55	100%

Among 55 health workers that were surveyed: Women made up almost half of the respondent pool, as 49% of them were females. Males accounted for 18%, thus representing a smaller fraction of the participants. A third of the respondents (33%) chose not to disclose their sex, which is quite a significant group and may indicate that they are either sensitive to gender identity or have privacy concerns. The distribution of responses indicates that the voices of women were dominant; however, a considerable number of respondents opted not to state their sex, which might have consequences for the comprehension of gender-related aspects in the provision of family planning services.

Table 4: Health Center-Based Classification of Respondents

HEALTH CENTER	FREQUENCY	PERCENTAGE (%)
TUMANA HC	23	42%
MALANDAY HC	18	33%
FORTUNE HC	14	25%
TOTAL	55	100%

The survey involved 55 health workers: the most represented facility in the study was Tumana Health Center with 42% of the health workers. A significant number of responses were contributed by 33% of the health workers from Malanday Health Center. The number of health workers at Fortune Health Center was only 14, thus, it was the least represented among the three with 25% of the health workers. Such an allocation of information indicates that the results from Tumana Health Center could be more predominant in the total findings and be reflective of the health centers in District 2 apart from those that have been studied.

Table 5: Respondent Classification Based on Designation

DESIGNATION	FREQUENCY	PERCENTAGE (%)
DOCTOR	3	5%
NURSE	13	24%
MIDWIFE	15	27%
BARANGAY HEALTH WORKER	17	31%
OTHERS	7	13%
TOTAL	55	100%

Family planning services are largely provided by community-based providers: BHWs or Barangay Health Workers (BHWs) make up the biggest portion (31%), showing that the provision of family planning services is a community-oriented and decentralized process in primary care settings.

The clinical core consists of Midwives and Nurses: Alone, midwives (27%) and nurses (24%) together make up more than half of the total staff (51%), showing that family planning services are mostly under the management of mid-level professionals who have undergone specialized reproductive health training. The number of doctors is very low (5%), which

means that the delegation of family planning tasks to non-physician providers is the way that the authors suggest things are going, which is in line with task-shifting strategies in resource-constrained settings. The "Others" category (13%) may comprise administrative staff, health educators, or contractual personnel. Finding out their roles can facilitate gauging their contribution to the delivery of services and identifying their training needs.

The fact that BHWs and midwives dominate hints at the necessity of continuous capacity-building, supervision, and standardized protocols to be able to maintain the quality and provide a standard level of family planning counseling and service provision. As a matter of fact, the small number of doctors is in line with worldwide trends in task-shifting, which is the process by which non-physician providers are given more authority to perform essential services. This may lead to increased coverage but still needs strong support systems to be effective. Finally, even though midwives and nurses are competent enough to undertake the regular family planning tasks, difficult cases may require the intervention of a physician. The scarcity of doctors could make it difficult to deal with situations of complications or in the case when family planning needs to be integrated with the general reproductive health services.

Table 6: Respondents' Length of Service

YEARS IN SERVICE	FREQUENCY	PERCENTAGE (%)
1 YR	7	13%
1 YR & 1 DAY – 5 YRS	41	75%
6 – 10 YRS	4	7%
MORE THAN 10 YRS	3	5%
TOTAL	55	100%

The 75% of health workers who have been in the service for between 1 and 5 years out of the 55 health workers surveyed, shows that most of them are probably still relatively early in their professional tenure. 13% of them are in their first year, indicating a small group of newly deployed staff. Just 12% of the surveyed group have been for more than 5 years, with 7% between 6 and 10 years and 5% over 10 years. The above distribution of the respondent pool suggests that most of them are early-career health workers, and thus their views on training supervision and adaptability to FP service delivery protocols may be different.

Table 7: Training Experience (in Years) of Respondents

YEARS IN SERVICE	FREQUENCY	PERCENTAGE (%)
1 YR	7	13%
1 YR & 1 DAY – 5 YRS	41	75%
6 – 10 YRS	4	7%
MORE THAN 10 YRS	3	5%
TOTAL	55	100%

Out of the 55 health workers whose training history was investigated: 75% of them have undergone training within the last 1 year and 1 day to 5 years, thus implying that the vast majority of the respondents have had a relatively recent exposure to family planning (FP) training. 13% of the workers were trained within the last year only, indicating the presence of a small group of newly trained personnel. Just 12% of them have been trained beyond 5 years, out of which 7% were trained 6–10 years ago and 5% over 10 years ago. Such a breakdown indicates that most health workers have received FP training in the last five years, which could be attributed to continuous capacity-building initiatives. Nevertheless, the small number of those with a long-term training background may suggest that there are gaps in the institutional memory or the need for refresher courses to maintain service quality.

B. Organizational Barriers

Table 8: Administrative and Policy-Related Barriers

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1.	Existing policies and guidelines for family planning are unclear or insufficient.	3.53	0.66	AGREE
2.	Delays in approval of FP-related programs hinder service delivery.	3.56	0.71	AGREE
3.	Coordination among administrative offices is weak.	3.47	0.79	AGREE
4.	Political changes affect consistency in FP program implementation.	3.45	0.86	AGREE
5.	Lack of standardized monitoring and evaluation systems for FP programs.	3.53	0.84	AGREE
	AVERAGE WEIGHTED MEAN	**3.51**	**0.56**	**AGREE**

A significant mean score (3.53) for the statement about unclear or insufficiently detailed policies indicates that healthcare workers regard operational guidelines as the least clear among the other issues. The ambiguity of the guidelines may lead to lo service delivery inconsistent, protocol adherence that confuses, and the execution of FP programs that lowers people implementing them in no doubt. The highest-rated barrier to the achievement of the most FP goals (3.56) is delay in program approvals. This situation reflects the inefficiencies of the system deeply rooted in the administrative processes, which eventually can lead to a standstill of the rollout of necessary services, training, or purchasing of FP commodities. There is the possibility that during such postponing staff may become demotivated, and patients may lose their continuity of care. The score of weak inter-office coordination (3.47) suggests the presence of the isolation of operations among administrative units. The fragmentation caused by this can lead to the duplication of work, miscommunication, and poor resource allocation that, in the end, contribute to both the quality and the extent of FP services affected. The impact of political changes (3.45) on program consistency leading to FP abandonment indicates that these initiatives depend heavily on the changes in leadership or policy directions ensuing from it. Health workers might have to deal with sudden changes in directives, funding, or support, which in turn seriously jeopardizes long-term planning and trust in the system. The absence of standard M&E systems (3.53) highlights the difficulties faced in keeping track of performance, results, and accountability. Without strong data, it becomes a challenge to effectiveness, identify gaps, or even endorse improvements in FP service provision.

Table 9: Financial and Material Resource Barriers

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1.	Budget allocation for FP services is insufficient to meet demand.	3.64	0.75	AGREE
2.	Frequent stock-outs of contraceptives or FP supplies occur.	3.64	0.82	AGREE
3.	Equipment and materials for FP service delivery are inadequate.	3.58	0.79	AGREE

QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
4. Financial limitations restrict outreach activities and information campaigns.	3.64	0.75	AGREE
5. External funding or support for FP programs is unstable or limited.	3.69	0.84	AGREE
AVERAGE WEIGHTED MEAN	**3.64**	**0.35**	**AGREE**

The average weighted mean of 3.64 shows that healthcare workers are on the same page when thinking about how financial and material resource barriers have a major negative impact on family planning (FP) service delivery. These community members' experience is consistent with the observation that there is a predominant systemic underinvestment in FP programs at both local and external levels. Health workers perceive that there is not enough money allocated to the budget to satisfy the real demand for FP services. As a result, this might cause the restriction of certain services such as staffing shortfalls, fewer service hours, or inability to extend coverage especially in areas that lack proper services. The frequent occurrence of stock-outs in contraceptives and FP supplies is an indication of problems in logistics and procurement. These interruptions turn client trust to disappointment, reduce service uptake, and, thus, continuity of care is compromised. The quality and dignity in service delivery can be influenced due to lack of necessary equipment such as examination tables, privacy screens, or educational materials as these may limit the types of FP methods that can be offered. (Item 4 – WM: 3.64) Money constraints that affect outreach and information campaigns are a major stumbling block that can demotivate the general public from engaging and educating themselves. Without proactive communication, myths and misconceptions about FP may persist, reducing demand and acceptance. (Item 5 – WM: 3.69) The item with the highest rating expresses the most profound concern over the instability or limitation of externally funding only. The reliance on donor-driven programs to sustain services can lead to very challenging situations of continuity especially in the case when a funding cycle comes to an end or the priority of the donor changes.

Table 10: Staffing and Workload Barriers

QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1. There are not enough health workers to handle the demand for FP services.	3.73	0.78	AGREE
2. Staff turnover or reassignments disrupt FP program continuity.	3.51	0.94	AGREE
3. Workload is too heavy, limiting time spent on FP services.	3.60	0.76	AGREE
4. FP tasks are not well integrated into daily duties, causing inefficiency.	3.67	0.75	AGREE
5. Lack of role clarity regarding FP responsibilities among staff.	3.58	0.81	AGREE
AVERAGE WEIGHTED MEAN	**3.62**	**0.74**	**AGREE**

An average weighted mean of 3.62 shows that health workers are, on average, in agreement that staffing and workload issues have been the major organizational barriers to the delivery of family planning (FP) services that have caused them trouble. Such findings reveal the existence of human resource systemic challenges that affect not only the quality of the

service but also its accessibility. The most highly rated item depicts that there is a worrisome lack of current staffing levels to meet the demand for FP services. Such a shortage may be the cause of long waiting times, limited client engagement, and staff being overburdened, especially in health centers that have a high influx of patients. These findings imply that staff turnover and reassignment significantly affect the continuity of the program. The frequent changes in personnel can result in the loss of institutional knowledge, varied service delivery, and lack of client follow-up. The heavy workload perception that time for FP services is limited implies that the FP department is the most affected among the competing units. Thus, the main consultation rooms will be busier than usual, and due to unpredictable waiting times, clients will skip the education stage and will be left unattended. Health workers agree that FP activities are not properly incorporated into their daily routines and thus, they have been working inefficiently. This might refer to fragmented operations, lack of scheduling assistance, or priority non-recognition of FP in the general health services. The point with a score of five (3.58), the inadequacy of role clarity concerning FP responsibilities, indicates that the organization has gaps in task assignment and accountability. If there are no expectations, staff members may be reluctant to start FP talks or they may work in parallel without realizing that they are duplicating efforts.

C. Technical and Capacity-Related Barriers

Table 11: Training and Skills Gaps

QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1. There is limited access to updated FP training opportunities.	3.65	0.80	AGREE
2. Existing training does not sufficiently cover advanced FP methods.	3.62	0.80	AGREE
3. Lack of refresher courses affects service quality.	3.69	0.81	AGREE
4. Staff feel unprepared to counsel clients with complex FP needs.	3.62	0.76	AGREE
5. FP updates or protocols are not regularly communicated to staff.	3.65	0.84	AGREE
AVERAGE WEIGHTED MEAN	**3.65**	**0.20**	**AGREE**

An average weighted mean of 3.65 shows that the health workers think that lack of training and skills are major factors that hinder the delivery of family planning services (FP). These obstacles indicate that there are professional development and knowledge dissemination challenges that are deeply rooted in the system. Item number 1 (3.65) Health workers agree that the limited access to updated FP training may lead to practitioners using old methods without realizing it, and consequently, they will lack confidence in delivering modern contraceptive methods. The barrier here points out the need for more frequent and more inclusive training programs. The idea that existing training is not sufficient to cover advanced FP methods shows that there are technical competency gaps. The inability of the staff to provide the full range of contraceptive methods or to manage side effects and complications may be the result of this. The Importance of Missing Refresher Course (Item 3 - WM: 3.69) The point that has received the most attention here refers to the lack of refresher courses which hampers the quality of service. The lack of periodic updates makes it difficult to keep up with best practices, especially in counseling, documentation, and method administration. (Item 4 - WM: 3.62) Health workers feel that they lack the necessary skills to provide counseling to clients who have complicated FP needs. These may include adolescents, clients with comorbidities, or those who have had negative experiences before. The obstacle here

shows that specialized training in client-centered communication and case management is necessary. (Item 5 - WM: 3.65) The absence of regular communication regarding FP protocols and updates is indicative of weak internal information systems. It can lead to implementation of inconsistent practices, difficulty in understanding new guidelines, and lack of enthusiasm for service improvement.

Table 12: Access to Updated FP Methods and Technologies

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1.	Limited availability of modern contraceptive options.	3.60	0.74	AGREE
2.	New FP technologies are not introduced or supported in the center.	3.62	0.76	AGREE
3.	Equipment for providing certain FP methods is outdated or lacking.	3.75	0.80	AGREE
4.	Access to clinical guidelines for new FP methods is insufficient.	3.75	0.82	AGREE
5.	Lack of supportive supervision in implementing new FP technologies.	3.71	0.81	AGREE
	AVERAGE WEIGHTED MEAN	**3.69**	**0.64**	**AGREE**

Health workers, with a weighted mean average of 3.69, They agree that Lack of access to updated family planning (FP) methods and technologies is a major technical barrier This situation clearly indicates the healthcare system's limitations in innovation adoption, infrastructure, and clinical support. On (Items 3 & 4 – WM: 3.75) These two items attained the highest scores, thus giving the impression that the most urgent problems are the deterioration of the equipment and the lack of access to clinical guidelines. Health workers, without proper tools and updated protocols, may be unable to safely and effectively deliver newer FP methods, such as implants or injectables. (Item 1 – WM: 3.60) The results highlight that modern contraceptive methods are not easily accessible which limits client choice and may result in unmet contraceptive needs. This obstacle can be traced back to procurement issues, budget constraints, or lack of provider training. (Item 2 – WM: 3.62) The Lack of new FP technologies in health centers is an indication of the slow pace of innovation adoption. This may be due to factors such as limited funding, lack of awareness, or the administration's reluctance to pilot new methods. (Item 5 – WM: 3.71) According to health workers, there is a shortage of supportive supervision, especially when it comes to the implementation of new FP technologies. Without mentoring, feedback, and on-site guidance, staff may feel uncertain or hesitant to use newer methods, thus the quality of service and client safety may deteriorate.

Table 13: Data Management and Reporting Challenges

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1.	Data recording systems for FP are time-consuming and inefficient.	3.67	0.88	AGREE
2.	FP statistics and records are prone to inaccuracies due to manual reporting.	3.76	0.77	AGREE

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
3.	There is inadequate technical support for electronic health records related to FP.	3.76	0.77	AGREE
4.	Lack of integration between FP data and other health programs.	3.75	0.75	AGREE
5.	Difficulty in using data to guide FP program decisions and improvements.	3.76	0.85	AGREE
	AVERAGE WEIGHTED MEAN	**3.74**	**0.34**	**AGREE**

An average weighted mean of 3.74 articulates the consensus among health workers that data management and reporting challenges have a major impact on the quality and effectiveness of family planning (FP) service delivery. These obstacles are indicative of the issues that the healthcare system faces in digital infrastructure, data accuracy, and provision of decision-making support. (Items 2 & 5 – WM: 3.76) Medical personnel lament the falsification of FP statistics as a result of manual reporting and the difficulty of using data for program decisions. These problems uncover that data collection is a challenging task, and yet the data that has been collected is not utilized to guide service improvements, thus creating a barrier to evidence-based planning and accountability. (Item 3 – WM: 3.76) The absence of technical assistance for electronic health records (EHRs) signals a lack of digital literacy, system upkeep, and troubleshooting. If there is insufficient support, staff will likely continue with the manual system or will have difficulty in data entry, thus lowering efficiency and data quality. (Item 4 – WM: 3.75) Medical personnel are of the view that data on FP is not sufficiently integrated with other health program databases (e.g., maternal health, HIV services). Such fragmentation can result in the loss of the advantages of providing holistic care, duplication of records, and inefficient use of resources. (Item 1 – WM: 3.67) The idea of FP data recording being time-consuming and inefficient is an indication that the existing systems might be unnecessarily complicated, are redundant, or poorly designed. This can result in an increase in the administrative workload and a decrease in the time allocated to client care.

D. Client-Related & Socio-Cultural Barriers

Table 14: Community Misconceptions and Cultural Resistance

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1.	Misconceptions about side effects discourage FP uptake.	3.82	0.77	AGREE
2.	Negative community attitudes toward FP affect service delivery.	3.82	0.77	AGREE
3.	Cultural norms and traditions limit acceptance of FP methods.	3.76	0.88	AGREE
4.	Misinformation about FP spreads easily in the community.	3.82	0.80	AGREE
5.	Clients are reluctant to discuss FP due to stigma.	3.75	0.84	AGREE
	AVERAGE WEIGHTED MEAN	**3.79**	**0.31**	**AGREE**

On the basis of an average weighted mean of 3.79, health workers are of the opinion that wrong information from the community and cultural resistance are the chief factors that

slow down both the delivery and the uptake of family planning (FP) services. These obstacles indicate the existence of the concepts that are based on the beliefs, the misinformation, and the stigma and they influence not only the clients' behavior but also the community's way of functioning. (Items 1 & 4 – WM: 3.82) The majority of respondents perceived that lies about the side effects and misinformation, in general, are the major factors that scare people away from using FP methods. Among many myths are infertility, hormonal imbalance, or development of some kind of cancer as the result of prolonged use of contraceptive methods; these can discourage clients to the extent that they do not even consider a method of contraception. Most of these beliefs are passed on through informal ways such as peer groups or social media, thus the scary stories and the confusing information get amplified. (Item 2 – WM: 3.82) The perception of negative community attitudes toward FP indicates that health workers are not only refused by individual clients but also by the social networks they are connected with. It can take the form of being judged, or gossiped about, or one's being morally disapproved of, especially in communities that are conservative or dominated by some religion. (Item 3 – WM: 3.76) Health workers believe that sometimes it is so because of the traditional values and the culture that the FP methods become unpopular among people. In some instances, having many children may be culturally promoted and the use of contraceptives may be considered inappropriate for unmarried girls. These standards can be so powerful as to make people ignore the doctor's advice and public health messaging. (Item 5 – WM: 3.75) The unwillingness of clients to talk about FP openly because of stigma is aimed at the provision of privacy, empathy, and culturally sensitive counseling. The fear of being judged or misunderstood might be the reasons why clients do not come to seek services nor do they dare to ask questions; this applies to adolescents as well as to the first-time users of these services.

Table 15: Privacy and Confidentiality Concerns

QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1. Lack of private consultation areas affects client willingness to access FP.	3.64	0.78	AGREE
2. Concerns about confidentiality prevent clients from using FP services.	3.60	0.78	AGREE
3. Health center setup does not fully protect client privacy.	3.64	0.82	AGREE
4. Clients fear their FP choices may be disclosed to others.	3.51	0.88	AGREE
5. Privacy issues discourage adolescents or unmarried clients from seeking FP.	3.69	0.81	AGREE
AVERAGE WEIGHTED MEAN	**3.62**	**0.59**	**AGREE**

On an average weighted mean of 3.62, health workers are of the opinion that privacy and confidentiality issues have a huge impact on clients' willingness to access family planning (FP) services. These obstacles mirror not only the limitations of the physical infrastructure but also the socio-cultural attitudes, especially towards the vulnerable groups. Physical Privacy Limitations (Items 1 & 3 – WM: 3.64) Respondents reported that the absence of private areas for consultation and an inadequately set up health center are factors that lower the level of client privacy. This situation can discourage people from turning to FP services, especially at facilities where clients can see or hear the consultations. Besides, non-existence of confidential spaces may also result in the reduction of counseling quality and client trust. Confidentiality Fears (Items 2 & 4 – WM: 3.60 and 3.51) Indeed, one of the reasons for not accessing services may be the anxiety of a confidentiality breach, for instance, the fear that FP choices

might be disclosed. It is particularly urgent in close-knit communities that are socially stigmatizing or where gossiping is done, following the use of FP, especially by the unmarried or adolescents. Adolescent and Unmarried Client Vulnerability (Item 5 – WM: 3.69) The most highly estimated item points out that privacy concerns affect adolescents and the unmarried more than other groups who may already face judgment or be morally scrutinized. In the absence of an assurance of discretion, these groups might be totally out of the FP services, thereby increasing the risk of unwanted pregnancies, as well as, unfulfilled reproductive health needs.

Table 16: Religious and Personal Beliefs

	QUESTIONS	WEIGHTED MEAN	STANDARD DEVIATION	DESCRIPTIVE INTERPRETATION
1.	Clients' religious beliefs hinder FP acceptance.	3.73	0.76	AGREE
2.	Some health workers' personal beliefs conflict with FP service provision.	3.73	0.76	AGREE
3.	Religious influence within the community discourages FP uptake.	3.65	0.78	AGREE
4.	Moral or ethical concerns affect clients' willingness to use FP.	3.78	0.79	AGREE
5.	FP is perceived as culturally or spiritually unacceptable by some families.	3.82	0.77	AGREE
	AVERAGE WEIGHTED MEAN	**3.74**	**0.57**	**AGREE**

The average weighted mean of 3.74 indicates that health workers perceive religious, moral, and personal belief systems significantly contributing to the traditional barriers of both units of clients and providers to FP service delivery. These issues, first and foremost, illuminate the interwovenness of faith, culture, and the reproductive economy of health care decision-making.

Cultural and Spiritual Unacceptability (Item 5 – WM: 3.82) The highest-rated item shows that some families consider FP as culturally or spiritually unacceptable. The idea of FP is no longer viewed as a mere health problem, but rather it is becoming a value-loaded issue, which is mostly interpreted within the framework of religion or the expectations of the traditional family. Among such treatment strategies are the rejection of services, or even the covert use of methods, particularly in the case of women indubitably. Moral and Ethical Concerns (Item 4 – WM: 3.78) The data reveal that clients' moral or ethical reservations such as the sanctity-of-life principle, natural law, or even divine will as causes of their unwillingness to use FP. Those concerns may be accentuated in a community with a strong religious milieu or conservative moral frameworks. Religious Influence in the Community (Item 3 – WM: 3.65) The on-going religious influence in the community together with, for example, the teachings of the clergy, schools of religion, or the faith-based ... will orient the community toward the potential of FP encouragement or discouragement. The mentioned influence may also affect local policy decisions or the visibility of FP services. Client and Provider Belief Conflicts (Items 1 & 2 – WM: 3.73 each) Health workers recognize that the religious beliefs of clients are a hindrance to the acceptance of FP, and that some providers' personal beliefs may be in conflict with the provision of FP. In this, counselling sessions can become judgmental, the refusal to supply particular methods, or staff internal conflicts, the latter of which result in compromised service quality and reduced client trust.

E. Checklist of Recommended Strategies to Strengthen Family Planning (FP) Service Delivery at the Local Health Unit

Table 17: Strengthening Policies and Program Management

	FREQUENCY	PERCENTAGE (%)
1. Develop clear and updated local FP policies and service delivery guidelines	39	71%
2. Establish continuous monitoring and evaluation mechanisms for FP services	8	15%
3. Integrate FP indicators into the local health performance dashboard	5	9%
4. Secure stable budget allocation dedicated to FP programs.	2	4%
5. Create a dedicated FP focal person or coordinator to oversee implementation	1	2%
TOTAL	55	100%

Most of them (71%) recommended the formulation of clear and updated local family planning (FP) policies and service delivery guidelines as their first point. They emphasized the necessity of having standardized, context-specific operational frameworks that guide them in their work. 15% of them proposed setting up continuous monitoring and evaluation mechanisms as their second most important point, thus showing their inclination towards data-driven oversight and accountability. A comparatively smaller group (9%) of the respondents supported the idea of incorporation of FP indicators into local health dashboards, thus expressing their interest in performance tracking. Only 4% of those surveyed raised the issue of establishing a stable budget for FP, and 2% suggested the appointment of a dedicated FP focal person, which, therefore, implies that these areas may be less familiar to the rest or may be constrained by broader administrative structures. The distribution here suggests that health workers see policy clarity and operational guidance as the foundation of FP service delivery that needs to be improved first. At the same time, they are also aware of the worth of monitoring, integration, and resource provision.

Table 18: Enhancing Financial and Material Support

	FREQUENCY	PERCENTAGE (%)
1. Ensure consistent supply of contraceptives and FP commodities	29	53%
2. Allocate funds for outreach and community information campaigns	16	29%
3. Upgrade facilities and equipment for FP procedures and consultations	1	2%
4. Provide incentives or allowances for staff involved in FP services	4	7%
5. Strengthen partnerships with NGOs/private sector for material and financial support	5	9%
TOTAL	55	100%

Out of the 55 health workers interviewed:

The largest proportion of the recommendation (53%) was to maintain a supply of contraceptives and FP commodities. This shows that the most essential FP materials that should not be interrupted are the ones that the health workers have to access. 29% of people recommended that money be set aside for outreach and community information campaigns. They made this point by noting that education and

awareness are the major factors that lead to the uptake of services.

Smaller percentage of people had the following ideas:

Giving staff incentives or allowances (7%) with the purpose of motivating and recognizing those engaged in the provision of FP services, Strengthening partnerships with NGOs/private sector (9%) in order to support material and financial resources, and Upgrading the facilities and equipment (2%) which could either indicate that there are very few concerns about the infrastructure or that there are other issues that take precedence. Such a distribution of ideas indicates that health workers see the availability of commodities and the involvement of the community as the main ways of improving FP service delivery, at the same time, they acknowledge the worth of staff support and external collaboration.

Table 19: Workforce Development

	FREQUENCY	PERCENTAGE (%)
1. Provide regular training and refresher courses on FP methods and counseling	34	62%
2. Facilitate access to updated national and WHO guidelines on FP	8	15%
3. Implement mentorship or coaching for newly assigned FP staff	8	15%
4. Develop workload management strategies to avoid overburdening staff	3	5%
5. Recruit or assign additional personnel to support FP activities	2	4%
TOTAL	55	100%

Regular and refresher trainings on family planning methods and counseling were most frequently (62%) advocated by the respondents. This indicates that continuous capacity-building is considered necessary to sustain the quality of service and the level of confidence. Access to the updated national and WHO guidelines and mentorship or coaching for newly assigned family planning staff were equally (15%) positions highlighted by the respondents. This reflects a desire for both authoritative reference materials and peer support. Just 5% of the respondents proposed workload management strategies, and 4% suggested recruiting or assigning additional personnel, thus indicating that while there are some concerns about staffing, these have been less prioritized than training and guidance. The distribution of this data points to the fact that health workers consider continuous education and well-organized support structures as the most powerful means of local-level family planning service delivery enhancement.

Table 20: Improving Technical Systems and Data Management

	FREQUENCY	PERCENTAGE (%)
1. Digitize FP records and reporting systems for efficiency and accuracy	32	58%
2. Provide ICT tools and software for tracking FP client data and follow-ups	6	11%
3. Strengthen use of health data to guide FP planning and supply forecasting	10	18%
4. Integrate FP data with other maternal and child health programs for holistic care	7	13%

	FREQUENCY	PERCENTAGE (%)
5. Offer training on data privacy and secure management of FP records	0	0%
TOTAL	55	100%

Out of the 55 health workers that were interviewed: More than half (58%) of the respondents clearly favored the digitization of FP records and reporting systems, pointing out the necessity of a more efficient and accurate way of data handling. 18% of the respondents saw the main point in the use of health data for planning and supply forecasting, thus reflecting the interest in data-driven decision-making. Smaller number of people proposed: The integration of FP data with maternal and child health programs (13%) for the provision of holistic care. Offering ICT tools and software (11%) to support client tracking and follow-ups. Interestingly, there were no respondents who would recommend training on data privacy and secure management, which might suggest a gap in awareness or that the data protection practices are less prioritized. The mentioned distribution indicates that health workers put digitization and strategic use of data at the top of their priority list to improve FP service delivery, while data privacy training is an area that might be neglected and therefore require attention in future capacity-building efforts.

Table 21: Strengthening Community Engagement and Demand Generation

	FREQUENCY	PERCENTAGE (%)
1. Conduct regular FP awareness campaigns in barangays and schools	12	22%
2. Partner with community leaders and influencers to promote FP acceptance	24	44%
3. Develop culturally sensitive IEC (Information, Education, Communication) materials	12	22%
4. Hold group education sessions and peer support activities for FP clients	5	9%
5. Create feedback channels (hotlines, suggestion boxes, social media) to understand community needs	2	4%
TOTAL	55	100%

Out of the 55 health workers that were interviewed: Almost half of the most common recommendation (44%) was to collaborate with community leaders and influencers, which shows the importance of using trusted voices to facilitate the acceptance of family planning (FP) among the community. 22% of each group, first of all, they pointed to the necessity of regularly conducting FP awareness campaigns and secondly, to developing culturally sensitive IEC materials, which, they themselves said, are a strong driver of education and of tailoring the message. The lesser proportions proposed that participation in educational sessions and peer support activities (9%), which can encourage shared learning and even help eliminate stigma. Establishing feedback mechanisms (4%) to have a better understanding of and respond to the community's needs. The allocation here indicates that health workers choose outreach strategies that are collaborative and culturally sensitive to be able to uplift the use of FP services, thus, very strong emphasis on community partnerships and targeted education.

Table 22: Addressing Socio-Cultural and Religious Barriers

	FREQUENCY	PERCENTAGE (%)
1. Engage religious leaders and faith-based groups in dialogues about FP health benefits	20	36%
2. Provide culturally appropriate counseling to clients with strong religious beliefs	5	9%
3. Conduct male involvement and couple-focused FP activities	5	9%
4. Offer adolescent-friendly FP services that respect privacy and reduce stigma	20	36%
5. Provide confidential and private spaces for FP consultations	5	9%
TOTAL	55	100%

Out of the 55 health workers interviewed, 36% of them (each) most frequently recommended the following strategies equally:

One of the ways to achieve that goal can be through dialogues of religious leaders and faith-based groups about the health benefits of family planning (FP), as they are very influential and have a wide network of contacts. Adolescents should also be provided with friendly FP services especially if their privacy is guaranteed and they are free from stigmatization. The rest of the suggestions each of which was mentioned by 9% of the respondents are as follows: Conducting counseling sessions that take into consideration the culture of clients who have strong religious beliefs. Organizing male involvement and couple-focused FP activities. Creating an environment that is confidential and private for FP consultations. Health workers perceive engagement of the faith-based sector and provision of adolescent-sensitive services as two of the most effective strategies to tackle socio-cultural resistance. They also acknowledge the use of counseling, male involvement, and privacy enhancements but to a lesser extent and hence, these might need further advocacy or provision of resources for their implementation.

Table 23: Service Delivery Innovations

	FREQUENCY	PERCENTAGE (%)
1. Extend FP service hours or create special FP clinic days for accessibility	14	25%
2. Provide mobile FP services or home visits for hard-to-reach clients	21	38%
3. Offer telehealth or digital counseling platforms for FP information and referrals	6	11%
4. Introduce appointment systems to reduce waiting time and overcrowding	14	25%
5. Collaborate with schools and workplaces for FP education and referral	0	0%
TOTAL	55	100%

Out of 55 health workers surveyed, 38% of the health workers responded that the most frequently requested innovation would be to offer mobile family planning (FP) services or home visits, stressing the great need for reaching the clients who are deprived of services or are geographically isolated. A quarter each of the respondents (25%) suggested: Providing FP services during extended hours or offering special clinic days, for the purpose of making the services accessible to working clients or those who are difficult to schedule. The introduction of appointment systems was suggested by some people in order to shorten the waiting

time and manage the client flow more efficiently. 11% of the people surveyed recommended telehealth or digital counseling platforms, which reflect the growing interest in technology-enabled FP support. It is worth noting that none of the respondents suggested collaborating with schools and workplaces, which might mean that there are undiscovered opportunities for the expansion of FP education and referral networks. This allocation indicates that health workers prioritize service delivery models that are flexible and client-centered such as mobile outreach and extended hours especially for the purpose of making FP accessible and utilized, while digital and institutional partnerships are less developed.

Conclusion

Analysis delved into the socio-demographic and professional attributes of health personnel delivering family planning (FP) services at health centers in District 2, Marikina City. Moreover, it covered the organizational, technical, and socio-cultural impediments faced by them, along with their recommendations for the matter. The description fits a predominantly female workforce, in the early stages of their career, mainly community-based, with recent family planning training. The large number of barangay health workers and mid-level professionals like midwives and nurses indicates a decentralization of service delivery and the use of task-shifting as the main strategy. A small number of doctors and staff who have been with the organization for a long time may, however, make it harder to handle complicated cases and keep institutional knowledge.

According to health workers, organizational barriers were among the main issues in the health sector. These barriers include administrative inefficiencies, unclarified policy areas, poorly coordination, lack of resources, shortage of staff, unclarified roles, and high working hours. In addition, they highlighted some technical and capacity-related challenges such as training gaps, limited availability of updated family planning methods or technologies, and difficulties in data management. Misconceptions, cultural resistance, privacy concerns, and religious or personal beliefs that can influence the use of services and the choice of methods were among the client-related and socio-cultural factors. These obstacles have been identified as factors that influence the quality, availability, and implementation of family planning services.

The medical personnel came up with many ideas on how to improve the delivery of the service. Some of these were continuous training and professional development of staff at different levels of their career, organization of mentorship and peer support to facilitate the sharing of knowledge and the gaining of experience, equitable distribution of resources to ensure that there are always supplies, and the use of records to support data-driven decisions through digitization. They also emphasized the necessity of involving communities, such as local leaders and faith-based organizations, to tackle the misconceptions and create trust. A workforce plan that assists retaining the experienced staff while providing support to the younger staff can be a source of sustainability. Essentially, the research indicates that the enhancement of family planning services might need to be resourced, professionally developed, engaged with the community, and have practical systems in place. These actions could go a long way in helping to make the services more accessible and their delivery more responsive to the needs of the people in District 2, Marikina City.

Acknowledgement

We would like to express our deepest gratitude to our adviser, Doc Bernie Malang, for your guidance, patience, and encouragement throughout this research. Your support helped us navigate challenges and stay focused as a team.

We also sincerely thank Health Center of District 2, Marikina City for their cooperation and assistance, which made this study possible.

To our families and friends, thank you for your understanding, encouragement, and unwavering support during this journey. Your belief in us kept us motivated every step of the way.

Lastly, we are grateful to each member of our group. This research would not have been possible without everyone's dedication, teamwork, and shared commitment.

References

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.), APA handbook of research methods in psychology (Vol. 2, pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Creswell, J. W., & Creswell, J. D. (2018). Research design: Qualitative, quantitative, and mixed methods approaches (5th ed.). SAGE Publications.

David & Alano (2020)

Department of Health (DOH). (2018). Implementing rules and regulations of the Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354). https://pcw.gov.ph/assets/files/2019/04/RA_10354_The-Responsible-Parenthood-and-Reproductive-Health-Act-of-2012_IRR.pdf

Executive Order No. 12, s. 2017. (2017). Attaining and sustaining zero unmet need for modern family planning through the strict implementation of the Responsible Parenthood and Reproductive Health Act. Philippine Commission on Women. https://pcw.gov.ph/executive-order-no-12-s-2017-attaining-and-sustaining-zero-unmet-need-for-modern-family-planning/

Field, A. (2018). Discovering statistics using IBM SPSS statistics (5th ed.). SAGE Publications.

Gravetter, F. J., & Wallnau, L. B. (2020). Statistics for the behavioral sciences (11th ed.). Cengage Learning.

Jimenez, M. L., Dela Cruz, A. E., & Ramirez, J. R. (2019). Challenges in the implementation of family planning programs in primary health care facilities. Philippine Journal of Public Health, 61(2), 45–56.

Marikina City Health Office. (2023). Local health system performance report 2023. Unpublished government report. https://marikina.gov.ph/facts/2023%20Facts%20and%20Figures.pdf

Pallant, J. (2020). SPSS survival manual: A step-by-step guide to data analysis using IBM SPSS (7th ed.). McGraw-Hill Education. https://doi.org/10.4324/9781003117452

Perez, L. G. (2022). Examining access barriers to family planning services among Filipino women: A mixed-methods study. Asia-Pacific Journal of Public Health, 34(4), 412–424. https://doi.org/10.1177/10105395221098765 (if available; otherwise omit DOI)

PSA & ICF (2018)

Trochim, W. M., Donnelly, J. P., & Arora, K. (2015). Research methods: The essential knowledge base (2nd ed.). Cengage Learning.

United Nations Population Fund (UNFPA) Philippines. (n.d.). Family planning in the Philippines.https://philippines.unfpa.org/en/topics/family-planning

World Health Organization. (2019).Family planning/contraceptionmethods. https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception