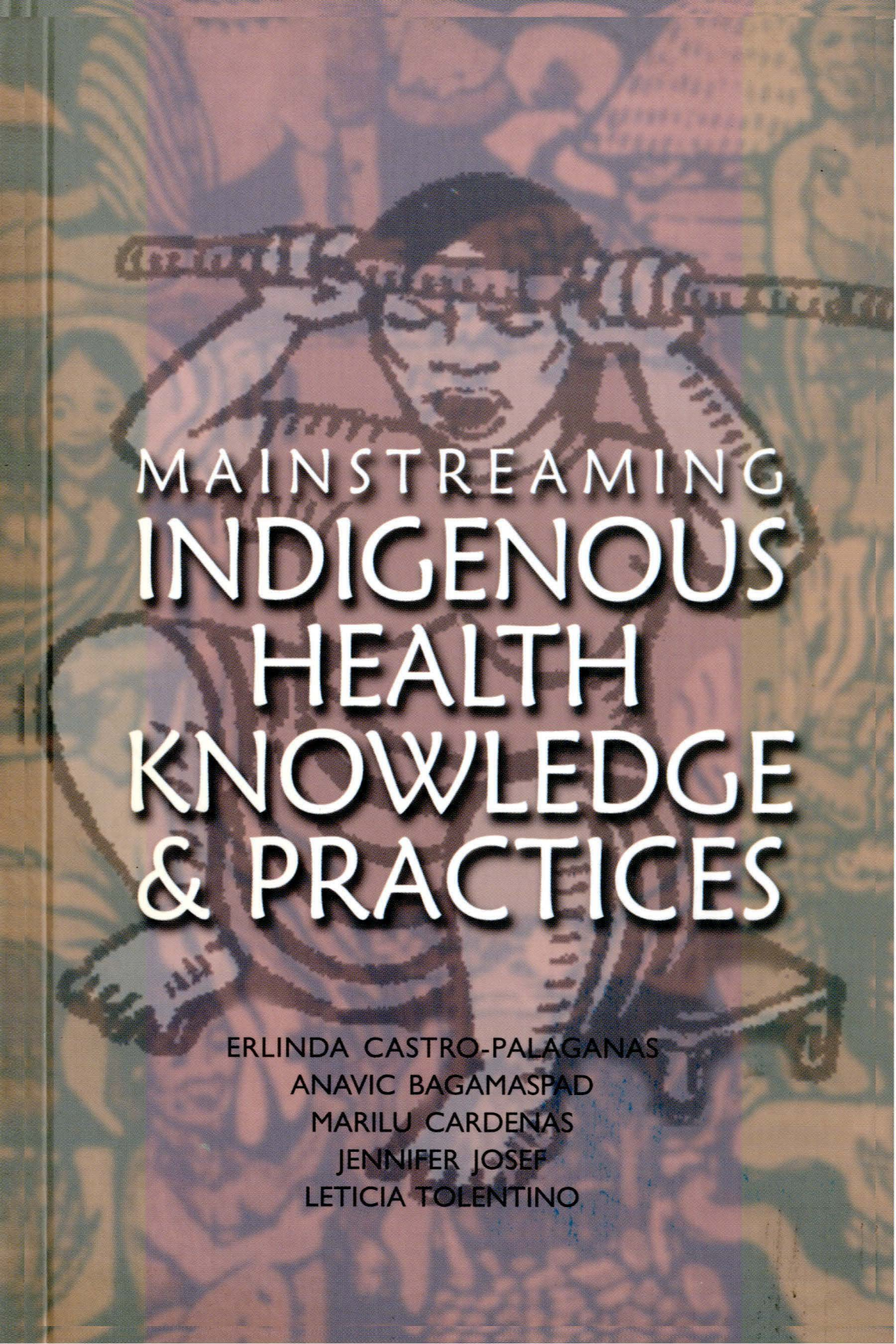




MAINSTREAMING INDIGENOUS HEALTH KNOWLEDGE & PRACTICES

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Let us all learn from the results of this study for a better life and a more efficient delivery of healthcare services, not only to the people of Badeo, Kibungan, Benguet, and the Cordilleras, but to the entire country as well!

PREFACE

Primary healthcare is an important facet of health delivery systems especially in developing countries like the Philippines where the rural sector constitutes the majority of the population and where primary healthcare delivery is inadequate. Social services hardly reach indigenous communities because the delivery of social services in developing countries conforms to the trickle down character of orthodox economic development paradigms. Thus, indigenous peoples (IPs) have to rely on their own health knowledge and practices.

Mainstreaming Indigenous Health Knowledge and Practices was conceived as a response to the urgent need to capture and document indigenous health knowledge and practices before the influx of modernity into indigenous communities undermines and obliterates these practices. One of the indigenous communities threatened by modernity are the Cordillera communities. These highland communities are increasingly drawn into the orbit of mainstream Philippine culture which draws heavily from Western culture.

In the area of health, the national government has instituted a health delivery system that principally purveys a Western medical approach. Unfortunately, government have been not too effective in the delivery of healthcare especially in far-flung communities, delaying the incursion of Western medicine into the Cordillera villages. However, medically sound indigenous health knowledge and practices still face the threat of oblivion as younger generations are secularized and modernized rather than socialized into their indigenous culture.

The study focuses on indigenous notions of health or *kasalun-atan* and women's life cycle with emphasis on women's health. This is especially relevant because as bearers of culture, women, especially indigenous women, have a comparative advantage over all others in the area of health knowledge and practices.

In this study, women's health includes such concepts as sexuality, reproductive health, childcare, nursing the sick, home remedies, and healing rituals. Women's health is explored in relation to gender division of labor and women's reproductive, productive, and community managing roles. Also covered are the larger socioeconomic, political, and cultural structures integral to the concept of health.

The study specifically aims to: (1) identify the concepts of health and illness of Kankana-ey women in Badeo, a Cordillera community; (2) identify the health knowledge and practices of indigenous women of that community; (3) validate these indigenous knowledge and practices; and (4) propagate the indigenous knowledge and practices as valid, feasible, and practical practices. Validation entails probing the participants' viewpoint on the soundness of the knowledge and practices and identifying the rational-scientific basis of these practices.

We deemed it necessary to employ various analytical lenses given the complexity of examining the phenomenon of health within a feminist participatory research. We analyzed this using the following approaches:

- (1) the primary healthcare approach, contextualized against the larger backdrop of macro-social structures such as the role of multilateral finance and development institutions like the International Monetary Fund (IMF) and the World Bank (WB), their structural adjustment policies that impact on the situation of people, particularly the health situation and programs of these countries;
- (2) the indigenous peoples and their rights;
- (3) indigenous health knowledge and practices;
- (4) gender roles and women's multiple roles; and,
- (5) the life cycle approach.

Data collection methods include key informant interviews, focus group discussions (FGD), life histories, and review of secondary data.

The study shows that aside from working in the *talon* and *uma*, engaging in *por dia* work, and busying themselves with their duties at home, Kankana-ey women are also healers. They are *mambunongs* or traditional healers, who perform prescribed rituals to ensure the health and well-being of members of the community.

The concept of health of the people of Badeo is integrally related to their cosmological belief system. They believe in the existence of unseen beings and spirits who possess the power to grant good fortune or to inflict evil such as diseases. Human beings can appease the spirits by way of rituals and sacrificial offerings of animals like pigs and chickens.

These indigenous health knowledge and practices continue to persist despite the inroads made by modern medicine. Many of these beliefs are

valuable while some may be harmful. Often, it is difficult to distinguish harmful superstitious beliefs from useful and scientific ones. It would be helpful if researchers and health practitioners keep an open mind in assessing the value of these indigenous health knowledge and practices. We propose that conventional medicine and indigenous health knowledge and practices be recognized as components of a holistic health approach.

Chapter 1

INTRODUCTION

There is a growing concern over the health needs of indigenous peoples among policymakers and service providers throughout the world. These policymakers and service providers recognize the necessity and moral imperative to develop services appropriate to multicultural communities. The Philippines, home to more than 4 million indigenous peoples belonging to more than 60 distinct ethnolinguistic groups, also recognizes the diversity of these groups. Majority of the indigenous Filipinos found throughout the archipelago live in the mountains or near the sea. They comprise a range of cultures, languages, religions, and lifestyles.

In the Cordilleras, indigenous peoples number more than a million. They are collectively known as Igorot, which literally means, those of the mountains. They belong to seven major ethnolinguistic groups within which are numerous subgroups. The major ethnolinguistic groups are the Isneg, Tinguian, Kalinga, Bontok, Kankana-ey, Ibaloi, and Ifugaw. At least five smaller groups occupy the Cordillera's lowland borders: Balangao, Amduntug, Ikalahan, Apayao, and Gaddang.

The National Consultative Meeting on Research on the Health of Marginalized Filipinos held in July 1997 concluded that there is a big gap in knowledge on the health of marginalized communities in the Philippines. Indigenous peoples belong to the marginalized sectors of society. Typically poor and powerless, they continue to occupy the peripheries of mainstream society's consciousness. This situation translates to the lack of access to basic health services. In this research, health and illness of the indigenous peoples (IPs) are seen as directly related to their marginalized situation.

The World Bank (WB) Operational Manual Directive 4.20 on IPs, describes indigenous peoples as social groups with a social and cultural identity distinct from the dominant society which makes them vulnerable to abuse. The label "IP" was adopted because it carries fewer pejorative connotations. It aims to demonstrate the common struggle of these peoples for the recognition of their right to ancestral domain and self-determination. Indigenous peoples are characterized as having the following attributes:

- (1) close attachment to ancestral territory and to the natural resources in these areas;

- (2) self-identification and identification by others as members of a distinct cultural group;
- (3) an indigenous language often different from the national language;
- (4) presence of customary social and political institutions; and
- (5) primarily subsistence-oriented production.

Walpole (1999) defines Filipino IPs as “a group of people or homogeneous societies identified by ascription and inscription by others, who have continuously lived as an organized community on communally bounded and defined territory, and who have, under claims of ownership since time immemorial, occupied, possessed, and utilized such territories, sharing traits, or who have, through resistance to political, social, and cultural inroads of colonization, non-indigenous religions and cultures, became historically differentiated from the majority of Filipinos.”

Martinez Cobo (1996), in the meantime, defines IPs “as indigenous communities, peoples, and nations which, having a historical continuity with pre-invasion and pre-colonial societies that developed, consider themselves distinct from other sectors of the societies now prevailing in those territories. At present they comprise the non-dominant sectors of society who are determined to preserve, develop, and transmit to future generations their ancestral territories, and their ethnic identity as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions, and legal systems.”

Corpuz (1998) says that based on international law, indigenous peoples stake the following claims:

- (1) the right to ownership and control of their territory—IP ancestral land rights are recognized in Article 11 of ILO Convention 169;
- (2) the right to self-determination—recognized in the International Covenants of Civil and Political Rights and of Economic, Social, and Cultural Rights; and
- (3) the right to represent themselves through their own institutions—recognized in Article 2 of ILO Convention 169.

Despite international law’s recognition of their rights, the IPs continue to suffer from disenfranchisement and oppression. Corpuz (1998) observes that in many countries, IPs find themselves subject to:

- (1) government policy that discriminates against them; and
- (2) deeply entrenched prejudices that underpin the disenfranchising policies of the government denies them the rights to ancestral domain. This stems from the conflict between customary law and ancestral domain rights on the one hand, and state laws and private property rights on the other.

The indigenous peoples of the Cordilleras continue to face threats to their survival from attempts of big business and the state to encroach on their lands. The Cordilleras has been identified as a "resource base." Time and again, people have been asked to sacrifice their welfare for the supposed benefit of the majority. This meant surrendering thousands of hectares of ancestral lands to logging and mining corporations, resort projects, geothermal projects, and several mega dam projects. The government claims the legal right to evict all the inhabitants of areas covered by the development programs. Sadly, it still does not recognize the customary rights of indigenous people to their ancestral lands (Okubo 1991; CDP 1993; Palaganas 1996).

But it is not only their ancestral rights that are being trampled upon. Other factors also serve to disadvantage the people of Cordillera by stopping them from participating in the mainstream economy. Some of these factors are the deplorable conditions of farm-to-market roads, poor flow of market-to-farm information, inaccessibility of credit, and the inadequacy or inappropriateness of government extension services in agriculture and forestry. Furthermore, public education is substandard, while private education and medical care, where these can be had, are extremely expensive.

Both private and public health services do not reach the majority of villages in the Cordillera interiors. The health situation thus continues to be plagued by malnutrition, high infant mortality, poor environmental sanitation, high incidence of communicable diseases, lack and poor distribution of health personnel and facilities, and the prohibitive cost of healthcare. Jalal (1998) characterizes the failure of government to effectively deliver healthcare as "social exclusion" which is defined as "a process through which individuals or groups are wholly or partially deprived of full participation in the society in which they live."

Evidence suggests that within marginalized sectors, women are most affected by crisis and the inadequacies of government in terms of healthcare

delivery. Ang and Antonio (1995) claim that as the economy collapses, poverty becomes largely feminized. The impoverishing effects of the economic crisis intensify the multiple burdens of women. Their role in production is increased, limiting further the little time they have for themselves. On top of everything are their household chores that reduce further their time for rest. This inevitably affects their health (See and Tauli-Corpuz 1990). Women also have to perform traditional roles as wife, mother, and/or sister even when they are working outside of the community or overseas.

Moreover, a large majority of women have absolutely no control over their reproductive functions. The right to have or not to have children is dictated by conditions, such as the need for labor power, security in old age, religious and traditional beliefs, and male chauvinism. And yet, the use of contraceptives, when available, is largely the responsibility of women. Often, women, especially those in the rural areas, are left with no choice but to have as many children as possible because of the high rate of infant mortality and lack of appropriate birth control methods.

Furthermore, according to Pizurki, *et al.* (1987) women play a greater role in the delivery of health than men, even predating the emergence of modern healthcare. As mothers, grandmothers, wives, daughters, and neighbors, they serve as the principal providers of informal healthcare in families and communities. They are also traditional birth attendants, often doing this without compensation. They pass on their health knowledge and practices to their children and to the community.

Carpenter (in Pizurki, *et al.* 1987) describes the responsibilities of women as providers of non-formal healthcare as: making/taking decisions concerning healthcare of family members; rearing children on health sustaining attitudes and behaviors; producing, selecting, preparing, and distributing the family's food; providing health services at home for convalescent, chronically ill, and disabled members of the family; keeping family histories; identifying illness; escorting the sick for necessary care; and providing nursing care, physical therapy, and first aid.

Despite voluminous information on the multiple roles of women in healthcare, there still is a dearth of information, globally, on the following areas: the informal healthcare provided within the family; the preparation of women to provide such care effectively; how burdensome they find this aspect of their family responsibilities; and how much help they receive from their spouses and significant others.

This study focuses on the indigenous Cordillera notion of health or *salun-at*. Other areas integral to health, such as the socioeconomic, political, and cultural structures are also covered by the study. Health, particularly women's health, is related to women's reproductive, productive, and community-managing roles that last the entire life cycle. Topics include sexuality, reproductive health, childcare, caring for the sick, home remedies, and cure rituals. By conducting this research, we hope to contribute to the preservation and popularization of the sound indigenous health knowledge and practices of the people of Badeo, Kibungan, Benguet.

The growing concern and recognition of the health needs of indigenous peoples has led to the deeper understanding of the diverse health behaviors, perceptions, and needs of various indigenous communities. Among the concerns being addressed by the Cordillera Studies Center of the UPCEB is the recognition of the indigenous culture of the Cordillera communities and recognition of the role of women in society and culture. These two concerns came together in the inquiry on our particular role of Cordillera women as culture-bearers, specifically of health knowledge and practices.

SIGNIFICANCE OF THE RESEARCH

Primary healthcare is an important area of health delivery systems, especially in developing countries like the Philippines, where the rural sector constitutes the majority of the population. According to the World Health Organization (WHO), the notion of extending health services to the people in an isolated, sectoral approach should be abandoned. The WHO rejects the claim that there are "technical fixes" to the problems of health in the developing world (Djukanovic and Mach 1975 in Bloom 1987):

The enthusiastic application of new knowledge and technology has not always achieved the results expected, and some of the consequences have been untoward. In sum, history and experience show that conventional health services, organized along "Western" or other centralized lines, are unlikely to meet the basic health needs of all people...

The value of indigenous health knowledge and practices as an alternative to mainstream healthcare services becomes paramount in light of government's inadequate health care delivery mechanisms. With the trickle down character of orthodox economic development paradigms in developing

countries such as the Philippines, the benefits of social services hardly ever reach indigenous communities. Thus, indigenous peoples have to rely on their own knowledge and practices related to health. Indigenous health know-hows have been proven to embody valid health properties; therefore, it should be propagated and used. Such an approach makes health services appropriate and accessible. This research attempts to contribute to primary healthcare initiatives for the improvement of the delivery of healthcare services.

National Study Group on the Health of Marginalized Communities

The National Study Group on the Health of Marginalized Filipinos was formed by the University of the Philippines Manila (UPM) in coordination with the Essential National Research Program of the Department of Health (ENHRP-DOH), and the Philippine Council for Health Research and Development (PCHRD). This is to facilitate the process of collaborative and multidisciplinary research. The group has found that studies on marginalized communities have not been comprehensive, thus the dearth of information on certain aspects like health. The group, therefore, has identified the health of marginalized groups and communities in the country as the focus of its research.

This research is a contribution towards this national research agenda for marginalized communities, particularly indigenous communities.

Research and the Recognition of the Role of Women in Society

The paradox of it all is that while women contribute immensely to the provision of healthcare, their contribution to health development is frequently undervalued. The importance of women's contribution to the health and welfare of individuals, families, and societies has gone largely unrecognized.

The data we have gathered will serve as bases for government and non-government agencies in planning services for women in general, and indigenous women in particular. This study views women not as sources of

health problems that require special programs such as maternal and child healthcare, family planning, nutrition, and the like. In this research, women are seen as resources for the solution of society's health problems.

Traditional and Alternative Medicine Act of 1997

The results of the study can lead to the integration and popularization of traditional and alternative medicine. The study contributes to the better understanding of traditional medicine: how they should be used, its general actions, side effects, and dangers that may accompany their use. Findings here will serve as supporting data to the Alternative Medicine Act of 1997.

Challenge to Healthcare Planners and Providers

Study of indigenous health knowledge and practices remain few and concentrated in anthropological and social science circles. The understanding of their culture remains a challenge to health workers tasked to serve them in culturally congruent ways by planning and organizing appropriate activities for the indigenous peoples in general and women in particular.

The results of the study will serve as inputs to program and policy planning by policymakers at the Commission on Higher Education (CHED). The results could as well be used by decision-makers in the academe of health and health-allied disciplines to make their curriculum culture-sensitive. It can also be used in the conduct of culture assessment and culturally congruent healthcare services.

The study, in attempting to identify beneficial, effective, and neutral indigenous health knowledge and practices, will reinforce and integrate such practices into mainstream healthcare delivery system. Harmful practices will be recommended for modification or discontinuation based on the acceptance of the people of Badeo.

TARGET BENEFICIARIES

In qualitative research, significance is synonymous to transferability of the findings of the study. Streubert and Carpenter (1995) say that transferability or significance refers to the “probability that the findings of the study have meaning to others in similar situations.” This contributes to the rigor of the study. Greene, Lincoln and Guba, and Sadelwoski, (in Streubert and Carpenter 1995) claim that the expectation for determining whether the findings fit or are transferable rests with the potential user of the findings and not with the researcher. Although the transferability or the significance of qualitative studies depends on the potential end-users, this study may benefit:

- (1) Healthcare providers (professionals and policymakers) who can have a clearer understanding of the health and healing practices of indigenous peoples, particularly women. This can lead to their adoption of culture-friendly and cost-effective healthcare delivery for them;
- (2) Village health workers, government and non-government health professionals, and private individuals who may gain insights from the research;
- (3) Future researchers, as well as students interested in qualitative research methods who can learn from the process documentation materials and research journals (e.g., notebooks on researcher self-reflexivity and research methodologies) of the researchers; and
- (4) Indigenous women whose voices were heard and their role in the promotion of good health recognized when they participated in this research. The women and the community of Badeo can also benefit from the study through the direct feedback/validation activities where their experiences, knowledge, and practices were processed. As such, their role as culture bearers and change agents were recognized and given premium.

RESEARCH OUTPUTS

Since the project is designed as a participatory research, the activities undertaken during the project period were an integral part of the output of the research. The goal was the mutual consciousness-raising of both researchers and the participants of the research, the indigenous women of Badeo, Kibungan.

The AAG-I TAKO ED BADEO, a scholarship program intended for the young people of Badeo, was also founded. Since education was identified as one of the limitations of young women and men of Badeo, this project was established as a joint undertaking with the barangay and municipal officials. At present, there are two high school scholars and two college scholars being funded by the program.

Since consciousness-raising is expected to be reciprocal, outputs relevant to the research team include process documentation materials and research journals.

An unplanned output of the research are two documentary videos that highlight the medical knowledge and practices of the community. The videos also validate the indigenous practices and outline the research methodology. We came up with the video after we brought a video camera for documentation purposes in one of our later immersions in the community. Interestingly, we neither had the training nor the experience in handling a video camera. Before our fieldwork, one of us had a quick instructional session on how to operate the video camera. We then proceeded to shoot some footages while we were conducting our research in the community. We did not really intend to come up with a video presentation. It was much later that we decided to include a video documentation component in the research. Eventually, we hired a professional videographer to accompany us in our community immersion.

Given these limitations, it is expected that the technical quality of the video leaves ample room for improvement. Moreover, the sheer physical exhaustion from trekking up and down the mountains, lugging our heavy packs and equipment has affected the quality of our video work. Despite this, we felt that the video documentaries will still serve as useful information and education materials. Thus, despite the technical limitations, we are hopeful that the videos can contribute to the efforts of popularizing and

mainstreaming validated health practices and enhancing research methodologies.

The two video documentaries are: 1) *The Lives and Roles of the Women of Badeo, Kibungan or Biag Ken Akem Dagiti Babbai iti Badeo, Kibungan, Benguet*; and 2) *Indigenous Health Knowledge and Practices of the People of Badeo, Kibungan or Nainsigudan nga Kaamuan ken Aramid Panggep ti Salun-at Dagiti Tattao iti Badeo, Kibungan, Benguet*.

Chapter 2

OVERVIEW OF THE RESEARCH SITE

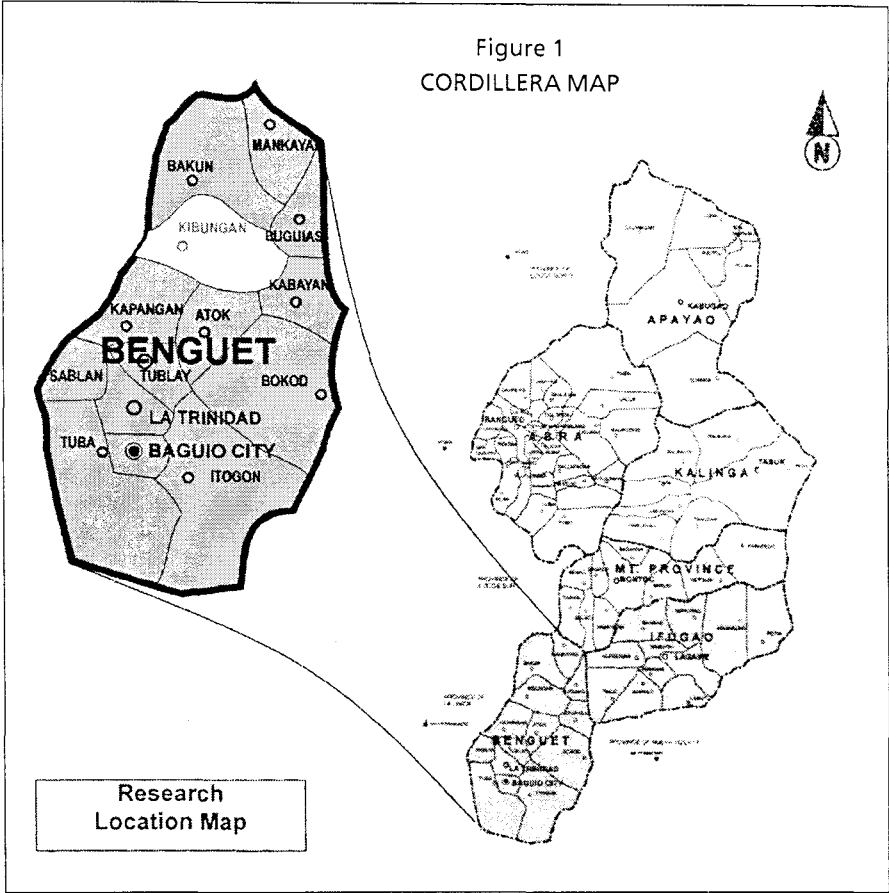
Badeo is located in the municipality of Kibungan in the province of Benguet. Historical records show that the municipality of Kibungan was one of the 31 original *rancherias* of *Distrito de Benguet* during the Spanish regime. *Distrito de Benguet* belonged to the mountain region districts organized into six *Commandancias Politico Militar* by a Spanish commandant named Don Guillermo Galvey on 25 November 1864. During the American Occupation, Benguet became the first Philippine civil government by virtue of Philippine Commission Act Number 48 enacted on 22 November 1900. This Act made the organization of local civil governments in the townships of Benguet possible. Meanwhile, Philippine Commission Act No. 49, enacted on 23 November 1900, allowed a civil government to be established in the province of Benguet.

Nineteen townships made up the Province of Benguet when Benguet was still a sub-province of the Mountain Province. The enactment of Commission Act No. 2877 on 4 February 1920 abolished and merged some of the townships and the sub-province of Benguet, leaving 13 towns all in all. In 1983, the 13 towns were later renamed into the 13 municipal districts.

The municipality of Kibungan is one of the municipalities of Benguet (Fig. 1). Oftentimes referred to as the Switzerland of the Philippines, it boasts of scenic, steep, rocky, and mountainous terrain. Oral tradition has it that the name Kibungan was derived from the sound of the gong. Another states that the word was derived from a certain species of monkeys—the native term for which is *kibung*—that inhabited the lofty virgin forests years ago.

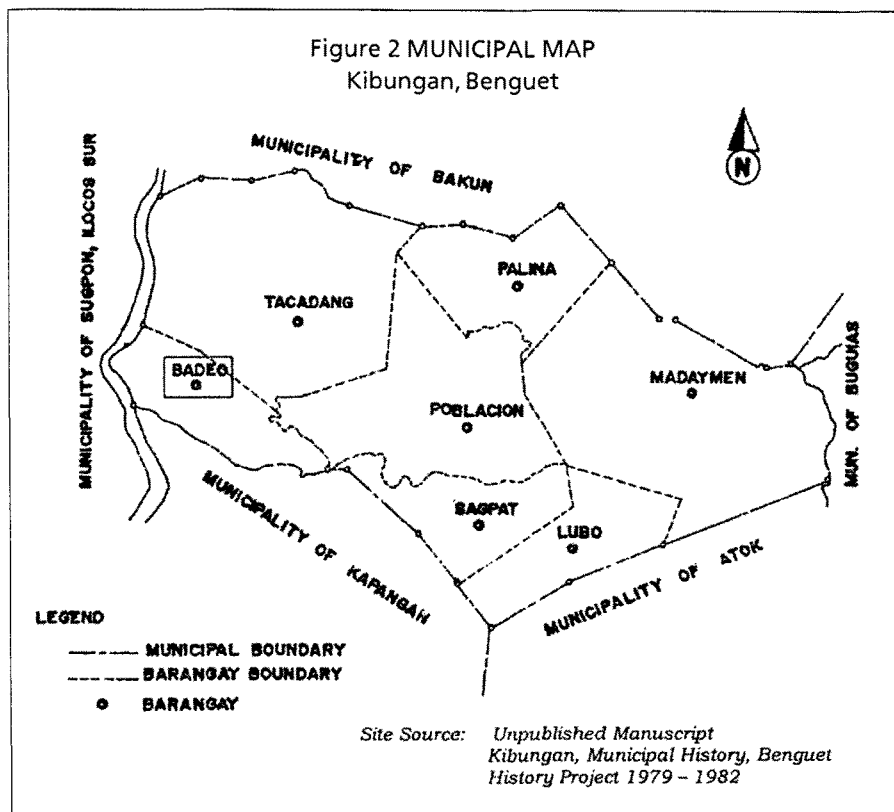
The municipality of Kibungan lies in the northwestern side of Benguet Province. It shares its boundaries in the north with the municipality of Bakun and Mankayan, in the south with the municipalities of Kapangan and Atok, in the east with the municipality of Buguias, and in the west with the Province of La Union and Ilocos Sur.

The municipality is divided into seven barangays—Badeo, Lubo, Madaymen, Palina, Poblacion, Sagpat, and Takadang (Fig. 2)—separated by deep ravines and rivers.



TOPOGRAPHY AND LAND USE

Barangay Badeo (Fig. 3) is located at the Southwest part of Poblacion, Kibungan. It is 20 kilometers away from the poblacion-proper and 17 kilometers away from Acop-Kapangan-Kibungan National Highway, the main route going to the barangay. Badeo shares its boundaries with two other barangays in Kibungan, one barangay in Kapangan, and another in La Union: Tacadang to the northwest, Poblacion to the east, Kapangan to the south, and La Union to the west. Badeo is one of the most remote barangays in Kibungan and can only be reached by a difficult six to seven hour trek up and down rugged mountains in the Cordilleras.



Badeo's terrain is basically mountainous and hilly, with flat areas used for *uma*, swidden farms, and small gardens. People do not use their land for large-scale planting or gardening. Produce is difficult to transport from the farm to the market due to the rough and craggy roads. Grazing is also uncommon because some grass species are unfit for cattle consumption.

The people of Badeo practice swidden farming. They burn portions of the forest twice a year for use as agricultural land. After the fertile soil of the *uma*¹ becomes infertile, it is left fallow for three years. After this period, the land can be worked on again.

Swidden farmers move from place to place within their own lands or they rent land to till from other landowners. In preparing the *uma*, trees and *runo* (*Miscanthus Floridulus*, a common plant used for a variety of purposes) are slashed and burned. The *uma* has an average size of a basketball court. Almost all people have their own *uma*.

Badeo produces its own food. In one *uma*, a variety of crops are planted. One side can be planted with beans and other vegetables while *camote* is planted on the other. The primary root crop and staple food in Badeo is *camote*. It is raised in Central Badeo and in Tableo but not as much in Mocgao where the weather is warmer. *Camote* dries up and rots easily in hot weather. Another root crop is *gabi*. Vegetable crops raised are *kardis*, *patani*, Baguio beans, ginger (specifically in the Mocgao area), and squash. Fruit bearing trees include avocados and bananas.

The people of Badeo still engage in traditional forms of subsistence agriculture, with rice as the main crop grown on irrigated terraces/paddies and swiddens. However, rice production levels are low and insufficient for local consumption. This is due to a variety of factors such as climate, elevation, and terrain. Rice, as part of the harvest, is bartered for other household needs and for social obligations during deaths and other community occasions.

People earn from selling agricultural products. Market days for the community are Wednesdays and Saturdays when crops are brought to the public market in Saddle. If prices are low, people do not sell their crops; instead, they use their products for home consumption. Apart from the sale of crops, cash is generated by entry to casual jobs, *purdiya* [corrupted form of the Spanish *por dia* or daily wage] in places such as Buyagan, La Trinidad, or Baguio City.

Comboy or carrying baggage and vegetables along the mountain trail where large gardens are located, also generate cash. People who engage in *comboy* go to places like Bineng, Madaymen, or Abatan in Buguias, a neighboring municipality.

Badeo residents engage in basket weaving. They also make *kayabang*—a basket carried at the back and held by a rope around the forehead—and *bilao* which they sell for profit. People also raise backyard livestock like hogs, cattle, goats, and chickens.

Finding a source of income is still largely a male responsibility. There are very few women who set out to find work. These are usually younger, unmarried women. However, some Tableo women also work as *comboys*. Surprisingly, although the work is physically taxing and requires much muscular strength, these women have the reputation of being good *comboys*.

Husbands of women with small children are the ones who find work in places outside Badeo. Unmarried men fend for themselves, usually working

por dia. Elderly people without children take care of their own needs. Relatives take on the responsibility when the old folks become too old to fend for themselves.

Table 1 presents the common occupations in Badeo. The data shows that the major source of livelihood of families in Badeo is agriculture or subsistence farming. Sixteen percent are non-agricultural or service workers or those who work in offices, teachers, baby sitters, storekeepers, barangay officials, and community health workers. Most often, these service workers also work in the farm but only on a part time basis. A predominantly agricultural community, there are no industries in the community.

TABLE 1
Common Occupations of Families
Badeo, Kibungan
1997

TYPE OF OCCUPATION	NUMBER OF FAMILIES	PERCENTAGE
Agricultural workers	140	84
Service Workers	27	16
Industry	0	0
TOTAL	167	100%

Source: *Kibungan Municipality Profile, 1997*

In 1992, the Provincial Planning and Development Office conducted a field survey in Badeo where it was found that the labor force in 1980 increased from 365 to 391 in 1990. Only 26 workers or 7.12 percent were added to the work force in a span of 10 years. This increase in 1990 implies an increasing need for employment in the barangay.

Table 2 reveals that in 1997, 95 percent of the residents primarily derived their livelihood from farming; three percent from salaried occupations, and two percent from business and livestock raising. Subsistence farming, the main source of livelihood, often cannot sufficiently provide for basic needs such as clothing, health needs, and other food supplements and

family needs. Poverty forces the people to find ways to generate more income. Income is thus augmented through seasonal labor such as *comboy*, and moving out of the community to work in commercial farms in other parts of the province. Those who remain on the farm are left with no choice but to work harder.

TABLE 2

Principal Sources of Livelihood
Badeo, Kibungan
1997

SOURCE OF LIVELIHOOD	PERCENTAGE
Farming	95
Wage and Salary Occupations	3
Business and Livestock Raising	2
TOTAL	100%

Source: *Kibungan Municipality Profile, 1997*

Table 3 reveals that 90 percent live below the poverty line. This supports the finding that majority of the households depend on subsistence farming as their main source of livelihood. This is not to say that being a farmer necessarily makes one poor. In Badeo, crops are usually for the farmers' own consumption since marketing these products is often difficult. Sometimes, when the prices of these crops are high, they are brought to Saddle to be sold. There is no road leading to Badeo and the nearest access to public transportation is in Saddle, Sagpat. It takes residents four to six hours to reach Saddle by foot.

Furthermore, Badeo has no public or private market. Only a *sari-sari* store in Sitio Cabutotan caters to the immediate needs of the residents. People secure other needs from markets in Saddle, La Trinidad, Baguio, or La Union.

TABLE 3

Income Level of Families
Badeo, Kibungan
1997

INCOME LEVEL (Php)	NUMBER OF FAMILIES	PERCENTAGE
Less than 2,000.00	151	90
2,000.00 – 2,999.00	9	6
3,000.00 – 3,999.00	2	1
4,000.00 – 4,999.00	2	1
5,000.00 & above	3	2
TOTAL	167	100%

Source: Kibungan Municipality Profile, 1997

POPULATION FIGURES

In 1990, the total population was 779 with the computed population density at 0.23 persons per hectare. In 1997, the total population slightly grew to 926, with a population density of 0.28 persons per hectare.

Table 4 indicates that 54 percent of the population are males and 46 percent females. On the other hand, 30 percent of the total population belong to the economically dependent 5-14 age bracket while eighteen percent belong to the 0-4 years age bracket. Forty two percent are economically productive adults aged 15-49 years. The remaining 10 percent are people 50 years old and above. This data gives an idea of the size of specific groups covered by special health programs like maternal and child health programs, control of communicable diseases, etc.

TABLE 4
Population According to Age-Sex Distribution
Badeo, Kibungan
1997

AGE GROUP	MALE		FEMALE		TOTAL	
	N	%	N	%	N	%
Less than 1 year	17	2	14	2	31	3
1 – 4 years	76	8	65	7	141	15
5 – 6 years	53	6	33	4	86	9
7 – 14 years	96	10	93	10	189	21
15 – 49 years	207	22	182	20	389	42
50 – 64 years	30	3	28	3	58	7
65 years & above	17	2	15	2	32	3
TOTAL	496	54%	430	46%	926	100%

Source: *Kibungan Municipality Profile, 1997*

Table 5 shows that 85 percent were able to obtain an elementary education, 29 percent finished secondary schooling, while 17 percent are out-of-school youth. The major constraint to attendance in elementary and secondary schools is the terrain of Badeo. In some *sitios*, children have to hike one to two hours to reach the school. Classes with multi-grade levels are held, either due to lack of students or teachers. Going to high school means having to live away from the family and community since the schools are half a day to a day's hike away. Slightly more females (109) than males (90) obtained primary and secondary education.

TABLE 5

Educational Attainment According to Age-Sex Distribution
Badeo, Kibungan
1997

EDUCATIONAL ATTAINMENT	MALE		FEMALE		TOTAL	
	N	%	N	%	N	%
0-5 years w/ECE	10	10	14	19	24	14
Participation rate						
Elementary	78	76	91	94	169	85
Secondary	12	20	18	43	30	29
Out-of-school youth	45	25	11	7	56	17

Source: *Kibungan Municipality Profile, 1997*

HEALTH STATUS

The over all health status of people reflects the socioeconomic level of the community, as well as its healthcare system. In Badeo and in many parts of the country, health indices reflect a picture of ill health. People are afflicted with and dying of communicable but preventable diseases. The scarcity and the unplanned distribution of health facilities, services, and human resources reflect a deficient response mechanism by the government. Majority of the diseases in Badeo and the whole country as well are obviously related to poverty. In Badeo in particular, access to health care is further compounded by geographical access problems.

MORBIDITY FIGURES

Table 6 shows that acute respiratory infection is the leading cause of morbidity at 27.71 percent. Based on records, acute respiratory infection was most common during the rainy season and the months of December, January, and February—the coldest months of the year. Second in rank is parasite infestation at 15 percent indicating the sanitation problems of the community. Poor sanitary conditions also contribute to the occurrence of skin

problems which rank fourth at 10.41 percent. Such problems occur all year round and affect both children and adults. Bronchitis, influenza, and pneumonia are also common respiratory ailments brought on by wet and cold weather.

Diarrhea, abdominal pain, and amoebiasis may also be attributed to unsanitary conditions such as the lack of toilets. Conditions such as fever and peptic ulcer/hyperacidity are symptoms that could be secondary to the aforementioned diseases. These leading causes of morbidity are basically preventable diseases.

TABLE 6

Ten Leading Causes of Morbidity
Badeo, Kibungan
1996

CAUSES OF MORBIDITY	FREQUENCY	PERCENTAGE
Acute Respiratory Infections	189	27.71
Parasite Infestation	139	20.38
Headache	73	10.70
Skin Infections/Problems	71	10.41
Fever	48	7.03
Bronchitis	34	4.98
Influenza	26	3.81
Diarrhea	24	3.51
Pneumonia	18	2.63
Goiter	18	2.63
Toothache	18	2.63
Abdominal Pain/ Amoebiasis	12	1.75
Peptic Ulcer/Hyperacidity	12	1.75
TOTAL	682	100%

Source: *FHSIS, RHM Report, 1996*

MORTALITY FIGURES

There were five deaths recorded in 1996 and two of these deaths were due to pneumonia (Table 7). One death was each reported for diarrhea, typhoid fever, and kidney disease. The rural health midwife's record reveals

that most of these did not receive medical attention. Hence, the above diagnoses were based on the symptoms exhibited by the patient. These are all preventable diseases, and imply poor environmental sanitation and possibly poverty.

TABLE 7

Leading Causes of Mortality
Badeo Kibungan
1996

CAUSES OF MORTALITY	FREQUENCY
Pneumonia	2
Diarrhea	1
Typhoid Fever	1
Kidney Disease	1
TOTAL	5

Source: *MHO Annual Report, 1996*

INFANT AND MATERNAL MORTALITY

Data from the Municipal Health Officer (MHO) and the Barangay Annual Report in 1996 show that there was no reported infant death for the year 1996 indicating a good and effective maternal and child healthcare program by the rural health midwife. The challenge, though, continues throughout childhood.

No cases of maternal mortality out of the 23 deliveries for the year 1996 were reported. This could be an indication of good prenatal/postnatal care rendered by the rural health midwife and indigenous birth attendants. These are atypical statistics; however, these statistics can be validated because records are properly kept by the midwife who lives in the community.

Data on deliberate abortion appears to be a data gap as none was gathered nor mentioned by the women of Badeo in any of the interviews. In some interviews, the women expressed sadness over the incidence of spontaneous abortion, especially when they looked forward to having the child.

Researches indicate that termination of unwanted pregnancies is a

common concern in many communities. This phenomenon may have to be explored by the midwife or health care providers for its integration in healthcare services. Recent researches by Palaganas and de los Reyes (2000) indicate that women who fear pregnancy after each sexual contact generally use indigenous methods such as herbs, to terminate an unwanted pregnancy. They tell of women resorting to unsafe methods of abortion who suffered infection, or worse, died from hemorrhaging or of infection.

An overall critique of the morbidity and mortality data presented in this particular section is the fact that figures are not sex aggregated. The data would have been more meaningful if the health status of women could be analyzed vis-à-vis the health status of men.

HEALTH FACILITIES

Badeo has no private and public hospital. It only has one barangay health station serviced by the rural health midwife, Mrs. Marliana A. Gatungo, who is solely responsible for monitoring and checking on the health status of the people.

The services provided by the health station include first-aid treatment, simple medical/surgical treatment, and referral of serious cases to proper authorities. Residents also bring their patients to the Rural Health Unit at Poblacion, Kibungan or to the nearest hospital such as Kapangan Medicare Hospital or Benguet General Hospital for further evaluation and management. Obviously, accessibility to these health care facilities is a problem given the condition of the road system and the inadequate transportation facilities. All these cause great difficulty in transporting patients.

There is a rural health physician, a public health nurse, a dentist, and a rural health sanitary inspector, but they can only visit Badeo on a scheduled basis since they service the whole municipality of Kibungan. Indeed, traversing several mountains to reach Badeo is not very enticing to the health team who prefer the comforts of the Rural Health Unit in the center of the municipality. Like other rural communities elsewhere, the situation in Badeo can be characterized by the "inverse care law" where people in the greatest need of medical care have the poorest access to it.

COMMUNITY HEALTH WORKERS

One way by which the people remedy the lack or shortage of health personnel is to gather volunteers who undergo training on basic healthcare knowledge and skills. As of the second quarter of 1997, there were 10 active barangay health workers who helped manage the health situation of the 167 families in Badeo. Although the ratio is at par with the average national ratio of 1:20, there is still a need to train more volunteers due to the topography of the place. There is only one barangay nutrition scholar—Mr. Accdang Bagesbes—who is also a barangay health worker and a trained *hilot* at the same time.

HEALTH PROGRAMS

The health programs implemented in Barangay Badeo are based on the National Development of Health Programs. There are more or less 25 health programs. Some of these include the following:

Maternal and Child Health Services

Maternal and child health services include prenatal and postnatal care, breastfeeding, nutrition, immunization, dental services, and family planning. These services are available at the Barangay Health Center. However, dental and immunization services are only provided based on the availability of resources.

As indicated in Table 8, only 59 percent of pregnant women had three or more prenatal visits because most of them visit the clinic only on their third trimester. Forty four percent of the pregnant women were given tetanus toxoid vaccine, while the rest had completed their tetanus injections from their previous pregnancies. Some had incomplete tetanus injections due to unavailability of the vaccine at their barangay health station. A few deliberately avoid immunization for fear of side effects. For other services, the accomplishment rate is above 80 percent, which implies that mothers are concerned with postpartum care and their child's well-being.

TABLE 8

Maternal and Child Health Services
Badeo, Kibungan
1996

SERVICES RENDERED	TARGET PEOPLE	NO. OF SERVICED	PERCENTAGE
Ante Partum with 3 or more prenatal visits	32	19	59
Ante Partum Tetanus Toxoid plus (TT2)	32	14	44
Ante Partum given complete iron dosage	32	32	100
Postpartum with at least 1 postpartum visit	28	28	100
Postpartum mothers given complete iron dosage	8	24	86
Postpartum women who initiated breast feeding	28	23	82
Lactating mothers given vitamin A	38	24	86

Source: *MHO Annual Report, 1996.*

Nutritional Services

Table 9 shows that for two calendar years, there was a 5 percent increase in the number of children weighed from 1996 to 1997. A few preschool children, save for those classified as second-degree malnourished children, improved in their nutritional status. Not all children were weighed because some children were out of town when weighing was done.

Tables 9 and 10 also present the nutritional status of school children in Badeo for the calendar year 1996. Of the 171 school children, 22 percent had normal weights while 68 percent had weights that went under or over the normal weight. Majority of these schoolchildren were mildly and moderately undernourished while four percent were severely undernourished. The data also reveals that 19 percent are overweight. Such status, however, can be attributed to the high carbohydrate Cordillera diet.

TABLE 9

Nutritional Status Of Preschool Children
Badeo, Kibungan
1996-1997

STATUS	1996		1997	
	N	%	N	%
Total number of children	230	100	218	100
Total number of children weighed	209	91	209	96
First degree malnutrition	62	27	47	22
Second degree malnutrition	12	5	12	5
Third degree malnutrition	0	0	0	0
Normal weight	133	58	148	68
Overweight	2	1	2	1
TOTAL	209	91	209	96

Source: *MHO – Kibungan FHSIS A2 Report, 1996-1997*

TABLE 10

Nutritional Status Of School Children
Badeo, Kibungan
1996-1997

STATUS	NUMBER	PERCENTAGE
Normal	37	22
Mild	49	29
Moderate	48	28
Severe	4	2
Overweight	33	19
No. of children enrolled	171	-
TOTAL	171	100

Source: *MHO – Kibungan, FHSIS A2 Report, 1996-1997*

Current research indicates that 70 percent of Filipinos are malnourished, especially children and mothers who belong to the most vulnerable groups in the country. Tan (1991) claims that Filipinos have the lowest daily consumption in Asia, and the food intake of Filipino adults and children has steadily decreased over the years. The problem of undernutrition, however, is not one of inadequate food supply but is a reflection of the low purchasing power of Filipino families, as well as landlessness. (Pardo de Tavera 1985; Paredes 1986; Palaganas 1996)

Malnutrition is a condition which calls for immediate medical intervention. It complicates common diseases or develops a cycle of diseases with long-term debilitating effects. Although studies and related reports on nutritional status may vary, evidence points to the critical nature of the problem (Sanders and Carver 1985; Paredes 1986). The nutritional status of children in Badeo thus presents a continuing challenge to health workers.

IMMUNIZATION

The data in Table 11 indicates that 93 percent of children were immunized with BCG vaccine from January to October 1997. However, only 57 and 61 percent of the children were able to complete DPT3 and OPV3 immunization, respectively. Sixty eight percent were given measles immunization. Likewise, 45 percent were immunized with the hepatitis B vaccine. As a whole, it implies a low coverage of immunization which could be attributed to lack of vaccines as erratic schedule of immunization dependent on the availability of vaccines, or of non-compliance.

Immunization is an effective and affordable way of preventing diseases. The Department of Health (DOH) has responded positively to the Universal Child and Mother Immunization campaign of the WHO and United Nations International Children Emergency Fund (UNICEF). The principal concern now is sustaining immunization efforts.

The recently conducted research by Palaganas (1999) indicates that local government units (LGUs) in selected Cordillera Provinces have not been able to reach the benchmark of 85 percent Fully Immunized Children since 1996. Devolution of power from the national government to LGUs has commonly been blamed for the dwindling immunization levels.

TABLE 11

Immunization Status Of Children
Badeo, Kibungan
1997

TYPE OF IMMUNIZATION	TARGET POPULATION	NUMBER OF CHILDREN	PERCENTAGE
BCG	28	26	93
DTP3	28	16	57
OPV3	28	17	61
Measles	28	19	68
Hepatitis B	22	10	45

Source: MHO, January–October 1997

There were also disturbing reports of under-dosing of vaccines because of inadequate supplies. As it is, immunity to a disease can only take effect upon completion of a full round of vaccination. To be completely safe from diphtheria, whooping cough and tetanus, the child has to receive three shots on the child's first year at two, four, and six months interval. Apart from this, a booster shot is given when the child turns five or six years old, and another one at puberty. Thus, part of the government's program should be to ensure that correct dosages of vaccines are given and immunization is completed.

Family Planning Methods

Table 12 shows that more couples in Badeo practice various family planning methods. Seventy percent of women practice Lactational Amenorrhea Method. LAM is a family planning method promoted by the DOH and used by women who have just given birth six months or less and whose menstruation period has not yet returned. It requires mothers to regularly and fully breastfeed their babies to delay ovulation and avoid pregnancy. It is a temporary method that can be used only until the infant reaches six months.

Table 12 also reveals that the annual target for both new acceptors and current users was relatively achieved, except for IUD, rhythm, and vasectomy.

This may be attributed to lack of facilities, insufficient information and supplies, and the distance from facilities where one can avail of these services. This practice of setting targets for contraceptive acceptors has been criticized and is against the program of action of the Integrated Contraceptive Population Development (ICPD).

The use of targets and accomplishments to evaluate the program's performance is under criticism because sectors in need of such services are possibly not being reached because the program only focuses on predetermined targets. Thus, the number of acceptors only gives a general picture of the situation. The figure also has fundamental limitations. It excludes important information such as the sustained use of contraceptives and possible sources of family planning support for community members (e.g. from the non-government sector). Moreover, it does not provide a standard against which to base the acceptance or rejection of contraceptive methods. These are important areas that need to be explored particularly with regard to family planning services and the reproductive rights of women. Such will redound to a more comprehensive and relevant health service delivery.

TABLE 12
Family Planning Methods Used
Badeo, Kibungan
1996

METHOD	TARGET	NUMBER OF NEW	ACCEPTORS IN PERCENT	CURRENT NUMBER OF USERS	USERS IN PERCENT
Pills	17	3	18	12	27
Condom	17	1	6	11	25
IUD	17	0	0	0	0
DMPA	17	3	18	3	7
Rhythm	17	0	0	0	0
LAM	17	12	70	18	41
BTL	17	1	6	1	2
Vasectomy	17	0	0	0	0
TOTAL	17	20	118	45	102

Source: *MHO, FHSIS Report, 1996*

As presented earlier in Table 4, 42 percent of the total population is within the age group of 15-49 years old considered to be the reproductive age. Belonging to this age group are 22% males and 20% females. The family planning program focuses particularly on this age group.

Among the women of this age group, there is a need to further assign categories to discern more complex needs in terms of pregnancy. To be able to identify the high-risk pregnancy and childbirth groups, the following categories have to be identified: those aged below 20, those above 35, pregnant mothers who have had four or more births, and mothers who have delivered in less than 15 months.

Other Services

Table 13 indicates that at least five of their maternal and child health (MCH) programs successfully attained their targets. Ratings of other programs' were only a little off their goal. However, more intensive monitoring and evaluation especially of their program on nutrition is needed since only 11 percent of the cases were actually seen and treated.

However, these types of data should be viewed with caution because they may not give the general picture of services provided. It is possible that services are provided based only on the targets and not on the needs of the population. Thus, as mentioned earlier, it is possible that the population may not have received the services they need because the target has already been achieved. Furthermore, reports can be embellished to reflect accomplishment of targets. Thus, such data do not indicate continuous provision or use of services.

Although antenatal visits are low, maternal and infant mortality remain at zero level. There may be a need to explore the practices of mothers and families during these periods of life.

There is also a need to probe the quality of the minimum health services according to DOH standards—if present and appropriate—which include: expanded program on immunization; disease surveillance; control of acute respiratory infections; control of diarrhea; micronutrient supplementation/nutrition; family planning program; tuberculosis control program; sexually transmitted diseases (STDs)/Acquired Immune Deficiency

Syndrome (AIDS) prevention and control program; environmental health and sanitation program; and cancer control program, including cervical cancer screening program.

TABLE 13

Other Forms Of Health Services
Badeo, Kibungan
1996

SERVICES	TARGET	NUMBER OF PEOPLE SERVICED	PERCENTAGE
Infants seen at 4 months	25	25	100
Infants exclusively breastfed up to 4 mos.	25	25	100
Diarrhea cases given ORS (0-59 mos.)	37	20	54
Pneumonia cases seen	16	16	100
Pneumonia cases given treatment	16	15	94
Children (9-11 mos.) given Vitamin A	28	33	118
Children (12-59 mos.) given Vitamin A	104	126	121
Moderately Underweight children (6-59 mos.)	113	17	11
Given food supplement	12	3	25
Receiving food supplement	0	3	25
Rehabilitated	0	2	24

Source: *MHO Annual Report, 1996*

The DOH recommendations leaves out data on violence against women and reproductive tract infections (RTIs). Women's experiences on these did not surface during the focus group discussions and were not consciously

explored by the researchers. However, three rituals performed by the community namely *Pecpecley*, *Bas-ing* and *Basil* seem to be attempts to counteract RTIs and STDs. Provision of comprehensive women's health services should explore the possible occurrences of RTI and STDs in the community.

WATER SUPPLY

Existing water facilities in a community are classified in terms of their levels of development and sophistication. There are three levels: I, II and III. Level I water facilities mean an underdeveloped water source like free flowing springs. Level II facilities are developed common water sources like spring water piped to tanks and faucets. Level III water facilities refer to treated water distributed by the Baguio Water District to households.

In Badeo, where the concern is not limited to issues of access but also to the safety and sanitation of the available water supply, only 21 percent of the households benefit from Level II water facility. This includes the barangay health station. The remaining 66 percent fetch water from Level I supplies. Others share their water supply with neighbors. Potential health problems may arise from Level I water sources especially during the rainy season because of exposure to possible contaminants.

An underdeveloped and unprotected water supply could account for the high incidence of gastrointestinal and skin diseases in Badeo (see Tables 6 and 7). The incidence of intestinal parasites is high, possibly aggravating malnutrition.

SANITARY CONDITIONS

Fifty one percent of the households dump their wastes openly. This increases the risk of land pollution and incidence of diseases. Twenty nine percent of the population burn their garbage, which is relatively ideal because it targets potential breeding places of insects, therefore preventing the occurrence of insect borne diseases. Ten percent of the residents practice composting, while the remaining 10 percent feed edible refuse to livestock or bury the rest.

Sixty one percent use open containers to dispose of their wastes in contrast to four percent who use covered containers. Furthermore, it should

be noted that 35 percent of households have no refuse containers at all. This poses a health threat to the community since exposed garbage serves as breeding grounds for disease carrying flies.

TOILET FACILITIES

From another survey conducted by the Social Reform Agenda–Minimum Basic Needs (SRA-MBN) from January to June 1997, only 19 out of 160 households have sanitary toilets, which are further classified as water sealed and pit privy. Eight percent have unsanitary toilets while 73 percent have no toilet facilities at all. Residents use pigpens or areas behind bushes as toilets.

The above environmental factors are closely linked with each other. Inadequate potable water supply is closely related to lack of toilets. A majority still depend on rivers and springs which are largely unprotected, for their bathing, washing, and drinking needs. The health team should explore strategies to improve the existing environmental situation.

SOCIOCULTURAL BACKGROUND

Kibungan is part of the cultural area known as the Southern Kankana-ey. The following section culled from *A People's History of Benguet* by A. Bagamaspad and B. Pawid (1985) will provide the sociocultural background for the research on health knowledge and practices of Badeo.

Class Distinctions in Badeo

There are two identifiable economic classes in Badeo, the *baknang* or rich and the *abiteg* or poor. The stratification, although not as well-defined as in Ibaloi or Kankana-ey communities, is noticeable. The rich own rice lands, have more animals, and belong to well-extended families. A *baknang* acquires prestige through a series of feasts that begins with a three-pig *pedit* or feast which progresses to more prestigious feasts.

For the host, the feast is a clear manifestation of an excess of wealth and a means of sharing resources with the community. The society is headed by the rich or the *baknang*, who are almost always the most able and the most

respected as well. The *kadangyan*, the richest person in the community who is also considered one of the oldest or the wisest of the group, is the acknowledged leader.

In the past, the village elders, known as *amaen-a* or *lallakay*, were part of the community elite that directed, restrained, and gave advice to the heads of families. They also prescribed the holding of feasts. Today, informal power still rests with the *baknang* and *lallakay*. Formal structures are now in place and administration rests with the elected officials headed by the barangay captain and his council.

Religious Personages

The *mambunong*, *mansip-ok*, and the *mankutom* are significant community figures because of people's preoccupation with ceremonies, the necessity to obtain healing, and a belief system of securing good fortune from the *anito* or spirits, which the *mabunong* performs. The *mambunong* holds a special place in feasts for he/she recites the *bunong* or prayers.

Becoming a *mambunong* requires knowledge of the different ceremonies and the prayers that accompany each ceremony. Through constant observation or through the *mambunong's* direct instruction, the novice soon learns the role. For some, initiation into the position takes the form of a revelation like dreams. Others feel an irresistible calling to become one. But the litmus test for a *mambunong* is effective prayer. A *mambunong* apprentice whose prayer is granted is hailed as a *mambunong* and is given the right to perform ceremonies.

Mambunongs are further classified as those who perform familiar rituals and those who perform rituals reserved for special ceremonies. The former is called *mambahi* while the latter in the *mansip-ok*. They are usually older *mambunong* and thus, experienced in all types of ceremonies. They also enjoy close ties with the *baknang* as they are requested to perform special feasts held only by the rich.

The *mansip-ok* determines the cause of illness by tying a stone with a piece of string and holding it close to the forehead. While doing this, the healer prayerfully mentions the probable causes of the illness. If the string swings faster and farther away from the usual course, this indicates that the mentioned cause was the reason for the person's sickness.

Omens and premonitions are sensitively awaited. As these are perceived, the *mankutom* or wise man reads the meanings of the events. For example, when a wooden utensil breaks during marriage ceremonies, the *mankutom* may interpret this to be a premonition of the break up of the marriage. Ceremonies to offset the ill effect of this event are dutifully performed.

While the three functions are separately performed by individual persons, it is possible that one is a *mambunong*, *mansip-ok*, and *mankutom* at the same time.

Deities

Marriage introduces the husband and wife to the performance of rituals. From the time the first child is born and throughout the whole cycle of life—including sickness, building a house, or community-oriented activities related to agriculture—there are ceremonies to perform.

Anitos play a central role in these ceremonies. Prayers and petitions are addressed to the *anitos* and particular gods and goddesses.

Anitos are of two general kinds: the nature spirits and the ancestral spirits called *kaapuan*. Nature spirits are frequently more malevolent, causing disturbances in the environment resulting in death and disasters. Therefore, careful regard for their abode, permission to use what belongs to them, and due respect are always observed. The *kaapuan*, on the other hand, are reverently regarded, their particular preferences in food and clothing kept in mind as one prepares the offering. When satisfactorily executed, ceremonial offerings to the *kaapuan* ensure blessings upon the performer.

The following are the specific kinds of *anitos*:

- (1) *Pinad-eng* are spirits who dwell in forests who are owners of wild pigs and chickens to whom hunters offer sacrifices to ensure successful hunting.
- (2) *Tinmongao* are spirits who dwell in caves, stones, and trees. They cruelly inflict sickness and injury on any person who steps on their abode. Victims must sacrifice chickens to appease these spirits.
- (3) *Penten* are water dwelling spirits, believed to be of people who died violently by accident or drowning. They malevolently cause the river to rise when one crosses, specially during rainy days.

- (4) *Butat-tew* group themselves at night and use lights to misguide humans from their paths or activities. They appear and disappear unexpectedly.
- (5) *Ampasit* are generally malevolent spirits believed to dwell in caves who have the power to steal the souls of persons. They also mislead people who travel at dusk or at night.
- (6) *Banig* are spirits of persons on the verge of death or those who just passed away. They make their presence felt through various means or in animal form.

Whereas good health, long life, and good fortune are implored from the gods and goddesses, sickness is generally attributed to the *anito*. *Anitos* do not have definite dwelling places, and are believed to inhabit big trees, stones, and rivers. They are regarded as having human needs like food, clothing, and other things, which they demand from the living by inflicting sickness upon them. To appease the *anito*, the people hold feasts or simple ceremonies during which they make their offerings.

HEALING RITUALS

Usually, gifts are offered to deities to seek healing for the sick members of the family. Following is a list of specific rituals for specific sicknesses:

Ampasit is a ceremony offered to dwarfs and hobbits or *pinad-eng*, *ampasit*, and *tinmongao*. This is performed with the chicken as the sacrificial animal. It is carried out at the backyard of the afflicted person. This ceremony is intended to cure sore eyes or foot diseases.

An-anito wherein the object of the angry spirit's ire performs the ceremony in front of his or her house. Three pigs are butchered to appease the angry spirits of dead ancestors who inflicted the sickness on the victim.

Amdang is an offering made to the Supreme Being called *In-amdagan*. It is believed to cure stomach, head, and other body aches. A chicken or several chickens are butchered on this occasion.

Awil is an offering made to the *ampasit* or *tinmongao* who are believed to cause sudden and unbearable pain. Chickens and pigs are butchered for the occasion and wine is served. Native dancing is not a requisite in this ceremony.

Baeng is a *cañao*² where a pig or two is butchered to cure a sickly child as well as to hasten the delivery of a child. During prolonged and painful labor pains, this offering is made in behalf of the mother.

Bajog is an offering to please the *kaapuan* who assists the family, together with other native gods. No less than two big boars are butchered. The feast accompanied by dancing and drinking lasts for one or two days.

Batbat is a ceremony offered to the gods and goddesses to appease evil spirits or to cure illnesses. This feast is started in the evening and ends the following day. At least two pigs are butchered, one in the evening and the other the next day. There is no dancing during the celebration of this *cañao*. *Batbat* is performed to ensure prosperity of the family. It may also be performed to cure lingering illness in the family.

Bomokod is a ceremony involving the offering of a pig to appease the angry spirits who cause a person to be paralyzed. These are selfish spirits who do not want to share with others, so a special offering is necessary. (*Bokod*, the root word for *bomokod* means to have a thing alone.)

Buang is a ritual cure for deafness that involves the offering of chickens and *tafey* or fermented rice drink. A *mambunong* presides over the ceremony.

Dosad is a ceremony that calls for the *mambunong* to hold a spear against the chest of a hog and start praying. The hog is later butchered as an offering. This is done to cure chest pains.

Kedaw or *Kechao* is an offering made to the gods who are believed to ask for such a sacrificial animal. A chicken, pig, carabao, or any other animal is required by the *mansip-ok* or *mansibik* or as dreamt of by the deceased's family members. This *cañao* is also believed to cure any kind of illnesses.

Kolos involves the offering of a piglet, *tafey*, or chicken to *Kolos*, the water god, to cure stomach pains or diarrhea.

Lawit is a *cañao* performed in honor of dead ancestors. The souls of the dead are called upon to cure the illness.

Kading is performed after the *lawit*. A pig or a carabao is butchered to offer to the spirits who linger on earth so that they would help cure the illness of a person. The ceremony is performed in the backyard where the *kading* eats. The *kading* are believed to be shy beings.

Mante-e si Bileg is a ceremony that follows the *kading* and is performed a stone's throw away from the sick person's house. A pig or a carabao is butchered as an offering to the deities of the mountain to cure the malady, especially coughing (see also *Seg-ak*).

Nansa-ang is to cure a headache, where a cup of *tafey* covered with a leaf, is placed on the head of the sick person. The *mambunong* then holds a chicken over the cup and prays over the afflicted person.

Palis is a ceremony performed to bring back the spirit of a sick person taken by the *tinmongao*. The ritual animal is a dog. It is also performed to cure the victim of a *manmantala* or warlock. Besides the dog, a jar of rice wine is procured. The *mambunong* proceeds to pray and the assembled kin sing the *angba*. After the chanting, loud noise is created by beating bamboo sticks or pieces of wood together. One man then dances with a bolo in one hand while brandishing it in the air and later with the skull of a dog tied to the end of a string. After the ceremony, the dog's skull is tied under the house to prevent any further harm from the warlock.

Sabosab is a feast similar to *bokod* and is performed to cure skin diseases and any deformity of the human body. One pig is normally required in this ritual but the number may increase depending on the decision of the *mambunong* or *mansip-ok*.

Sakde is a ceremony performed two weeks after the *an-anito*. Three pigs are butchered to offer to gods and goddesses. The purpose of the ceremony is to ask the deities to put an end to the sickness because all necessary rituals had been performed (see *An-anito*).

Sibisib is a ceremony offered to the *Kabunyan* or Supreme Being for the speedy healing of wounds.

Sikpo is done principally to cure coughs. It is done without the necessity of sacrificial animals or *tafey*. The *mambunong* rubs ginger and salt solution on the neck of the sick person while praying.

Tomo is a ceremony offered to departed headhunter ancestors who caused the person's insanity. The dog is the ritual animal.

Topya is a feast performed to counteract a curse and to cure illness or physical deformity caused by an adversary. Usually, the enemy is identified by the victim through dreams. It is generally believed that a person can be afflicted by someone he or she has quarreled with. Sometimes, death even ensues. The curse takes effect usually through the intervention of *padpadja* or witchcraft, hence the need to perform this *cañao*. The ceremony is performed by an expert *mambunong*. Chickens, ducks, dogs, and goats are the ritual animals used in this feast.

Besides the ceremonies performed to obtain healing and good fortune, there are ceremonies related to specific events and activities like the following:

Conception and Birth Rituals

Dawdawak, Maksil, Anawang, Passang, Sagaosao are offered for a pregnant woman approaching the day of delivery to ensure that she would not experience severe labor pains.

Passang is performed by a childless couple to obtain favor from the *Kabunyan* to give them children.

Basaklang is offered after the woman had given birth to prevent either profuse bleeding or skin diseases.

Sex and Marriage Rituals

Kape is a marriage celebration.

Amlag is a ceremony to free a person believed to have been married to a spirit.

Pecpecley is a ceremony performed to cure sexually related diseases like loss of libido or sexual desire. The rooster is the ritual animal.

Bas-ing is a ceremony performed to cure illness contracted through liaisons outside of marriage. The ritual animals are a hen and a rooster.

Basil is a ceremony to cure diseases associated with sexual organs, including chills and fever, caused by sexual indulgence. A horse or a dog is necessary for this ceremony. It is necessary to butcher a horse because the *Ibaloi* believe that extra-marital sex is a cardinal offense.

HOLISTIC APPROACH TO HEALTH

The people of Badeo view the causes of diseases in terms of their relationship with the supernatural (NEHCC 1989):

A long time ago, our ancestors' lives were bound to the ways of nature. To survive, they would hunt, plant, and harvest with their primitive tools. If the natural conditions were favorable, they would have a good harvest. If the

climate and soil were bad, they would go hungry. They lacked the necessary knowledge and tools to harness nature to their favor. Nature to them was unpredictable. It was beyond their understanding and control. Under these conditions, they explained all things as caused by supernatural beings. Diseases were believed to be due to supernatural causes. They were considered as punishment from gods or spirits of dead ancestors. Sprits were believed to dwell in the mountains, rivers, trees, and forests. Anyone who causes displeasure to them or intrudes into their domain without offering sacrifices would probably get sick. Based on these beliefs, treatment consisted mainly of rituals like animal sacrifice and chanting...

The physical, ecological, and sociocultural setting of the research area suggest that traditional structures, customs, and beliefs are operational in the day-to-day life of the people of Badeo. Likewise, the introduction and acceptance of modern health practices, primarily through government rural health workers, the educational system, and popular media is noticeable. The continuing reliance on traditional health knowledge and practices and the increasing availability of modern medicine are two resources that the people can use. Depending on the accessibility, cost-effectiveness, and the overall well-being that each can offer, each is bound to prosper or to be disregarded.

Health professionals realize that the prevailing paradigm used in the delivery of health services is still predominantly "curative" in orientation. A person receives medical attention or is "subjected to cure" only when he is sick. The health belief model that attributes the causes of diseases to lifestyle, biological and physical reasons dominates the landscape. Such models fail to recognize the factors that breed ill health. Regrettably, such self-contained health programs are bound to fail. Many health professionals fail to realize health's inextricable relationship to the socioeconomic, cultural, and political structures that dominate society. It should be realized that health is but one component of total human development.

Good health does not exist in an economic and social vacuum. Since ill health is strongly linked with socioeconomic factors, health conditions will only improve if these socioeconomic factors are addressed. Sadly, there are no palpable signs of economic recovery nor are there sincere efforts to change existing social inequities.

The role of health in economic development is often underestimated or ignored by policymakers. Too often, plans for economic development

concentrate exclusively on capital investment. Health and human capital are eventually neglected and disregarded. The WHO claims that it is unrealistic to plan the development of a country without taking into account the health of those who must implement that development. In other words, a healthy worker is indispensable to the attainment of economic goals.

Upgrading the health of people requires more than health education, disease prevention, and cure-oriented medicine. Elevating the socioeconomic level of people through collective efforts is as important for the promotion of health. Besides health and allied health professionals, other professionals, namely, community organizers, development workers, agricultural nutritionists, veterinarians, etc., play very important roles in the delivery of an integrated health model.

Primary healthcare recognizes that good health requires the provision of basic necessities, namely, enough food to eat, plenty of safe water, clean environment, land to till, and employment. All these are attainable through a multidisciplinary approach at the primary healthcare level (Honglian *et al.* 1991; Palaganas, 1996). Health professionals, therefore, should broaden their roles to include a more holistic approach to health promotion namely: involvement in building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. With this, health professionals enable people to increase control over, and to improve their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment (WHO 1986).

Primary healthcare, as it is, limitedly contributes to the alleviation of health problems at the community level. It should be part of a broader program to improve the status of people. Political action rooted in a strong political will to effect structural changes is necessary to the success of this scheme. This can be attained with all sectors participating within a democratic institution with a total development program aimed to improve the Filipino people's quality of life.

Indeed, the absence of sincere efforts toward socioeconomic transformation will fail to bring lasting improvements in the field of health not only in Badeo but to the whole country as well. Thus, the ultimate goal of the critical practice of health professionals should be to facilitate change in the overall condition of people. These conditions, more often than not, threaten safety

and well-being, inhibit health behaviors, and limit access to resources necessary for the pursuit of health.

The self-subsisting, often insufficient, agricultural economy of Badeo fails to provide the people's basic needs. Poverty reinforces the traditional way of dealing with diseases, some of which are effective, others injurious. Poor economic conditions, coupled with geographical inaccessibility curtail access to health services. As a result, superstition and traditional means of healing prevail.

In view of the economic and sociocultural conditions of Badeo, beneficial traditional health beliefs and practices should be promoted. On the other hand, harmful beliefs and practices should be patiently corrected. Health professionals should keep an open mind on these practices and continue to investigate the common beliefs of the people they encounter in the course of their health services delivery.

Notes

- 1 The practice of slash and burn agriculture has left vast open spaces in place of forest growth. In places where irrigation is accessible, terraced farming is practiced, changing the topography of the area.
- 2 *Cañao* is a general term that refers to different kinds of feasts. The feasts could be community events such as a harvest celebration or family affairs such as births, death, weddings, and others.

Chapter 3

REVIEW OF LITERATURE

One of the major themes in this review of related literature is the concept of indigenous health or *salun-at*, in the Cordillera tongue. We explored this in order to come up with an appropriate framework of analysis. In this instance, health and indigenous health are viewed and analyzed in relation to other substantive areas integral to health, such as the socioeconomic, political, and cultural structures in society.

Moreover, women's health in particular, was explored in relation to their triple reproductive, productive, and community-managing roles. Specific topics covered include sexuality, reproductive health, childcare, caring for the sick, home remedies, and cure rituals.

This review of related literature focuses on indigenous knowledge, particularly health knowledge and practices, namely:

- (1) concepts of health and illness and their causes;
- (2) cosmology of indigenous peoples and its relation to health;
- (3) traditional healing/healers, traditional remedies, and cure rituals;
- and,
- (4) the dynamics between traditional/indigenous health knowledge and practices and modern medicine.

INDIGENOUS KNOWLEDGE

The concept of indigenous knowledge, according to Olanyan (1982), can be formulated as "the ability to survive in harmony with the environment and to cope with traditional occupations like hunting-gathering, agriculture, handicraft, and healing." Thus, such knowledge acts as a tool used by local people to make a living in their particular environment. Evolving from sociological and ecological particularities, indigenous knowledge is specifically tailored to the needs of local peoples and conditions. This does not mean that indigenous knowledge is a closed system that does not allow outside influences. ERP (1999) characterizes indigenous knowledge as "creative and experimental, constantly incorporating outside influences and

inside innovations to meet new conditions." The dynamics of experimentation is, nonetheless, bound by the framework of the indigenous so that assimilation is in fact a process of indigenization. Rovillos (1999) notes that locals "adapt introduced technologies to their needs and blend them with indigenous knowledge."

"Indigenous knowledge systems are by and large ecological" (Shiva 1997). They present a holistic view of reality. The Rural Advancement Foundation International (1994) asserts that they are not an accidental accumulation of knowledge but are "organized, dynamic system(s) of investigation and discovery." They are "based on experience and often tested over centuries of use" (ERP 1999).

The International Development Research Center classifies the knowledge embodied in indigenous knowledge systems into 11 categories: information, practices, technologies, beliefs, tools, materials, experimentation, biological resources, human resources, education, and communication.

These various forms of knowledge are "stored in people's memories and activities and expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, community laws, local language and taxonomy, agricultural practices, equipment, materials, plant species, and animal breeds" (Grenier 1998).

Indigenous knowledge exhibits both general and specialized aspects. Martinez (no date) says that the general aspect of indigenous knowledge refers to knowledge shared by all or a large portion of society such as home remedies, general agricultural practices, birthing practices, everyday maintenance activities, while specialist knowledge is known and practiced by a select group covering detailed aspects of agriculture, crafts, medical practices, and rituals.

There are two views regarding societies and cultures as bearers of indigenous knowledge. The first only identifies indigenous peoples as bearers of this knowledge: "the original inhabitants of a particular geographic location like the tribal native, first, or aboriginal people of an area who have a culture and a belief system distinct from the international system of knowledge" (ERP 1999). The other view offers a broader definition that includes peoples who may not be the original inhabitants in an area but have lived in it for a long time and have evolved and continue to evolve a body of knowledge specifically adapted to the requirements of the local environment. The terms used to designate the concept of indigenous knowledge in this respect

include traditional knowledge, local knowledge, cultural knowledge, folk knowledge, systems, oral knowledge, traditional wisdom, and rural knowledge.

INDIGENOUS HEALTH KNOWLEDGE AND PRACTICES

Available literature on indigenous health knowledge systems covers various terminologies. These are referred to as traditional medicine (Landy 1977; Tan 1987), traditional pharmacological knowledge, traditional human health competence and cultural health customs and practices (Negussie 1988), folk medicine, and local health practices (Jocano 1973). Traditional medicine is defined by Landy (1997) as "those practices, methods, techniques, and substances embedded in a matrix of values, traditions, beliefs, and patterns of ecological adaptation that provide means for maintaining health and preventing or ameliorating disease and injury to...members."

Kaba's (1996) study on the traditional health competencies of the Oromos of Ethiopia reveals a structure of self-reliance where "indigenous knowledge builds upon a certain degree of self-sufficiency. Traditional health knowledge is one example [of this]."

Negussie (1988) admits that traditional health "includes both beneficial and harmful customs." However, she points out that it "has many positive values such as an active participation in the health care procedure and a holistic perspective upon health and health care."

COSMOLOGY AND NOTIONS OF HEALTH AND ILLNESS IN INDIGENOUS SOCIETIES

In traditional societies, "the field of medicine is inextricably linked to the area of social relationships and to the magico-religious world" (Amundsen 1987). Almost always, religious interpretation is accentuated by the people's knowledge of the world and how one intimately manipulates this world for one's intents and purposes (Dulawan 1985; Douglas 1966; Eggan and Scott 1963).

Health among the Oromos of Ethiopia, for instance, is interpreted in relation to "Rabby," their omnipresent god and savior. The Oromos' belief in

Rabby dominates their entire existence. This belief commands their filial obedience to harmony among themselves as a people and the world they live in. To the Oromos, this harmonious continuum spells the key to a prosperous and healthy life. Illness is perceived as the "disturbance of well-being." Any such disturbance indicates Rabby's wrath over the people's breach of obligations to him. The Mapuche tribe, likewise, believes that health and illness are but processes involving struggles between good and evil (Kaba 1996).

Tan's (1987) exhaustive documentation of traditional theories of the causes of illness in Philippine society provides a good picture of the continuities among medicine, social relations, magic, and religion. Tan (1987) enumerated three general classifications of theories: (1) personalistic theories; (2) mystical theories; and (3) naturalistic theories.

Quoting Murdock, Tan (1987) defines personalistic theories as based on the premise that impairment of health is an automatic consequence of the victim's act or experience. He cites the Bukidnon and Panay belief about menstruation as contagion or pollution. Another example is a traditional belief in the Tagalog region where a pregnant woman's kin is prohibited from digging earth as this implies the preparation of a grave for her.

Mystical theories assume that illness is caused by "the active, purposeful intervention of a sensate agent who may be a supernatural being or a deity or an *engkanto*, a nonhuman being such as ghost, ancestor, or evil spirit, or a human being or a *mangkukulam* or *aswang*."

Theories that attribute disease to "natural forces or conditions as cold, heat, winds, dampness, and above all, from an upset in the balance of the basic body elements" are classified as naturalistic theories. Examples are *pilay-lamig*, *pasma*, and *singaw ng lupa*, or the heat that escapes from soil during an initial rain pour. All these are believed to cause aches and ailments.

Similar patterns of interconnectedness and interdependence between the human world and the world of spirits have been documented in the Cordilleras. The life cycle are marked by rites that implore blessings and forgiveness of ancestors, *ampasits*, *tinmongaws* or spirits, *ameds* or gods, or *Kabuniyan* or the Supreme Being (Igorota Foundation 1997; Canilao, et al. 1998; Lewis 1987; Kohnen and Kohnen 1986; Scott 1976; Eggan and Scott 1963).

According to Tan (1987), Filipinos exemplify health as being free from disease, hence the description, *walang sakit* or *walang nararamdaman*. A

healthy person is called *malusog* while health is called *kalusugan*. The typical indicator of this physical state is the ability to perform usual tasks.

Maliksi, *malakas*, and *masigla* are common descriptions of a healthy person. On the other hand, a sick person is normally described as *may dinaramdam*, *may karamdaman*, *may sakit*, *walang sigla*, and *matamlay*. Psychologically, a sick person may also exhibit melancholia, hence the description *malungkot*, while a healthy person demonstrates verve, vivacity, strength and happiness.

HEALERS AND TRADITIONAL HEALING

Health and treatment-seeking behaviors are determined by beliefs about the causes of health problems (Becker 1984). With traditional medicine in the Philippines being so closely tied to the world of spirits, it is not surprising that “traditional healers are [generally] believed to be empowered by gods or spirits” (Jocano 1973; Kaba 1996).

In some communities in the Visayas, the traditional medical practitioners are called *manugbulong* (Magos 1992). This is an umbrella term that covers the *ma-aram* or native priest, the *paltera* or midwife, *manughilot* or traditional chiropractor or bone setter, and the *herbolario* or herbalist. The *babaylan* occupies the highest status among the *ma-aram*. Magos (1992) considers these indigenous healers as “folk philosophers who ponder and muse about the universe—its origin and structure and the beings inhabiting it..and hold a more or less coherent and comprehensive set of ideas about the world often explicitly expressed in rituals.” They are also seen as “norm-setters” who prescribe rules of conduct that they believe come from gods. Members’ compliance is expected.

The Ibalois of Benguet have a number of folk healers differentiated by their specific specialization (Lim *et al.* 1996). The *mengidut* attends to muscular and bone ailments. The *manpa-nak* assists in child delivery. The *menga-ut* assists the *manpa-nak*. Specifically, her job is to pull out the placenta after the infant is delivered. The *mengekas mi mata* performs treatment on eye ailments. The *mengkal ni singai* extracts teeth. The *menbubugao* cures ailments caused by spirits of the dead. The *menguenap* is a diviner who determines the illness and prescribes specific healing rituals. The *menupsop* treats the patient by sucking

out the illness from the person's body. And the *mengakas* is a general practitioner similar to the aforementioned.

Among the Kankana-eyes of Bakun, Benguet, the *man-anap* performs divinatory rites for curing illness. Native priests are known as *mambunong*. Majority of them are men but there are also women practitioners called *manggengey*. The position is often passed on to the next generation but this is not a general rule. The Kankana-eyes claim that anyone can become a *mambunong* "provided he/she acquires the necessary knowledge" (Bello 1967).

WOMEN AND HEALTH

Health is a domain generally ascribed to women. In an extensive WHO evaluation of the state of health delivery services in the world, it was shown that women in most countries play a more profound role than men in health care delivery (Pizurki, *et al.* 1987). This role, according to the WHO, is "a relatively well-established phenomenon," even "predating the emergence of modern health care systems."

The WHO study (Pizurki *et al.* 1987) reveals how much of health, especially primary health, rests on informal care and in this, "women hold a unique position, both in the family and in the community." As documented, women are generally involved in the following: health education and family life education, nutrition (women store, process, prepare, and produce food), supply of safe water and basic sanitation, immunization, maternal and child care, management of illness, and provision of essential drugs.

There are various reasons why women generally play a more vital role in providing health care. Individual and institutional authorities have assigned women to functions that include "not only looking after the home and the family but also the more general caring, counseling, and nurturing functions extending into neighborhood and community." Since health care involves all such activities, it has therefore become a socially ascribed feminine role.

Negussie, (1988) who calls Ethiopia's health traditions "traditional human health competence," similarly makes the observation that "health is related to...gender." Negussie's findings highlight "women as important bearers and transmitters of traditional health knowledge." In her narrative, she uses the term "women's life and knowledge" interchangeably with

“traditional health,” “folk knowledge systems,” “rich oral knowledge,” “traditional human health competence,” and “indigenous knowledge.”

But even as traditional health is part of the competencies of women, it appears that indigenous norms in some societies are flexible enough to accommodate male practitioners. Negussie implies as much when she writes how Ethiopian, “wives and daughters to traditional practitioners either assist their fathers/husbands or inherit their position.” A study by Bello (1967) on the Bakun Kankana-eyes in the Philippines suggests the same pattern of non-rigidity. To this ethnic group, male or female folk medical practitioners or *man-anaps* can perform divination to determine the cause of an illness.

Nonetheless, some health practices are exclusively women’s. In Ethiopia, Negussie (1988) identifies traditional midwifery and female circumcision as “naturally belong(ing) to the women’s sphere.” A related study cited by Negussie (1988) on a particular ethnic group in Ethiopia, supports this claim.

The ascription of health roles to women can stem from religious imperatives. In Islamic communities for instance, “the midwife is always a woman, since a woman may not be seen by a male” according to Neguisse (1988). The absence of such religious proscription in Christianity may perhaps explain why in Marinduque, Philippines, male *hilots* or traditional birth attendants are accommodated in this female dominated profession (Burton 1986). Negussie (1988) also cites religion as a factor related to traditional health competence, although she did not dwell at length on the dynamics between them.

MODERN MEDICINE AND THE DYNAMICS OF INDIGENOUS HEALTH KNOWLEDGE AND PRACTICES

Traditional medicine constitutes “practices, methods, techniques, and substances embedded in a matrix of values, traditions, beliefs, and patterns of ecological adaptation, that provide means for maintaining health and preventing or ameliorating disease and injury to...members.” (Landy 1977)

Undeniably, there are indigenous societies that accept both modern and traditional medicines. However, modern medicine becomes a recourse only when traditional medicine fails (Gusfield in Negussie 1988). In fact, Negussie and Gusfield stoutly defend the viability of accepting both tradi-

tional and modern medicines. To their minds, these are not "misplaced polarities," nor are they "extreme opposites."

Modern medical advocates must learn to accommodate the beliefs and practices of traditional societies to hasten their acceptance of modern notions of health and health care (Gusfield 1967). Often, people's perception that modern medicine runs counter to their beliefs and practices prevents them from accepting modern medical ideas and practices.

Gusfield (1967) further asserts that people should learn to adopt a "perspective of change that does not deny the specific and contextual character of events." In short, he advocates the possible acceptance of modern health and health practices to solve some people's health problems.

Meanwhile, the value of traditional medicine is undeniable. It is recognized not only because it is as systematic as modern medicine but also because it has been consistently and inherently validated by countless generations. (Fukui and Brokensha, *et al.* in Negussie 1988)

Researches on indigenous medicine continue to increase in number, spelling out and acknowledging in wider proportions the contributions of traditional medicine to health and health care. However, some people argue that indigenous peoples have no concepts of health and illness, a contention we definitely disagree with. Indigenous people's knowledge may not come from books but this does not mean ignorance on their part or the inferiority of their knowledge systems (Negussie 1988). Arce and Long (1992) claim that everyone possesses knowledge; however, the ways beliefs are accepted and privileged differ remarkably from culture to culture.

The ways in which people categorize, code, process, and ascribe meanings to their experiences are essentially constitutive of knowledge. People consciously or unconsciously process information they encounter in their everyday life for meaning and understanding.

Several factors constitute knowledge. Pertierra (1997) argues that interpersonal relations, social milieu, cultural practices, and climate in which these prevail, together with various institutions, condition and determine the nature of knowledge. As a result, knowledge becomes the "byproduct of existing conceptual frameworks and procedures and is affected by various social contingencies such as the skills, orientations, experiences, interests, resources, and patterns of social interaction" (Arce and Long 1992). Because of all these, indigenous knowledge appears as a "solid amalgamation of

dynamic medical know-how and ancestral experience..." (Afro Technical Report Series in Negussie 1988).

Steeped in tradition and culture, traditional medicine continues to exert its influence. Its continuing popularity and acceptance even among mainstream societies reaffirm its efficacy as an alternative solution to medical problems. In the Philippines, the signing into law of the Traditional Medicine/Alternative Medicine Development Act of 1995, otherwise known as Senate Bill No. 995, recognizes the safety, affordability, and accessibility of traditional medicine. Tan (1992) deems this development a progressive move in health since traditional medicine is a "medical culture most Filipinos subscribe to. . . ."

TOWARDS A COMPREHENSIVE FRAMEWORK ON HEALTH

In analyzing the health situation and utility of indigenous health knowledge and practices, we used several lenses to provide us a more holistic and deeper understanding of traditional health knowledge, namely:

- (1) the primary health care approach, contextualized against the larger backdrop of macro-social structures such as the role of multilateral finance and development institutions like the International Monetary Fund (IMF) and the World Bank (WB), and their Structural Adjustment Policies (SAPs) which impact people's situations, particularly the health situation and programs in Southern countries;
- (2) the indigenous peoples and their rights;
- (3) indigenous health knowledge and practices;
- (4) gender roles and women's multiple roles; and
- (5) the life cycle approach.

We agree that "the health of people—as individuals and as communities, and as an endangered species on this endangered planet—is determined less by health services than by the relative fairness of social structures" (WB 1978). This and the growing frustration with Western medicine's failure to meet the world's health needs came to fore during the International Conference on Primary Health Care which was held in Alma-Ata, Kazakhstan in September 1978.

The Alma-Ata Convention declared that “the pursuit of health is inseparable from the struggle for a fairer, more caring society.” It further asserted that health is a basic human right and the goal was “Health for All by the Year 2000.” In the same conference, the Primary Health Care (PHC) approach was hailed as the means to achieve people’s basic needs. PHC was envisioned as “a comprehensive strategy that would not only include a people-centered approach to health services, but would address the social and political factors that influence health” (WB 1978). Primary health care engenders the complex dynamics between health and poverty, between individual and community health, and national and global macro-structures.

According to Werner (1994), the concept and approach of primary health care has long been implemented by NGOs, “and some ‘exceptional governments’ ...gave top priority to people’s basic needs.” He further states that China’s “barefoot doctors” provide much for the blueprint of primary health care.

The Alma-Ata Declaration envisions the PHC approach to engender the following principles:

- (1) It reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities. It is based on the application of the relevant results of social, biomedical, and health services research and public health experience.
- (2) It addresses the principal health problems of the community, promoting preventive, curative, and rehabilitative services accordingly.
- (3) It includes, at the very least, educating people concerning prevailing health problems and teaching them to prevent and control these problems; promoting proper nutrition; providing an adequate supply of safe water and basic sanitation; providing maternal and child health care, including family planning; immunizing people against major infectious diseases; preventing and controlling locally endemic diseases; giving appropriate treatment of common diseases and injuries; and providing essential medicines.
- (4) It involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular, agriculture, animal husbandry, food, industry, education, housing,

public works, communications, and other sectors; and demands the coordinated efforts of all those sectors.

- (5) It requires and promotes self-reliance and participation in planning, organizing, operating, and controlling primary health care through appropriate education and by using fully local, national, and other available resources.
- (6) It should be sustained by integrated functional and mutually supportive referral systems, leading to the improvement of comprehensive health care for all, giving special priority to those most in need.
- (7) It relies, at the local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, community workers, and when needed, traditional practitioners. These people are trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Werner (1994) situates the implementation of the PHC against the backdrop of “dominant sociopolitical and economic trends.” He recounts that the 1980s was a “period of global recession and retrenchment of conservative powers.” He adds that in the early the 1980s, mega-development projects and the growth driven development paradigm pushed by Northern countries and implemented by the so-called “multilateral finance and development institutions” were exposed as failures. Instead of addressing the people’s basic needs, the development paradigm and the mega-development programs were unmasked as contributing to the worsening world poverty problem.

Despite the obvious success of the primary health care approach, Werner (1994) declares that many governments and top-level health “experts” consider it too revolutionary. He states that, “to those in positions of power, the idea of giving ordinary people more control over their health and lives sounded dangerously leftist and subversive.” Thus, they mounted concerted efforts to undermine and emasculate the PHC approach. They reversed the original intent of primary health care and transformed it in such a way that it remained the means for “extending top-down health services into under-served areas.”

Werner (1994) identifies “three watersheds” that undermined primary

health care. These include the following: (1) introduction of Selective Primary Health Care in the early 1980s; (2) push for Cost Recovery or User-financed Health Services; and (3) the World Bank's take-over of Third World health care policy.

The World Bank, through the years, has taken an increasingly active role in Third World health care and health policies, which Werner (1994) calls "the WB's take-over of health policy planning." WB policy statements claim that "real development must take direct measures to eliminate poverty." How the WB envisions such development leaves much room for doubt and distrust. Werner observes that instead of eliminating poverty, the WB policies and programs make us wonder whether they would rather eliminate the poor. Population control targeting poor families is very high on the WB agenda.

In 1993, the WB came up with the World Development Report entitled "Investing in Health." Werner (1994) states that perhaps a better title for the report is "Turning Health into Investment." He adds that the WB takes a "dehumanizingly market-oriented view of both health and health care." The WB's thesis is that "the purpose of keeping people healthy is to promote economic development." Werner insist that it should be the other way around, that economic development should promote health. For the WB, health is a means to economic development. On the other hand, health activists see economic development as a means towards achieving health for all.

In the same report, the WB underscores the "urgent need to overcome poverty and to guarantee the health needs of all people." It goes as far as to criticize the "persistent inequity and inefficiency of Third World health systems." At a glance, the WB report echoes some of the principles of the Alma-Ata Declaration, such as community participation, self-reliance, and health in the people's hands. However, upon closer inspection, these claims are reduced to mere rhetoric. Werner points out that the WB is purportedly promoting an equitable, cost-effective, and country-appropriate health system. However, the WB's key recommendations proceed from the same market-friendly, structural adjustment paradigm that exacerbates poverty and results in very negative consequences on the health of the world's poorest.

The WB's prescription for a three-pronged policy approach of health reform is supposedly aimed at "saving millions of lives and billions of dollars." But analysts have shown that the WB's health reform approach is nothing but

a rehash of a conservative strategy, with elements of structural adjustment, which had systematically derailed Comprehensive Primary Health Care. Analysts add that the WB's health reform agenda is nothing but a "market-friendly version of Selective Primary Health Care combined with privatization of medical services and user-financed cost recovery." Table 15 below presents the WB policy approach to health reform, side by side with a reading of the policy.

TABLE 15

Analysis of the IMF-WB's Health Reform Policy

**IMF-WB's Three Pronged Policy
Approach of Health Reform**

Foster an enabling environment for households to improve health.

Improve government spending in health.

Promote diversity and competition in the promotion of health services.

**Analysis of the
WB's Approach of Health
Reform**

Puts the responsibility of covering health costs back on the shoulders of the poor...in other words, fee for service and cost recovery through user financing.

Reduce government spending on health by drastically reducing services from a comprehensive to a very narrow, selective approach...in other words, a new brand of Selective Primary Health Care.

Turn over to private, profit-making doctors, and businesses all government services that used to provide free or subsidized care...in other words, privatization of most medical and health services.

STRUCTURAL ADJUSTMENT POLICIES OF THE WORLD BANK

The 1980s also marked the beginning of developing countries' staggering debt problems and huge interest payments. Despite the economic growth posted by some "miracle economies," majority of developing countries were reeling from the problem of foreign debt servicing, a worsening economic crisis, and social unrest. To meet debt repayment obligations to Northern Banks, the WB and the IMF extended "bail-out" packages to developing countries. These bail-out packages came in the form of new loans tied to Structural Adjustment Policies (SAPs). These loans were necessary to ensure continued foreign debt repayment, and purportedly, to promote economic recovery.

The SAPs usually come in the form of policies which include: cut-backs in public spending; privatization of government enterprises; freezing of wages and freeing of prices; increased taxation, especially sales taxes; and increase of production—including food—for export rather than local consumption.

According to Walden Bello (1999), a noted political economist and activist, "structural adjustment is the paradigm of development that the WB and the IMF have prescribed for countries in the South since 1980...a new kind of loan program that was designed to support not just one project but an enterprise to restructure the whole economy."

For over two decades, approximately 90 countries were subjected to SAPs, notwithstanding the inherent differences among developing economies. SAPs had the following basic elements: long-term 'structural reforms' to deregulate the economy; liberalize trade and investment; privatize state enterprises; and short term stabilization measures like cutbacks in government expenditures, high interest rates, and currency devaluation.

According to Werner (1994), the SAPs were designed allegedly to "streamline" the economies of poor countries. SAPs also bound these developing economies to international trade agreements that catered to the interests of big business and "free market" forces in the North.

Bello (1999) echoes Werner's analysis of SAPs, that the IMF-WB pressured countries "to adopt policies that would facilitate the repayment of their debts to the big international banks." He notes that "the objective of SAPs went beyond debt repayment of the attainment of short-term macroeconomic

stability.” The IMF and the WB, Bello adds, wanted the total “dismantling of protectionism and other policies of state-assisted capitalism that the IMF and the WB theorists judged to be the main obstacles to sustained growth and development.”

SAPs AND HEALTH CARE

Studies suggest that SAPs hit the poor in southern countries hardest. In the face of cutbacks in public spending, the first to be sacrificed is social services such as budgets on health, education, and food assistance. Among the very first institutions to be privatized are public hospitals and health centers which render health services inaccessible to the poorest segments of society. Moreover, structural adjustments and the neo-liberal economic paradigm pushed by these Multilateral Finance Institutions (MFIs) have resulted in greater economic hardships and deleterious impacts on the state of world health.

Health and social activists have continually asserted that the WB, instead of reducing the world's poor, has consistently financed policies that worsen their situation. The WB also has a very poor track record of transparency and reforming itself. This being the case, activists have called for dismantling the IMF-WB as the most effective way of eradicating poverty.

Bello (1999) notes that the WB finally abandoned SAPs two decades after the first structural adjustment loan. It took them this long to ditch the program despite overwhelming evidence of its failure early on. The SAPs approach was replaced by the Comprehensive Development Framework (CDF). The reason behind this change of policy, according to Bello, is simply that of “spectacular failure that could no longer be denied at the pain of totally losing institutional credibility. Despite decades of experience with the SAPs in more than 100 countries, the WB and the IMF found it difficult to cite even a handful of success stories.”

Bello (1999) adds that, “while self-doubt began to engulf the WB, the IMF, in contrast, plowed confidently on.” The absence of success of SAPs was “interpreted to mean simply that a government lacked political will to push adjustment.” It took the Asian financial crisis to force the IMF to “confront reality.”

According to Bello (1999), the world has long resented IMF's arrogance. The adverse impact of SAPs and the 1997 financial crisis was the proverbial straw that broke the camel's back. From 1998-1999, "criticism of the IMF rose to a crescendo and went beyond its stubborn adherence to SAPs to accusations of being non-transparent and non-accountable." In a debate in the U.S. Congress over a G-7 initiative to provide debt relief to 40 poor countries, American legislators depicted the IMF "as the agency that caused the debt crisis of the poor countries in the first place and some called for its abolition within three years."

It was not so much from a change of heart but because of increasing isolation and criticism that these institutions issued a disavowal of the SAPs approach (Bello 1999). Bello raised the issue of accountability pointing out, "one cannot just walk away from the scene of the crime, saying I was wrong and let's move on. The Bank and the Fund have been responsible for tremendous economic and social damage wrought on Third World economies for over two decades." Bello states that the top leadership of the IMF and the WB Group should take responsibility for their mistaken policies. In defining the future role of the IMF and the WB, Bello warns that we should always "take into account that tremendous resources were wasted on 6,000 highly paid World Bank personnel and 1,000 IMF staffers for them to produce and pigheadedly stick to a wrong and destructive strategy despite early warnings from civil society groups over the years."

Bello (1999) further recommends that the following measures be undertaken before one can say that a real reform is under way:

- (1) drastic reduction of the staff of the WB from 6,000 to 1,000, and of the IMF from 1,000 to 200; and major cuts in both capital expenditures and operational expenses of both institutions as a first step in transforming these institutions;
- (2) immediate dismantling of all structural adjustment programs in the Third World and the ex-socialist world and the IMF stabilization and adjustment programs imposed on Indonesia, Thailand, and Korea following the Asian financial crisis; and
- (3) creation of a Global Committee on the Bretton Woods institutions to evaluate and decide on the future of the WB and the Fund.

As previously mentioned, SAPs impact negatively on health and health care. They have resulted in the imposition of strict limits on government

spending on social services such as health. Many countries, subjected to SAPs experienced a dramatic drop in budget spending for health. The Inter-Church Coalition in Africa (ICCAF) states that "these budget cutbacks, combined with the increased influence of private initiatives, has led to an erosion of government's ability to implement a coordinated health care system." Presumably, this is happening, not only in Africa, but also in other regions subjected to similar conditions.

In the Philippines, the impact of the 1997 financial crisis prompted stringent fiscal targets that call for the implementation of extensive cuts for education and health. In 1999, the budget for education was reduced by 3.05 percent from what was originally proposed. The health sector budget was cut by 11.19 percent.

Moreover, SAPs have had a negative impact on health because they engendered budget cutbacks in government spending on infrastructure supportive of health and nutrition improvements like water supply, sanitation, roads, national and local food storage facilities, education, and communication infrastructure that facilitate dissemination of information about health and health care (Werner 1994).

It was also pointed out that SAPs lessen the possibilities for good health because they result in serious ecological as well as social costs. By intensifying poverty, SAPs have affected the environment because they force people to move to marginal lands and to overuse scarce resources to survive. To promote better health, more environmentally sound development paradigms/policies should be implemented.

DEMOCRATIC HEALTH SERVICE AND AN INTEGRATED HEALTH CARE SYSTEM

The failure of top-down development methods and inappropriate health care programs resulted in the growing clamor for a democratic, community-based, comprehensive vision of health care where communities are given the power and the tools to reduce problems of ill health, which are intimately related to the economic and social patterns of their society. Promoting democratic health practices would mean placing the definition and control of health care in the hands of those who use up the services. This will mean that people, especially women, will not be treated as the targets of

health campaigns, but as members of society with equal political rights, social status, and economic value.

The following are the basic elements of a democratic health service:

- (1) equitable distribution of food, water, sanitation, preventive health services, and free curative medical care to women, children, and men of all social classes in rural and urban areas;
- (2) support for community-based health care initiatives which give all members of a community control over decisions involving their health and livelihood;
- (3) affirmation of and concrete support for indigenous health care knowledge and practice;
- (4) support for and promotion of food security. In particular, the production of crops for domestic consumption must be given priority over commercial production of export crops. The redistribution of land is another important component of food security, as a more equitable and appropriate distribution of agricultural services and inputs to small farmers, especially women;
- (5) support programs, which would enable groups to overcome poverty, such as housing development, literacy training, improved education, and skills development programs for the poor; and
- (6) programs to combat family violence and sexual inequality.

WOMEN, HEALTH, AND STRUCTURAL ADJUSTMENT

Gender inequity impacts, not only women's health, but also the health of families and communities. Since women are tasked with caring for the family, any policy that undermines women undermines the health of families. The ICCAF points out that in Africa, SAPs exacerbate the gap between women's economic responsibility and their access to resources, as well as stress, time, and health.

Moreover, the ICCAF asserts that the SAPs' ability to attain their objectives may be at the expense of women, *i.e.*, women work harder and longer hours. While this cost may be invisible to macroeconomic policymakers because it is unpaid time/labor, it will manifest itself in statistics on the health and nutritional status of women.

SAPs, according to the ICCAF, have struck at income, access to resources, and level of education, which are the factors that condition women's ability to promote health and nutrition for themselves and their families. In Africa, as well as in other poor countries, the decrease in formal sector employment has forced women to engage in lower paying and "less productive" work in the informal sector.

With reduced employment opportunities and limited income, women spend more time doing odd jobs for extra family income. They also devote time to hunting for bargains and making and mending at home rather than buying. Thus, there is an increased demand on women's time that should be devoted to health and nutrition-related activities. All these demands leave women with very little time to take care of themselves and their families.

Moreover, women are expected to make up for the government cut back on spending for social services, particularly on health. It is also women who are first to make up for losses in the family income by taking on additional paid work or by providing unpaid labor to family enterprises. Finally, women face increased stress and fatigue brought in by decreased income and time.

TOWARDS A COMPREHENSIVE WOMEN'S HEALTH FRAMEWORK

Studies suggest that Filipino women's concept of health is not limited to the "lack" or "absence of disease or pain," nor is it limited to biomedical conditions. During the 1992 national conference of traditional healers held in Manila, the healers provided a holistic definition and view of health. In the said conference, health was defined as encompassing not only the physical state of the person, but also the mental, emotional, and spiritual dimensions. This holistic view of health is believed to be common to traditional healers worldwide (Menon, as cited in Canilao, *et al.* 1998).

A primer on comprehensive women's health published by Womanhealth Philippines, a national network of women doing work in the area of women's health, states that the Filipino woman's concept of health is articulated as "a life not only free from disease, but also free from mental and emotional stress, safe from physical or sexual violence, free from constricting social roles, and free from disempowering relationships."

These holistic definitions of health and women's health point to the need to study health within the larger sociopolitical and cultural contexts. It

is for this reason that health, particularly women's health, will be studied in relation to women's status in society and their productive, reproductive, and community management roles. Women's triple roles and life cycle were viewed against the background of the larger structural whole and other relevant factors, including history, geography and ecology, class, ethnicity, and gender.

COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

The 1960s and the 1970s took a narrow vision regarding the protection of women's health, taking fertility as merely one issue in family planning and population control. Since the 1994 International Conference on Population and Development (ICPD) in Cairo, broader attention was given to women's health (Shane and Chalkney 1998). From a focus in contraceptive promotion, family planning services are now integrated into the bigger reproductive health services.

Reproductive health is now defined in the ICPD-POA (Shane and Chalkney 1998) as: "the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. [This] therefore implies that people are able to have a satisfying sex life and that they have a capability to reproduce and the freedom to decide if, when, and how often to do so." The concept of reproductive health now reflects a shift from the single-focused population control ideology to a broader, human rights-based population and development framework. The link between population and development is defined and implies other development-related factors such as inequities in the distribution of resources, unsustainable patterns of production and consumption, unequal trade relations, the debt burden, and other social factors.

Approved in the ICPD-POA is the Program of Action that emphasizes the need to improve reproductive health. Alongside this was the creation of the Panel of Reproductive Health in Developing Countries composed of independent experts from several countries and fields of expertise that adopted the reproductive health embodied in the ICPD Programme of Action, that: the very act of sex should be free of coercion and infection; every pregnancy should be intended, and every birth should be healthy.

Although, no country in the world has met these goals, the panel notes that shortfalls are particularly acute in developing countries:

- (1) between 20 and 40 percent of births in developing countries are unwanted or inopportune, posing hardships for families, and jeopardizing the health of millions of women and children;
- (2) an estimated 50 million abortions are performed each year, with some 20 million of these performed in unsafe circumstances or by untrained providers;
- (3) nearly 600,000 women die each year from pregnancy-related causes 99 percent of whom live in developing countries. Each year, 7.6 million infants are stillborn or die in the first week of life;
- (4) there are more than 333 million new cases of curable STDs worldwide each year. As a result of these infections, a large proportion of couples in some regions cannot conceive the children they want. Among women who have sexually transmitted infections and who become pregnant, between 30 to 70 percent will transmit the infection to their infants. Many of these infected women will deliver prematurely or suffer a miscarriage or stillbirth; and
- (5) nearly 22 million people are estimated to be infected with the Human Immune-Deficiency virus or HIV; 14 million of them live in sub-Saharan Africa, but the number of people infected is rapidly increasing in Southeast Asia. STD infection increases the risk of transmitting HIV through heterosexual contact by at least two to five times.

The same panel recommends that policymakers, researchers, and health care providers prioritize prevention and provision of information about STDs and other reproductive tract infections (RTIs). Among their other recommendations are:

- (1) provide treatment for RTIs at the family planning and health services level;
- (2) improve essential services for women;
- (3) expand access to contraceptive services and information; and
- (4) eliminate sexual violence and coercion.

In the 1995 Fourth World Conference for Women held in Beijing, commitments were made under the Platform for Action. Strategic Objective

C.1 states the need to “increase women’s access throughout the life cycle to appropriate, affordable, and quality health care, information, and related services.” Other commitments related to reproductive health under this strategic objective include:

- 106 (j) Recognize and deal with the health impact of unsafe abortion as a public concern...
- 106 (u) Rationalize drug procurement and ensure a reliable, continuous supply of high quality pharmaceutical, contraceptive, and other supplies and equipment using the WHO Model List of Essential Drugs as a guide, and ensure the safety of drugs and devices through national drug regulatory and approval processes.

Other Strategic Objectives that called for commitment include the following: Strategic Objective C.2 calls for strengthening preventive programs that promote women’s health; Strategic Objective C.3 calls for undertaking gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive tract health issues; Strategic Objective C.4 calls for promoting research and disseminating information on women’s health; Strategic Objective C.5 calls for increased resources and monitoring follow-ups for women’s health.

WOMEN’S TRIPLE ROLE

Women’s social status impacts on their individual health as well as on their ability to take care of the health of their families and their communities. Thus, the women’s social status, particularly their multiple roles, are all considered in this study of indigenous women’s health knowledge and practices.

Moser (1993) provides the conceptual definition of women’s triple roles where the reproductive role is comprised of:

... childbearing/childrearing responsibilities and domestic tasks undertaken by women, required to guarantee the maintenance and reproduction of the labour force. It includes not only biological reproduction but also the care and maintenance of the workforce (husband and working children) and the future workforce (infants and school-going children).

Overholt (1985) cites the following as other examples of activities related, but not limited to the reproductive role: fuel, fodder, and water collection; food preparation; birthing; childcare; education; health care; and laundry.

Productive role, on the other hand, is defined by Moser (1993) as "work done by both women and men for payment in cash or in kind. It includes both market production with an exchange value, and subsistence/home production with an actual use-value, but also a potential exchange value. For women in agricultural production, this includes work as independent farmers, peasant's wives, and wage-workers."

Community work, on the other hand, consists of two activities, that of community-managing work and that of community-political work. This distinction is made in the context of Third World countries with low-income communities where community-managing work is usually the task of women while community-political work is often considered the domain of men. Moser (1993) defines community-managing work as "activities undertaken by women at the community, as extension of their reproductive role. This is to ensure the provision and maintenance of scarce resources of collective consumption such as water, health care, and education. It is voluntary unpaid work, undertaken in "free time." The community politics' role, in contrast, comprises [of] activities undertaken by men at the community level and organizing at the formal political level. It is usually paid work, either directly or indirectly, through wages or increases in status and power."

Feminists assert that these roles should be complementary rather than hierarchical. They also advocate an equal valuation of these roles. Sexual division of labor is evident in the traditional roles played by women and men, *i.e.*, productive work is the "responsibility" of men, while reproductive work and community managing roles (e.g., self-help community initiatives) are women's "concerns." Feminists also question the privileging of productive work over the other socially necessary labor. They assert that gender should not be the organizing principle in the social division of labor and that both men and women should share in performing these roles. They reject the essentialist assumption of a "natural" division of labor. Such assumption posits that it is "natural" for men to be breadwinners while it is "natural" for women to stay home and perform the productive roles. And should the women leave the house, they should confine themselves to community-

managing tasks. These roles, according to feminists, should rightly be viewed as "different but equal" and complementary.

LIFE CYCLE APPROACH

Indigenous health knowledge and practices cover the entire life cycle. From the start of the research process, we were conscious of not imposing our own lowland and perhaps western concepts. The life cycle approach was adapted to the concrete realities of the Kankana-eyes of Badeo. They were the ones who identified the significant stages and events from their own perspectives and realities. Moreover, indigenous health knowledge and practices throughout the life cycle were considered in relation to the community residents' lives, gender roles, and responsibilities.

The life cycle starts at birth, and in many traditional or indigenous cultures, is usually accompanied by the announcement of the birth to the community. The announcement is in turn accompanied by the observance of purification rituals which may vary depending on the sex of the child (Negussie 1988). The life cycle approach is employed in this study since women have different statuses and roles throughout their life cycle. For example, in many societies, the subordinate status of female children and their performance of reproductive tasks at a young age affect their health. In the meantime, how society views elderly women and their prescribed role in the community has an impact on the elderly women's health status. In some societies, the prevalence of purification rituals and genital mutilation in the guise of "cultural practices," especially among girls and female adolescents, have onerous consequences to their health. The general situation of women in the particular society/culture (e.g., female subordination), the different life stages and corresponding women's roles have profound impacts on women's health and well-being.

"REVALUING" INDIGENOUS HEALTH KNOWLEDGE AND PRACTICES

The growing interest in indigenous medicine as a "revaluation" of a natural means to health is a welcome development. This is manifested in the growing interest in herbs and their medicinal properties, organic products,

natural nutrition, home remedies, integrated/holistic health care, and alternative therapies and the acknowledgement of the important role of female as well as male traditional healers. (Canilao, *et al.* 1998)

Integration into the market economy cost the Cordillera people the integrity of their indigenous cultures. Although indigenous languages, arts, and social institutions persist, therapeutic healing traditions are slowly disappearing due to the onslaught of modernization.

Fortunately, Badeo is one of the most remote barangays of Kibungan. The relative isolation of Badeo has made it one of the few areas where indigenous health knowledge and practices continue to flourish.

Chapter 4

PARADIGMS AND METHODS

A quiet methodological revolution has been taking place in the social sciences, especially among the health professions over the past two decades. Where only statistics, experimental designs, and survey research once stood, research has now opened its doors to ethnography, unstructured interviews, textual analysis, and historical studies.

In the past, the watchword in research was, "We're doing science." Now, research is *experimenting with the boundaries of interpretation*. Research is no longer the rigid, mechanistic, and self-contained scientific system it used to be. More and more, research is taking into account social change and characteristics of race, ethnicity, gender, age, and culture to fully understand social phenomena. In the health sciences, an implicit critique of the traditional scientific worldview and quantitative methods is also taking place. All of these trends have fallen under the rubric of "research."

Various paradigms and perspectives guide the conduct of any inquiry or research. This chapter presents the paradigms and perspectives underlying the conduct of this research study. In this section, we will first look at scientific research by examining the meanings of methodology.

PARADIGMS AND PERSPECTIVES OF THE RESEARCHERS

This section explores our worldview as researchers, the participants' place in it, and the range of possible relationships that exist in this world and its parts. It delves into our basic assumptions, the important questions that need to be answered, and the research techniques that will ensure this to be a good scientific research.

One of the things we had to deal with in the process of our research was the multidisciplinary nature of the research group. We come from different backgrounds and thus have varied experiences and perspectives. The struggles we went through as a team and the learnings and insights we derived in the end contributed to the framework of this feminist participatory research.

The research paradigm is based on epistemology, ontology, and methodology. Our paradigm and perspectives as feminist researchers also cut across that of critical theory and other related ideological positions and that of constructivism. We found it quite difficult to draw the line, though as feminist researchers, we argue that the more crucial issue is how our worldview was applied in this research undertaking.

Ontology raises basic questions about the nature of reality—how things really are and how things work. In ontology, reality is believed to be shaped, over time, by social, political, cultural, economic, ethnic, and gender factors. It crystallizes into a series of structures that can be incongruously taken as real, natural, and immutable. For our purpose, we think that the structures are “real,” but only as virtual or historical reality.

Realities can come in the form of socially and experientially based multiple and intangible mental constructions that are local and specific in nature notwithstanding the fact that individuals across cultures may share many of these constructions. The key word here is construction because reality is seen only as an interpretation of experiences. These realities depend on the individual persons or groups making these mental constructions. Constructions are not “true” in any absolute sense, but simply conventions which are informed or sophisticated. Constructions are alterable, as are their associated “realities.” The same holds true for the knowledge, practices, and experiences of the women who participated in the study. Their perceptions, practices, and beliefs are historically constructed truths, and thus, are not immutable. Because they are context-bound, these “realities” are alterable.

Epistemology probes into how well we know the world. It looks into the nature of the relationship between the knower and the known. As investigators and participants, we are interactively linked with our values which inevitably influence our inquiry. Research findings, therefore, are value mediated. Since what can be known is inextricably intertwined with the interaction between researchers and participants of the study, we assume that “findings” are literally created as the investigation proceeds. This is shown in the interplay of the *emic* and *etic* perspectives presented in the study.

Methodology focuses on how we gain knowledge about the world and what is perceived to be reality. This guided us in the research process. Methodology should be dialogic, dialectical, and relative. Since we viewed

our relationship with the participants as transactional, the research required a dialogue between the researchers and the community. We believe the relationship to be dialectical in nature because there is a need to transform lack of awareness and misapprehensions—accepting historically mediated structures as immutable—into more informed consciousness—seeing how the structures might be changed and identifying the actions required to effect change. As Giroux (1988) puts it, “transformative intellectuals [need to]... uncover and excavate... forms of historical and subjugated knowledge that point to experiences of suffering, conflict, and collective struggle... [and] to link the notion of historical understanding to elements of critique and hope.” We view the nature of social constructions as individual constructions that can be elicited and refined only through interaction between and among the investigators and participants.

Based on the above positions, we tried to grapple with their implications on some issues that usually confront researchers.

DEALING WITH SELECTED ISSUES

The first issue we dealt with in this research was the aim or purpose of our inquiry. We did not want a mere explanation of phenomena. What we wanted was to understand and possibly, to reconstruct the constructions that people—the community, the women of Badeo, and ourselves—believe in. We aimed for consensus, keeping ourselves open to new interpretations as the information was had. Over time, everyone formulated more informed and sophisticated constructions and became more aware of the content and meaning of competing constructions.

Advocacy and activism are key concepts in this view. Thus, in the research process, we found ourselves in the double role of participant and facilitator, a position that went beyond our expertise and competence.

The advocacy and activism inherent in the research process allowed us to critique and work towards transforming the social, political, cultural, economic, ethnic, and gender structures that constrain and exploit humankind. We did this by engaging in confrontation and conflict. Again, this is to adhere to the holistic framework of the study. However, judgment on needed transformations should rest on the people whose lives will be most affected by such transformations, *i.e.*, the people of Badeo themselves.

The second issue dealt with the nature of knowledge. As feminist participatory researchers, we were not verifying hypotheses. Knowledge consists of a series of structural/historical insights that will be transformed as time passes.

Transformations occur when ignorance and misapprehensions give way to more informed insights by means of a dialectical interaction. Since we believe that women's reality is not only historically constructed but also constructed individually by their experiences, knowledge consists of constructions that have achieved relative consensus or at least some movements toward consensus among those competent to interpret the substance of the construction or in this case, the community and the women of Badeo. These constructions are subject to continuous revision, with changes most likely to occur when relatively different constructions are juxtaposed in a dialectical context.

Therefore, the "knowledge" generated by the study may be "true" for a limited time such as the time of the study, and therefore cannot be considered a definitive generalization. Context is ever changing, as the perception of reality is. Generalization cannot be achieved, since this was not the aim of the study in the first place.

The third issue we dealt with was the way knowledge accumulates. Knowledge does not accumulate in an absolute sense. Rather, it grows and changes through a dialectical process of historical revision that continuously erodes ignorance and misconceptions and gives way to more informed insights. Also, knowledge accumulates in a relative sense through the formation of more informed and sophisticated constructions via the hermeneutical/dialectical process. This occurs as various constructions are juxtaposed against old constructions. One important mechanism for transferring knowledge from one setting to another is providing vicarious experience such as the case studies or experiences of women in the study. Women pass on health knowledge and practice to their children thus, the dialectical process of knowledge accumulation.

The fourth issue we looked into was the appropriate criteria for judging the quality of the research. A good research study situates itself historically. It bears in mind the social, political, cultural, economic, ethnic, and gender antecedents of the studied situation. Good research helps erode ignorance and misapprehensions by providing a stimulus to action to transform existing structures. These motivated us to collectively work with the community to

target a priority concern. Thus was born the *AAG-I TAKO ED BADEO* or Friends of Badeo, an educational assistance program for young Badeo men and women.

Data should be trustworthy in the sense that it should accurately represent the participants' experiences. The study should be credible, dependable, confirmable, and transferable. This is the reason we stayed in the area for at least five days per visit. We visited the site several times for a span of one and a half years. We also employed local interviewers who returned to the research site to see whether our findings were true to the participants' experiences. Two validation sessions were held to check whether the reported findings were accurate. This is important because it establishes dependability on the study. Data cannot be dependable without credibility.

All our activities were recorded over the entire duration of the research in a way that can be understood by other researchers. This is to chronicle the thinking that led to our conclusions. However, the transferability of the findings still rests on the potential user of the findings and not on the researchers. Lincoln and Guba (1985) state that it is the "responsibility [of researchers] to provide a data base that makes transferability judgment possible on the part of the "potential appliers."

For the *authenticity* criteria of fairness, we looked into ontological authenticity (enlarges personal constructions); educative authenticity (leads to improved understanding of constructions of others); catalytic authenticity (stimulates to action); and tactical authenticity (empowers action) (Denzin and Lincoln 1994). Though our response to this was quite limited, we believe that this contributed to the rigor of the study.

The fifth issue we dealt with was the role of values in the research process. The values of researchers inevitably shape research outcomes. Our ontological and epistemological positions reveal the role of subjectivity in the research. We believe that the original constructions or *emic* deserve equal consideration with those of other, more powerful audiences and the researchers or *etic* (Denzin and Lincoln 1994; Streubert and Carpenter 1995). As facilitators of the research, our values reflected the research topic we chose and the outcome of the study.

We also looked at the place of ethics in our research. This is the sixth issue we had to face. Ethics is intrinsic. This is illustrated by the desire to change the ignorance and misconceptions of people, and to take full account of values and historical context. Ethics is *intrinsic* because of the inclusion of

participant values in the inquiry (starting with respondents' existing constructions and working toward increased information and sophistication in their constructions as well as in the inquirer's construction). As mentioned earlier, the hermeneutical/dialectical methodology itself provides a strong but fallible safeguard against deception.

We also asked ourselves what "voice" our activities should mirror, especially our activities that aim to change. We would like to borrow Giroux's (1988) term, "transformative intellectual" and Lincoln's (1991), "passionate participant" to illustrate the voice we want to describe our efforts with. This voice is the voice of expanded consciousness that aims to confront ignorance and misapprehensions.

As passionate participants in the research process, we were actively engaged in facilitating the multi-voice reconstruction of our own construction as well as that of the community's and women participants.' Change is facilitated by this voice as the community and women develop greater insight into the existing state of affairs or the nature and extent of their condition. This is hoped to stimulate them to act on and to change their situation and circumstance (Denzin and Lincoln 1994; Guerrero 1999; Maaguire 1999).

As the seventh issue, we confronted the implications of our research paradigms and perspectives from a multidisciplinary point-of-view. The research team was composed of a historian, two sociologists, a philosopher, and a health professional. Understandably, we had varied perspectives in research. We resolved to remedy this by re-socializing our early and usually intense exposure to the orthodox view of science. We accomplished this by reviewing the postures and techniques of positivism and post-positivism vis-à-vis the more progressive postures of critical theory and constructivism.

The acknowledged role of quantitative research played a useful informational role in the study and the qualitative research methods where it carries out the dialogic/dialectical or hermeneutical/dialectical methodologies. We had to help one another in understanding the social, political, cultural, economic, ethnic and gender history and structure that served as our framework. We also endeavored to incorporate the values of altruism and empowerment in our work.

As researchers, our philosophical commitment lies in discovering knowledge using the means that most appropriately explain the research interest. We are inclined to embrace human understanding of experience,

meaning of life worlds, the essence of experience, the attentive practice of thoughtfulness and caring attunements with such commitment because we are social scientists. To us, this is what being a social scientist is all about.

RESEARCH DESIGN

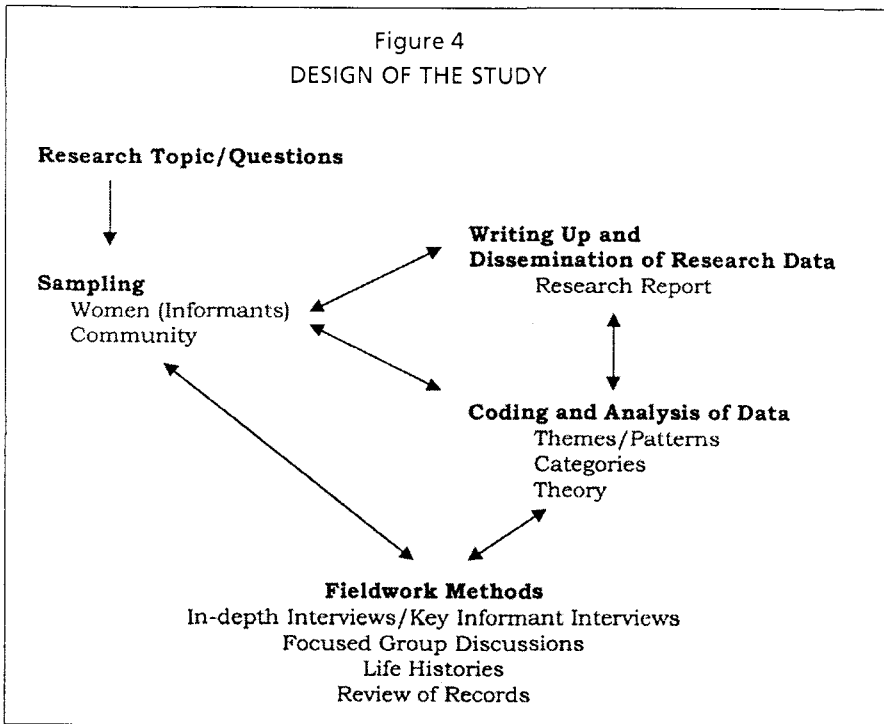
The research project is basically qualitative. Feminist ontological, epistemological, and methodological insights guided this feminist participatory research. It employed the participatory method that involves respondents in all stages of the research cycle: from conceptualization to completion of written report. In depth-interview methods, consciousness-raising, problem-posing, and capability-building were incorporated. Coming from different disciplines, we used the dialogical and nonhierarchical method where we only acted as facilitators. The study explored various qualitative and alternative research methods including life histories narrated by women, aided by tape recorders and video cameras; focused-group consciousness-raising about the worth and capabilities of a woman who is an expert knowledge-producer; community meetings—where participants other than women were invited—to determine the locus of women's knowledge in the life world of the community.

SELECTION OF PARTICIPANTS

The indigenous women served as sources of information. They are referred to as participants or informants, not subjects, because they will not be acted upon. They were part of the study and were active participants in helping the researchers better understand their lives and social interactions.

The participants were selected based on their first-hand experiences with a culture and social interaction or phenomenon of interest. There was no need to randomly select the participants because manipulation and control was not the intent of inquiry. Since the goal was not to generalize the findings, there was no need to determine how many individuals in the group needed to be observed and/or interviewed.

The type of sampling used is purposeful (Guba 1985; Patton 1990) or theoretical (Glasser and Strauss 1967; Patton 1980; Minichiello *et al.* 1990;



Guerrero 1999; Patton 1999). This type of sampling denotes a commitment to observing and interviewing those who have experience with the culture or to the phenomena of interest. Table 16 presents the participants of the study.

In the study, there were 24 key informants 12 of whom were women who shared their perspectives on indigenous health knowledge and practices throughout their life cycle. It was difficult to tell the respondents' exact ages as they had no birth certificates to show. Events, such as World War II and their grade level during that time, were used as time reference. Most of the informants have little exposure to other communities outside Badeo. Their contact is limited to marketing or seeking professional help for health-related matters. None of them had ever been employed outside of Badeo.

Fifty percent of the respondents have grandchildren. Two of the respondents have children at the primary school level. All of the women married through the *kalon*, a system of arranged marriages.

Two of the five *mambunongs* were women. Only one of the four *mansip-oks* was a woman. Two of the three *man-ilots* were women. One of the two *hilots* was

TABLE 16

Key Informants Identified by Group and Sitio, Badeo, Kibungan
1997-1998

KI GROUP	NAME	SITIO
Mambunong	Martes Papsa-as Alladog Bagesbes Dalina Gapad Francisco Abansi Lagdao Jose	Lebeng Tebteb Makbas Libo-ong Paitan
Mansip-ok	Francisco Abansi Martes Papsa-as Dalmo Vicente Lagdao Jose	Libo-ong Lebeng Tableo Paitan
Man-ilot	Gimsoy Abasi Masalin Ducayang Agnes Tagtag	Mocgao Proper Tuba
Hilot	Modesto Bagesbes Marina Lagitao	Lebeng Tuba
Bab-baket	Romana Gatung-o Martes Wanaten Dalina Gapad Mrs. Gigia Sayap Giwaden	Proper Proper Makbas Poblacion Tableo
Lal-lakay	Fred Caoili Edong Wanaten Mr. Cawatig Lomindo Balang	Proper Proper Amlawa Kabututan
Married Women	Herminia Gapad Agustina Quilino Maxilinda Padilla Maselene Ducayag Aida Anud	Makbas Proper Mocgao Proper Tableo

a woman. There were five *babbakets* or elderly women, four *lallakays* or elderly men, and five married women who were interviewed for the study.

Almost all adult men and women participated in the community assemblies held for the purpose of gathering and validating data. Separate sessions were held for community and women's concerns.

The above women and men participants, considered "experts," gave sufficient perspectives for us to capture the intent of the study. While in the community, we were able to observe community affairs/activities such as a wedding, daily activities, and community assemblies.

INSTRUMENTATION

In this type of research, as mentioned in our epistemological position, we, the researchers, were the main instruments. This was because of our active participation in the research process, where we were deeply immersed with the data. Thus, we, together with the local interviewers, were the observers, interviewers, and interpreters of the various aspects of the research. Such process required us to dwell on the data, which in turn required from us an extremely high level of dedication and commitment to reading, intuiting, analyzing, synthesizing, and reporting what we discovered. This proved to be most difficult and challenging because of the multidisciplinary characteristic of the team.

Triangulation of data collection methods was utilized namely: in-depth interviews of key informants, focused-group discussions, and life histories.

Interviews

The principal method employed in this study was the conduct of informal and formal guided interviews or conversations, where the indigenous women shared control of the interview and participated in setting the agenda. Often described as "a conversation with a purpose" (Khann and Cannell 1957), an interview is a method of data collection that aims to obtain valid and reliable information. It also aims to find out what is in and on someone else's mind and to access the perspective of the person being interviewed (Thorne 1980; Patton 1990).

Several approaches were used for collecting data. Most of the interviews—done by the local interviewers and researchers—were unstructured and informal. It transpired during fieldwork. Our encounters with the indigenous women during the fieldwork provided extensive opportunities for conversational interviews. The indigenous women spontaneously offered information and the flow of the interactions were natural. Broad issues were raised in the early interviews and emergent themes were followed up in successive meetings by a process of progressive focusing. This technique goes beyond the concern with formal interviewing or fieldwork itself, thus bringing to fore the integrity of the phenomenon and preserving the viewpoint of the women through observation, exploration and explanation-seeking (Fontana and Frey 1998). These interviews transpired whenever possible, especially with the local interviewers. Being with the indigenous women during the fieldwork provided extensive opportunities for informal conversation interviews.

The content of informal interviews guided the formal interviews that were subsequently conducted with the indigenous women. Interview guides were formulated based on the informal interviews and observations in the field.

Each indigenous woman in the study was interviewed one to three times. The interviews took place in Badeo where the participants live. All formal interviews were tape-recorded with their approval. The language of the interview was in Ilocano or in Kankana-ey. English was used once in a while but participants were checked whether they understood the questions posed in English. The taped interviews were transcribed using the approach suggested by Minichiello *et al.* (1990). Researchers were asked to write their personal logs while the research associate assisted in writing the transcript files which were validated by the participants.

Writing the interview reports was one of the more tedious and difficult tasks of the research. It involved many hours of listening and rewinding the tapes to transcribe them. The advantage, however, was that we were able to internalize the contents of the interviews while mentally forming a picture of the themes and sub-themes that were emerging.

Focused-Group Interviews

While in-depth interviews with individual women provided us a deep insight of the experiences, knowledge, and practices on health of the people of Badeo, focused group interviews offered the potential of gaining a wider range of opinions and experiences. We considered “user-friendly” research methods to allow each informant the freedom to participate at a level she felt comfortable with. This also allowed us to value the contributions made by each person (Morgan and Krueger 1993; Conaco 1999). The focus group allowed intensive exploration of opinions, feelings, attitudes, and behaviors. The stimulating nature of the focused group interviews gave us additional and equally, if not richer information, than the information elicited from individual interviews.

A guide question was formulated in the conduct of the discussion. With the approval of the women who participated, the sessions were tape-recorded. The recordings were also transcribed and analyzed.

Life Histories

A life history is a research method where researchers listen to life histories for the purpose of understanding a particular aspect of the individual's life (Polit and Hungler 1995; Streubert and Carpenter 1995; Burns and Grove 1993; Aquino 1999). Leinenger (1985a) notes that this method is valuable for studying patterns and meanings of health and health care among the target groups. In the study, we asked indigenous women to narrate their ideas and experiences regarding various aspects of health knowledge and practices. This method was facilitated by the interview methods earlier discussed.

DATA PROCESSING AND ANALYSIS

According to Marshall and Rossman (1989), the process of bringing order, structure, and meaning to the mass of collected data is a tedious, ambiguous, time-consuming, creative, and fascinating phase of the research. It involves organizing the data, generating categories, identifying themes and patterns, searching for alternative explanations, and writing the report. It

goes hand in hand with data collection. Though the researcher is guided by initial concepts, these are shifted or discarded as the data are collected and analyzed. (Glaser and Strauss 1967; Vidich 1969; Marshall and Rossmann 1989; Minichiello *et al.* 1990). The identification of the life cycle, for example, emerged from the people of Badeo's experiences. Interestingly, their characterization of the life cycle does not coincide with the traditional notion of the life cycle found in books.

In this study, data analysis was a continuous process. As is apparent in Figure 4, it was not a distinct stage isolated from the data collection process. In the course of gathering data, ideas about possible meanings occurred and thus constituted the start of analysis. Data were analyzed as they were collected. It was through this cyclical process of gathering and analyzing data that theories and patterns were developed or hypothesized and further explored.

It was anticipated that the data generated by the fieldwork methods would be voluminous. At certain points, we logged data in our personal logs and those of the local interviewers. Then the data were categorized/organized and written in a more analytical form after the fieldwork. Analysis entailed data reduction as the reams of collected data were brought into manageable components for interpretation.

The combined process of reflection, imaginative thinking, and systematic sifting and analysis of evidence from the data guided its analysis (Spradley 1980; Hammersley and Atkinson 1983). The end point of analysis was to identify conceptual categories such as concepts linked together from an analysis of the observations, interviews, and other sources of data.

After we reached the point of saturation, we stopped gathering data. We came to this point when we noticed the data becoming repetitious, with the same issues being raised by the respondents. According to Morse (1994), saturation refers to the repetition of discovered information and confirmation of previously collected data and no additional data can be found that would add to the categories being developed or examined (Minichiello *et al.* 1990). Rather than sampling a specific number of individuals to gain significance based on statistical manipulation, the researcher is looking for repetition and confirmation of previously collected data. The researcher recognizes the repetition and determines that the addition of new information confirms the findings rather than adding new information.

However, according to Streubert and Carpenter (1995), saturation is achieved for a specific culture or phenomenon at a particular time. If another group of individuals were observed or interviewed at another time, new data maybe revealed.

Issues of "reliability and validity" as mentioned earlier were addressed to establish the trustworthiness or rigor of the findings. Every systematic inquiry must address the following issues: the value of the study, its applicability, its consistency, and its neutrality (Lincoln and Guba 1985; Kirk and Miller 1986; Reid 1991; Muecke 1994; Paterson 1994).

The research methods utilized in the study created many difficulties in establishing reliability. Techniques for gathering data were highly individualistic and involved complex intermingling of observations, interviews, and other procedures. Informants do not remain static over months of research and neither do the researchers. However, Robertson and Boyle (1984) claim that it is possible to establish reliability for portions of the research inquiry. Two or more observers can observe the same event or interaction simultaneously and establish inter-rater reliability. It is also feasible to determine inter-informant reliability for key informants, especially with concrete data (Pelto and Pelto 1978). In the study, the involvement of the local interviewers contributed to the reliability of the study.

Considering the various areas of the research design, we addressed the issues of validity and reliability or as mentioned earlier, trustworthiness, using measures suggested by various scholars. Validity or measuring what is intended (Mackenzie 1994) were addressed by the following measures:

- (1) *Sampling: People, Time, and Place.* Validity was addressed by choosing indigenous women who have an insider's knowledge of the topic of interest. The information gathered was sufficient to identify and develop the themes and sub-themes of the study.
A great amount of the research time was also spent with the indigenous women in the communities, which facilitated the development of the themes and sub-themes.
- (2) *Data Collection Methods and Fieldwork.* According to various researchers, a lengthy stay in a community, as well as extensive and intensive data collection, contribute to the validity of findings. Interviewing and observing over time allowed us to check the consistency of responses or activity. The mix of methodologies that we used helped

verify findings and pointed out areas that needed to be scrutinized further (Pelto and Pelto 1978; Field 1983; Steckler *et al.* 1992; Mackenzie 1994).

The triangulation of data gathering methods and multiple samples was utilized to overcome threats to validity. Triangulation is the use of multiple methods or perspectives to collect and interpret data about a particular phenomenon in order to come up with an accurate representation of reality (Field 1983; Mitchell 1986; Hinds and Young 1987; Burns and Grove 1993, 1995; Mackenzie 1994; Polit and Hungler 1995). We used triangulation by collecting data from various sources.

Information was validated through feedback from the indigenous women. The validity of the findings was increased when the feedback was beneficial to us, the researchers and to the participants. In such instances, we were able to validate observations and information from informal interviews, and the participants were able to reflect on the feedback given. Repeated field visits provided opportunities to validate previous observations or interviews. The research went as close as possible to the setting to establish familiarity with the indigenous women.

- (3) *Analysis.* An explicit framework for data collection and analysis as shown in Figure 4 guided our research. As mentioned earlier, data analysis was part of the data collection, not a distinct stage. According to Robertson and Boyle (1984), contradictions or other puzzling features of the data can be further assessed in the field.
- (4) *Report.* Verbatim responses of the indigenous women and local terminologies/terms were used to document evidence for interpretation of the findings. Also, information from other methods of data collection that included dates and places where information was derived was also included to allow readers to decide on the level of generalizability to the research setting and relevance to practice.

The reliability or consistency of measurement (Mackenzie 1994) was addressed by the following measures:

- (a) *Data Collection.* In the study, data collection was conducted over a period of one and a half years to check the consistency of

response or activity. Also, our role as researchers and our relationship with the indigenous women and the community were made explicit as a measure to increase reliability of study.

- (b) *Analysis.* Field notes were conscientiously reviewed to uncover potential sources of bias as well as inconsistencies in the data. Interviews were transcribed and comments/recommendations were solicited to check inferences with the indigenous women and the community. Comments of colleagues on drafts of analysis were also solicited to check the consistency of our interpretation and to reduce researcher bias that may have been introduced in the study. The initial results of the study were presented in public fora on three occasions.

LIMITATIONS, WEAKNESSES, AND UNCONTROLLED BIASES

There were several shortcomings and potential sources of bias in our approach. A major limitation of the research was the validation of the indigenous health knowledge and practices. It was limited to medical soundness, *i.e.*, the scientific basis of such knowledge and practices. Coming up with an ethnographic study was simply beyond the capability of the researchers and the methodology used. Nevertheless, we attempted to provide a preliminary, albeit very limited ethnographic, validation for the indigenous health knowledge and practices of the people of Badeo, Kibungan, Benguet.

The study was limited to the perspective of indigenous women in Badeo, Kibungan, Benguet. It was beyond the scope of the study to include other communities in the Cordilleras. The results of the study cannot be assumed to reflect the perspective of all indigenous women in the Cordilleras. Notwithstanding, the participation of the indigenous women who are traditional health providers would provide rich and expert information.

Among the study's limitations were the methods of data collection. The quality of information gathered during in-depth interviews, focused group discussions, and review of documents were largely dependent on the researchers including the local interviewers. Despite our past experiences and our involvement with other studies, selective perception was possible during the study. Psychology and sociology claim that human perception is highly

selective so that what people see is highly dependent on their interests, biases, and backgrounds. Culture tells people what to see; early childhood socialization instructs on how to look at the world; and value systems tell how to interpret what passes before the eyes. We attempted to improve the accuracy, validity, and reliability of observations by preparing the method and by soliciting feedback.

The use of secondary data also posed as a limitation to the analysis of the study. The available secondary data were from surveys conducted by the municipal staff from various programs. Thus, the data collected were reflections of their needs and biases as well as of government mandates and thrusts. This resulted in major data gaps, especially along the lines of comprehensive reproductive health and other socioeconomic, political, and cultural data needed in relating their influences to health.

A limitation during the initial interviews was the presence of men during the discussions. Initial analysis revealed that women's voices were not heard as often as the men's. Although they were not invited, we could not exclude the men from the interviews because they were there. It would have been impolite to send them out and to exclude them from the interview. The entire community was curious about what was going on: who we were, and why we were in such a remote area. We remedied the situation by requesting the community to send only women to some focused group discussions. The reasons were heard and respected by the men.

Since the time for interviews varied, conversational data recorded were only as accurate as our memory allowed. Notes were not taken at all times and the tape recorder was not always used so we had to struggle with recalling and writing notes after the interviews, especially for informal and unplanned interviews. The constraints of fieldwork, such as absence of electricity, physical fatigue, and limited space also contributed to this limitation.

Translating the interviews from the local dialect to English also presented a difficulty. Meaning and impact of the words in the vernacular could have been lost in translation. To counterbalance this limitation, we hired a translator who spoke the local dialect who also critiqued the final output.

The time frame of the study posed as another constraint. Although efforts were made to make life in the field orderly and manageable, the dynamics of field research proved to be unpredictable at certain times. We encountered problems such as defective recording equipment. Another fieldwork saw a majority of the women in the *uma* busy with their economic

activities. The rainy season also prevented us from conducting field visits because of unexpected landslides and slippery foot trails.

We recognize that personal and professional biases may have influenced our observations, findings, analysis, and conclusions.

Another methodological dilemma had to do with the interdisciplinary nature of the research. While we recognize the value of interdisciplinarity, going through this feminist research process has made us more aware of the difficulties of such an undertaking. Coming from different disciplinary backgrounds and ideological perspectives could also be very problematic. We felt a couple of times that perhaps we were making the research process more difficult and belabored. The challenge lay in coming up with complementary insights, which in turn, could provide us with deeper and broader understanding and insights. We would like to believe that our “belabored” experiences with this “feminist research process” and with reflexivity and self-reflexivity have provided us with an added wealth of experience for future endeavors in our professional and personal lives.

We still believe that researchers should continue viewing experiences of those being studied through the eyes of the informants, giving emphasis on the dynamic, holistic, and individual aspects of human experience. Researchers should capture these aspects in their entirety and within the context of those experiencing them.

ETHICAL CONSIDERATIONS

While we did not have a research review board, we believe that qualitative studies, like quantitative studies, should be conducted with the highest ethical standards. We recognize that the protection of human subjects is essential in the conduct of any type of research as individuals have the right to self-determination. Therefore, ethical considerations of consent and reciprocity in terms of decision-making were considered. The participants knew of and agreed to be partners in the research process and were aware of and agreed on how data were utilized and the benefits of participating.

Before any interview, the purpose of the research was discussed with the respondent to assure confidentiality and to gain consent. Although a written consent could be obtained from each informant as an ethical consideration, we gathered that it was not necessary and doing so may be potentially intimi-

dating and offensive in this particular research setting. Literacy was also a problem. However, in their culture, the spoken word is taken as a binding contract. As such, to ask for a signed consent may imply mistrust. Gaining consent in this situation was not a “one-off” event, but a continuing process of negotiation between us, the women, and the community, implying a long-term obligation on our part as researchers to maintain a relationship of trust and mutual consent.

The informants were assured that we would do our best to keep the information confidential and anonymous. Transcript files were coded, as well as the names of the participants in the personal and analytical field notes. They were informed that they could decline the interview. They could choose to forego participation in the study. The researchers’ presence during the early stage of the fieldwork was potentially stressful or disquieting for participants, thus, effort was exerted to establish rapport and trust before engaging head on in the research.

Because of the intimate nature of qualitative data collection and the researcher as instrument, we kept ourselves aware of the intertwining roles of caring professionals and scholarly researchers. We were guided by the fact that neither role can, or should be, suspended in the conduct of the research.

Chapter 5

RESEARCH FINDINGS

We present the data in two major divisions: the first is health as defined and understood by the people of Badeo, which includes a discussion on community health and second is data on the people's health in relation to their self-identified life stages.

The data focuses on the life stages of the people of Badeo. This includes the seven life stages where we describe the uniqueness of each stage in light of individual characteristics, sicknesses, roles, and functions. Whenever possible, scientific or medical rationale—either modern or western medicine and traditional or alternative or traditional Chinese medicine—is provided to validate or even refute the traditional health practices of the people of Badeo.

This chapter chronicles the people's struggle to sustain their health by using indigenous practices and available resources. It also touches on how traditional healers, indigenous healing knowledge, the government midwife, outside institutions have all contributed to the way Badeo has adjusted to the challenges of health and disease.

CONCEPT OF HEALTH IN BADEO

The people of Badeo have a variety of local terms to describe health. Terms like *naragsak* or happy, *nakaradkad* or of sound body, *nasalun-at* or well-being, *naimbag* or fit, *nadalus* or clean, *napaltak* or quick/alert, *awan sakit wenno rikriknaen* or free from disease or physical ailments, or *maidwed ligat* or free from suffering, describe, if not refer directly to health. The word health possesses multiple meanings and interpretations such that no single word can encompass it. Yet, two common words—*masawiding* and *malmaliteng*—come closest to the English word health.

Sino dadi adi malmaliten si kunkunayu ... Nu din maila ay maid sakit, din mabayag ay maid sakit na, nan baken si acunit mensakit esnan tawtawen, siya nan kana da ay maliten ... (*Those who have no*

ailments, those who do not get sick for a long time, those who do not get sick throughout these years—they are those who we refer to as “maliten” [healthy]).

Several women interviewed during the research said that in order to be healthy, one must eat health-giving food like rice, sweet potato, legumes, and vegetables. They also enumerated numerous factors that destroy health like illness, insufficient food, and eating prohibited food especially those counter-indicated by doctors.

Being healthy is perceived as a gift from God. The people contend that through *kararag* or prayers, a healthy and happy life is attainable. The spiritual dimension appears, in this case, ultimately significant. The following excerpt from our interview illustrates this.

Q: Nu agurigor ti ubing, sino ti mangagas?
(*If the child has fever, who heals him?*)

A: Si Apo Diyos... pangaasim ay Apo Diyos dawdawatek... kuna mi sa ap-aprosan diay ubing.
(*God, have mercy, I ask of you... saying it while touching the child*)

COMMUNITY HEALTH

An interplay of traditional perceptions and modern or western medical views influence the concept of health and illness of the people of Badeo. Traditions are strongly observed to maintain their health. But with the increase in interactions with other communities and recent western technological advances, “scientific” explanations have already began to influence old customs and traditions used in managing health.

As with many other societies, majority of the people believe that certain diseases are caused by supernatural beings. The *mambunong*, *mansip-ok*, and *mankutom* continue with their traditional practices. Ceremonies and rituals are continually performed in an effort to cure sickness, enhance body functioning, promote health, secure good harvest and marriage, communicate with ancestors, and even ensure that the dead take a safe trip to the afterlife.

Earlier, we mentioned various rituals performed to cure or treat diseases. In each stage of the life cycle, these rituals play significant roles in the

people's effort to maintain good health. Rituals and ceremonies accompany the individual as he/she begins or ends each stage of life. However, we did not witness all of their rituals and our informants described but a few of these rituals as they shared their experiences with us. The following are some of the rituals described to us by our informants.

When a child is being born and the mother is experiencing difficult labor, they call a *mambunong* to perform the *dawdawak* wherein a pig is butchered. If the *dawdawak* performed by the *mambunong* is not successful, they then call on the *mansip-ok* who tries to determine the cause of the difficult labor. The *mansip-ok* is believed to have knowledge of how to identify the possible reasons for the difficult situation.

When pregnant, women go to a trusted *hilot* who determines, based on fetal position, if the delivery will be difficult. Commonly referred to as *sunì* or breech presentation, this occurs when the buttocks of the fetus are the presenting part or frank breech when the feet or arms of the fetus are delivered first. This is in contrast to the normal cephalic position where the head of the baby is the presenting part. The *hilot* will then reposition the fetus, especially if it is in breech presentation, by massaging the pregnant woman's abdomen. We were told that *hilots* learn their skills from other *hilots* and from a long history of experiences in child delivery. The women reveal that they have not encountered any untoward experiences so far.

Aside from medical situations, rituals are also performed for illnesses supposedly brought on by supernatural beings. Adolescent girls, for example, who often suffer from painful menstruation or who have delayed menarche are subjected to a ritual called *amdang* where a chicken is butchered to appease the spirits causing the condition. Couples who fail to have a child after a year of marriage perform the same ritual. When one of them is suspected to be infertile, they perform the *passang*.

People in Badeo not only attribute illnesses to spirits and to supernatural beings; traditional theories also influence their notions of the causes of diseases as seen by their perception that some diseases are brought on by cold and hot temperatures. Their belief that some illnesses are caused by exposure to rain, and hot or cold weather can all be traced to traditional healing principles and practices. Some of these principles have been validated by scientific findings.

Associating diseases to pollens that come out during particular seasons manifest an understanding of how the environment can affect health and

well-being. Their avoidance of alcoholic beverages as well as dog meat to control high blood pressure affirms a level of awareness of how lifestyle and diet can also affect health.

The people of Badeo do not associate sickness and health with a single cause, citing factors such as environment, weather, diet, and the presence of spirits of ancestors and unseen gods. They believe in multiple causes of sickness and health and see health as integral to all aspects of life.

However, health misconceptions still persist. Menstruating women, for example, avoid certain foods and are not allowed to bathe until the end of menstruation. Moreover, they have little or no concept of other factors that affect health such as communicable and hereditary diseases. They also do not associate health with existing sociopolitical, cultural, and economic conditions.

LIFE STAGES

All societies deal with the life cycle since nature confronts everyone with a biological cycle beginning with conception and continuing through old age and death (Vander Zanden 1993). The division of the life cycle into different stages, commonly partitioned by age, varies among societies and is dependent on each specific culture.

In Badeo, the life cycle of the people is divided into stages that they refer to as *muyang/enga* or the infancy stage, *anak* or childhood, *baro/ balasang* or adolescence, *sumeksekde* or adulthood, *namospos* or menopausal stage, *lal-lakay/ babbaket* or old age, and *pese* or death. These stages are quite different from the classical stages defined in many other societies where the life cycle is divided into nine stages delineated by the chronological age of a person. The people of Badeo delineate the life stages in terms of developmental milestones and compliance with socially prescribed tasks and functions instead of chronological age. The *muyang*, for instance, is a life stage based not on age but on the child's ability to walk and/or talk.

In an era of enhanced communication and technology, it is not surprising to note that modern societies have inevitably influenced traditional Badeo life. And each life stage is influenced, in varying degrees, by pervading cultural beliefs and practices pertaining to sickness and health. Nevertheless, traces of indigenous practices still persist.

MUYANG/ENGA

To the people of Badeo, the first life stage is called the stage of the *muyang* or *enga*—the stage covering the period of birth up to the time that the child is able to talk and/or walk.

The birth of a child is met with rituals and practices said to herald the child's future. The *balaya*, also called *kadkadwa* or placenta, for example, is hung on the branch of a large tree believing that this will make the child brave and enduring of cold weather. Burying the *balaya* in a well-trodden place, on the other hand, hastens the ability of the child to talk and/or walk. Equally important is to remember to keep the umbilical cord safely within the house or near the house lest the child forget his/her roots and heritage. This way, when the child grows and travels far, he or she would never fail to remember his or her ancestry and so will always return home. One mother speaks of her belief in this ritual.

I keep the [umbilical cord] inside the house. They say it should not be thrown so that the child won't forget his roots. Yes it is true, but there are those who forget. Like, when my eldest daughter's umbilical cord was thrown away and it is true that she is now forgetting.

Care of the *Muyang/Enga*

After the baby is born, it is common practice for family members, especially the mother, to hold the baby. The baby is wiped with a clean piece of cloth and rubbed with coconut oil by the husband or *hilot* to keep the baby from getting cold. The practice serves to bond the mother and child as well as its immediate family. Interestingly, this practice is now being promoted in hospitals all over the country.

In caring for the newborn, the navel is washed with boiled guava leaves. Only when the water becomes lukewarm can it be used to wash the child's navel. This practice is scientifically and medically approved because guava leaves contain anti-microbial properties. "The alcohol extract and decoction of (guava) leaves is bacteriostatic against *Staphylococcus aureus*. The volatile oil has been shown to have antibacterial properties against gram negative

bacteria" (Co 1989). Because of its astringent properties, guava leaves are also known to exert a drying effect on wounds, thereby hastening the healing of the umbilical stump. This is done until the navel heals and the umbilical stump falls off. The baby, however, is bathed only when the umbilical cord has fallen off.

DIET

As soon as the baby is cleansed and kept warm, the mother washes her breasts with warm water and breastfeeds the baby. The practice of feeding the baby immediately after birth is encouraged, a practice that helps increase the flow of milk. This also allows the baby to ingest the *basa* or colostrum which contains antibodies needed to protect the baby against diseases. However, the practice of suctioning off and throwing away the colostrum is still common among mothers as they consider this dirty. Such a belief has great implications on the health promotion activities of health professionals.

On the baby's third week, breast milk may be supplemented with mashed *camote* or sweet potato or *ba-ot* or banana. *Sig-get* or rice soup from rice or porridge or breastmilk is added to the mashed *camote* or *ba-ot* to produce a soft, liquid supplement. *Sig-get* is given as a snack or meal and is also a popular weaning food. But before this, the baby must be given *tugin* or fresh rice chewed by the father or mother to avoid diarrhea. This practice contradicts the claim that the lactational amenorrhea method (LAM) is a common family planning practice among the women of Badeo.

In the medical field, there is much controversy and debate over the provision of supplemental food to the newborn. According to Jensen and Bobak (1985), there may be excesses and deficiencies regarding newborn nutrition and feeding:

Today's infant feeding practices differ considerably from sound infant nutrition. Most studies confirm that there is an excess or over consumption of nutrients in general and of calories (energy), protein, and sodium, in particular. There may also be deficiencies of such minerals as iron and zinc. These deficiencies and excesses may be the result of early introduction of a mixed diet, such as cereals, baby foods, and adult table foods.

Health practitioners actively advocate giving supplementary food to infants beginning at four or five months. During the first four months, mothers are encouraged to feed their babies only pure breast milk sans any supplement. This is highly recommended in fact even until the sixth month, particularly for mothers who would like to employ the widely used family planning method, LAM, as a means to delay or avoid pregnancy. Moreover, most health practitioners, even advertisements for infant formula, acknowledge breastfeeding to be the best food for infants until the second year of life.

Despite efforts of health practitioners to promote this practice, many Igorot families continue to do supplemental feeding at very early months of life, as is done in Badeo. Little or no inquiry has been made to investigate the possible effects of the practice but Jansen and Bobak (1985) in their discussion of infant nutrition suggested the following:

The most convincing argument for withholding the introduction of solids until four to six months is based on the infant's neuromuscular development. The young infant obtains milk by rhythmically suckling with an up-and-down movement of the tongue. Solid foods given with a spoon in the first month of life are ingested with these same stroking movements, the tongue projecting as the spoon is withdrawn. Frequently, food is expelled from the mouth. At approximately four to five months, a [more mature] sucking pattern develops, with the tongue moving back and forth rather than up and down. Spoon-feeding is the easiest because the child can draw the lower lip inward as the spoon is removed. Infants are, thus, better prepared to consume solid food at four to five months, rather than at an earlier age. Another objection to the introduction of solid foods before four months of age is based on the possibility that it may interfere with establishing sound eating habits and contribute to overfeeding. At four to six months of age, the infant will be able to sit with support and will have good neuromuscular control of the head and neck. The infant will be able to indicate a desire for food by opening the mouth and leaning forward to indicating disinterest or satiety by leaning back and turning around. Fomon *et al.* (1979) have suggested that until the infant can express these feelings, feeding of solid foods will probably represent a type of forced feeding.

In Badeo, however, a child of four months starts to eat solid foods. In contrast to the *camote* or *ba-ot* as food supplement, supplemental food at this stage is given more liberally.

Camote, as the most important and accessible food, remains the staple. Rice porridge could also be given. Spicy food is never given to the baby. Chicken, in a conscious effort to prevent the child from replicating the chicken's constant defecation, is also not given.

Upon reaching the age of eight months, the child can begin to be totally weaned. Still, Whaley and Wong (1991) contend that there is really no one time for weaning that is best for every child. They further added that generally, most infants show signs of readiness to be weaned during the second half of the first year. While eight months is just about the same time as this, completely withholding breast milk or infant formula must be studied. Solid foods should necessarily provide sufficient nourishment with all the essential nutrients that can otherwise be provided by breast milk. Growth and development during the first year of life is very fast and the nutritive requirements to provide for energy and tissue formation are equally high.

In Badeo, it is necessary that a child be weaned before the birth of the next sibling. At times when the delivery is near and the child has not yet been weaned, mothers commonly rub their nipples with ginger or chili pepper. This practice can prove to be traumatic to the child.

Marlow (1973) emphasizes that weaning should be done gradually. By doing this, the infant is less likely to be frustrated by the change from sucking to drinking. Marlow further discloses that when the complete process of weaning is too abrupt, the infant may show signs of discomfort like anxiety, sleeplessness, and irritability and may cry a great deal while sucking his or her thumb excessively. De Guzman *et al.* (1976) likewise explains the many disadvantages of early weaning. In their book *Basic Nutrition for Filipinos*, local studies observe that among "Filipino babies, the peak period of weaning is 12-18 months. This is significant because the critical period of malnutrition occurs around the same time, 13-24 months. . . Early abrupt weaning leads to nutritional marasmus and infections."

Sicknesses of the *Muyang/Enga*

The common ailments of the *muyang/enga* are skin, respiratory, stomach or digestive diseases. Ailments caused by accidents, such as *bullo* or sprains are also common.

Dolid/gaddil or skin diseases are treated with young guava leaves, salt, and/or washed with soap. This is for the guava's antiseptic and bacteriostatic properties.

For dysentery, young *kaimito* leaves are ground, and the juice squeezed and taken orally. *Cogon* grass (*Imperata cylindrica*) is also prepared as a decoction for the child to drink. According to Co (1989), *cogon*, especially the rhizome, mainly contains sugars, starch, and potassium salts that are helpful in replacing metabolites lost in diarrhea. On the other hand, *kaimito* (*Chrysophyllum cainito* L.) contains high levels of tannin and pectin, both of which exert anti-diarrheal effects. These two substances slow down peristalsis and harden the bowel thereby stopping diarrhea. One must be careful, however, with the use of herbal anti-diarrheals. Loose bowel and frequent diarrheal bouts are oftentimes the body's natural mechanism to eliminate foreign or unwanted irritants in the gastrointestinal tract. Stopping it is tantamount to trapping the irritants in the body. The best solution for diarrhea is rehydration and replacement of lost electrolytes. In treating diarrhea, the cause must first be identified since it will be the basis for whatever management is necessitated.

The common respiratory diseases are *uyek* or cough commonly attributed to drinking cold drinks and being exposed to cold weather. Cough is treated with ginger root or guava leaves boiled and used for *banyos* or tepid sponge bath. Hot ginger cooked in coconut oil wrapped in a cloth is placed over the chest or back as a *tapal* or poultice. Lemon leaves, which contain substantial levels of Vitamin C and are known to help increase body resistance, could also be prepared as tea while cold drinks are avoided. Sugarcane and honey are also taken to cure coughs. Honey has been traditionally used in Chinese medicine as a cure for cough. Buchman (1996) in his book *Ancient Healing Secrets* wrote that among the Chinese, honey is poured into a hole made in an apple or a pear which is steamed and cooked, then mashed and eaten to treat cough.

Identified causes of fever are exposure to extreme temperatures and rain showers. Among toddlers, *man-bab-a* or teething is also blamed for fevers. The National Ecumenical Health Concerns Committee (1989) observes that many Filipinos who claim to have been overexposed to heat like ironing clothes or working under the sun and who suddenly are exposed to cold and moisture, complain of conditions such as *pasma*, colds, and pneumonia. Modern medicine validates this by saying that exposure to moisture and cold weather lowers body resistance against disease.

A child with fever is not brought out of the house. *Sangitan* (*Eleusine indica*), an indigenous plant, is boiled and given to the child to drink. Co (1989) claims that this erect, tufted grass is prescribed for high fever and convulsion, loss of consciousness, and difficulty in urination. After drinking, the child is wrapped in a blanket to induce sweating. Medically, it has been found that while this practice can help open the pores and therefore facilitate sweating, it may be equally dangerous since it also potentially increases the body temperature to an extremely high level thereby triggering convulsions. After sweating, the child's clothing is changed. This helps promote rest and relaxation—both of which are important considerations in the care of the sick.

Banana leaves and banana piths are also used for cold compress—both are effective conductors of heat and thus help reduce body temperature. The aid of the midwife is sought when the fever worsens. When all else fails, the family calls a *mansip-ok* to determine the cause of the fever.

ANAK OR CHILD

The *anak* stage is divided into two phases: (1) the *anak* or child aged two to four or five years old and (2) the *anak* aged four or five to 10 years old.

The first phase characterizes the child as *awawiren* or someone who needs baby-sitting. At this stage, the child is inherently dependent on parents and other older members of the family and community. Parents and elders attend to the child's needs and ensure that the child is safe and healthy. Husbands care for the children whenever necessary.

Developmental milestones are classified as *makasao* or being able to talk, *makapagna* or being able to walk, *makataray bassit* or being able to run a little, and eventually, *makiay-ayam kadagiti dadduma nga ubbing* or being able to play with other children. Still, the child's capacity to be involved in more social activities continues to grow as he reaches the age of three to five.

The second stage begins at age four and ends when the child reaches 10. This stage is marked with more independence as the child learns to take on different responsibilities. The child begins to take care of him or herself and his or her personal needs, such as changing clothes, bathing, and eating without help.

Children are described as *nasimpet* or disciplined, owing to the ability of the children to control themselves at play and at work. Children can be *aktibo* or active and full of life. The parents say, "They are always running ...jumping ... they are very playful. They have learned to get along with others."

Roles and Responsibilities of the *anak*

Children's *akem* or roles and responsibilities begin when they are able to carry out certain tasks. Responsibilities are categorized as either individual or community. Assigned tasks are determined depending not only on their physical abilities but also on their gender. This gender bias speaks of culturally dictated norms.

If the child is female, her individual responsibilities encompass mostly household chores, like sweeping the yard, cleaning the house, and washing the dishes and some light clothes. She also acts as a surrogate mother to her younger siblings in the absence of their mother.

Aside from various errands, the female child is also expected to *agsakdo* or fetch water, *agbayo* or pound rice, *agpakan ti taraken* or feed the animals, and *agkali ti kamote* or dig sweet potato. She also helps her mother in the *uma*, as well as in gathering firewood. The male child, on the other hand, is expected to bring animals to pasture and to assist in farm work. Basically, however, the male child shares the same obligations as the female child.

Teaching children about their expected developmental tasks are a major responsibility for the parents who find subtle means of educating their children:

We tell them, "Child, you go and help clean the house." When the child does not immediately obey, it is the parents who end up doing the housework. We talk to the children, advise them to obey us and help us with the household chores.

Doing errands for older members of the community also form part of every child's obligations to the community. Hauling construction materials for buildings are tasks that children render to the community. However, male children may be asked to help the menfolk fetch stones and other materials for ripraps. Sometimes, they may go along with their fathers in doing *por dia* work.

When the harvest season nears, the elders send these children to the fields to drive away tiny birds that feast on rice grains.

Common Ailments of the *Anak*

The immense contribution of children to the family and community warrants that health care for these young children be strengthened. The research identified various types of *saksakit* or illnesses and *ag-agas* or cures which the respondents use on their children.

Guava leaves are used to bathe and clean *gaddil* or sores of people of different ages. Ripe guavas, on the other hand, are used to counteract diarrhea. Co (1989), reveals that the fruit peel could be powdered and taken in *per orem* for children's diarrhea.

Symptoms of *pudot*/*gorigor* or fever, *uyek* or cough, and *buris* or diarrhea, although identified by the people as diseases, are quite common in children. Fever is usually caused by *bannug* or fatigue and *lami-is* or cold. In Traditional Chinese Medicine, the principle of *yin* and *yang* suggest balance in everything to maintain harmony, even in health. Over and again, fever and chills, together with cough are often associated with deficiencies in *Qi* or blood generated by the six pernicious influences: wind, cold, damp, heat, dryness, and summer heat (ATRC 1996).

Burtong or chickenpox along with *kamoras* or measles remain major health concerns. Measles continues to be responsible for many infant and child deaths. One mother relates the story of the children she lost due to measles.

Seven of my children died of measles while five survived. When the measles epidemic came, they were stricken with it, then that was it. They died. There was no cure for measles.

Diarrhea is equally fatal in Badeo:

I had 10 children but four died of severe diarrhea. One had a cleft palate. I would feed the child but the food would come out. The baby's condition deteriorated ..six of my children are alive.

Diarrhea is commonly treated with boiled banana leaves. Bananas or star apples are also eaten or *kinerog nga bagas* or roasted rice tea is drunk to treat diarrhea. *Dapo* or ash may also be diluted for drinking. Bananas and star apples are fruits that are antidiarrheal on account of their high level of tannin. The fruits' pectin and milky juice likewise act mechanically as an antidiarrheal (Co 1989). Drinking roasted rice and diluted ash are primarily for hydration purposes, although some claim that these substances coat and wash away toxins that may be causing the diarrhea.

Lelek or otitis media is also quite common in children. This is treated with *benday* or *bulak-manok* by extracting the herbs' juice and applying this to the infected ear. Co (1989) describes a similar method of treatment using the same herbs where the sap is squeezed out and absorbed by a piece of cotton, which is then placed inside the ear. Another method is to use a medicine dropper to place one drop inside the affected ear to treat the infection.

Dental hygiene is not a conscious practice and so children often suffer from *kedked ti ngipen* or toothache. To treat toothache, children are often given a decoction of the herbal plant locally known as *balusangi* (*Cyperus rotundus* L.) known to have an analgesic effect. The children are also advised to gargle with vinegar. It is theorized that the acidity of the vinegar has an anesthetic effect that somehow relieves the pain. Acids have also been found to be good disinfectants, "the bactericidal effect is due to hydrolysis and denaturalization of cellular fluids" (Volk and Wheeler 1984). Parts of the *pateleg* tree may also

be crushed and inserted into the aching cavity or boiled for gargling.

Another common illness during this age is *kamata* or conjunctivitis, which the people believe is caused by *lusung/sabbang* (*Vaccinium platyphyllum*), a tree that blooms during summer. Western medicine attributes conjunctivitis to *Haemophilus aegyptius*, considered a variant of *H. influenzae* and commonly known as Koch-Weeks bacillus (Volk and Wheeler 1984). Pollen, however, may irritate delicate eye membranes facilitating the entry of the infective agent. Conjunctivitis is treated with antimicrobials. In Badeo, people claim to have successfully used the *lusong* plant, the fruit of an unknown red tree found in their area; *sabbang*, a big tree; or the young leaves of *pinit*, a variety of wild strawberries. The leaves of any of these are boiled and the decoction obtained is used as a facial wash. These practices can be further investigated to check their safety and efficacy.

Snake meat or snake's gall bladder is given to a child with *angkit* or asthma. This is widely practiced not only in Badeo but throughout the whole region as well. This is an interesting *materia medica* that could be explored.

Body massage is used on children who are *mankikidas* or suffering from seizures. This is usually done by a *hilot*. The care of individuals suffering from seizures should be emphasized to prevent complications such as fracture.

Man-aaleng or epistaxis, more commonly known as nose bleeding, is treated by *nabasa nga lupot nga itapal iti maging wenno tengnged* or cold compress placed over the forehead or nape area. This treatment is also used for *kedked ti ulo* or headache. Cold compress causes vasoconstriction that alleviates bleeding and pain. According to Chichester (1998), applying a cold compress may stop a headache by constricting throbbing blood vessels and reducing inflammation that can lead to pain. Smith and Duell (1985) further support this by claiming that cold applications reduce pain.

Tabtabaho or tobacco may also be mashed and applied as a poultice on injured areas. There are claims of the use of pubic hair as an effective measure to arrest blood flow when applied to the wound. Aside from guava and tobacco, young leaves or shoots of a reed called *runo* are chewed and applied over the wound. However, documented experiences in community-based health programs show that chewing herbs to make poultice is considered a health risk. Saliva may contain microorganisms such as *mycobacterium bacilli* which when mixed with chewed herbal medi-

cine and used as poultice on open wounds can cause tuberculosis of the affected wound. The basic principle behind these practices is more to prevent bleeding.

Bullo or sprains and dislocations are also treated by a *hilot*. *Tagumbao* (*Jatropha curcas*) is popularly used as poultice over the sprained area. Co (1989), in his book, *Common Medicinal Plants in the Cordillera Region*, catalogues the use of this plant. He found that this can be used not only for sprains, dislocation of joints, fractures, and contusions, but also for rheumatism and arthritis. The saponins, alkaloids, flavones, and tannin of the leaves prove effective for these conditions.

Children who are *nakuwang* or infested with intestinal worms are given a decoction of sunflower leaves to drink. If this is not available, slices of *camote* or sweet potato are eaten raw. Sometimes, decoction of guava leaves is taken instead.

Eating fresh and raw *camote* is also claimed to treat parasitism. Eating papaya (*Carica papaya* L.) is also indicated as a purgative, specifically for tapeworm. Papaya contains the enzyme papain, "a proteolytic enzyme with action similar to pepsin, one of the digestive enzymes found in animals, including man. It is now commercially produced as a meat tenderizer and as a drug. In the same way that it dissolves protein in food, papain acts as an anthelmintic by dissolving the external skin of intestinal parasites. It is mainly effective against *Ascaris* and *Trichuris* (Co, 1989).

BUMALBALO/BUMALBALASANG OR ADOLESCENCE

Next in the life cycle is the *bumalbalo/bumalbalasang* or adolescence. This usually includes children ages of 11 to 14. This is described as the *paset* or period where the "young men and women" no longer sleep with their parents. They prefer to sleep alone in another part of the house. It is interesting to note that at this juncture, they could now get married. Most people, including children, consider this as the marrying stage so parents are quick to advise their children:

...not to rush into marriage, to finish their studies first before getting married. If we do not have the money to send them to school, we tell them to work first before getting married.

Nevertheless, conflicting ideas about marriage exist with some parents wanting their children to marry at a young age so that the children will become independent.

Characteristics of the *Bumalbalo/Bumalbalasang*

When asked to picture this stage, the respondents describe young women as beginning to be conscious of their appearance and their bodies. They say, *paspas da nga dumakel* or they grow faster, *agruqi da nga agpamukelen* or breasts begin to develop, *puminpintas dan* or they become more beautiful, and *agruqi da nga ag-estimar to bagi da* or they start to groom themselves. This stage also marks the onset of menstruation.

The respondents likewise notice behavioral changes. The *bumalbalasang* appears shy, more so in the company or presence of boys their age. They claim that the young girls exhibit unusual attitudes and behavior when they begin to accept suitors. They take a bath more often and become more fastidious with their looks.

Young men also experience physiological changes, which they note with increasing awareness. The signs often associated with this stage are: *agbaliw ti boses* or voice changes which the respondents termed as *mangegegleng*, improvement in facial features, fast growth, shyness, consciousness of physical appearance and hygiene among others. This is also the time when they begin to notice young women.

One parent observes the interaction between the *balo* and *balasang* and the beginning of some sort of a gender division of labor with the onset of puberty:

The young men and women start to have peer groups. The male adolescents become ashamed of doing "women's chores." They refuse to dig *camote*, saying that it is "women's work." Maybe, the young men classify digging for *camote* as women's work because they see that it is primarily the mothers who do this. Gathering firewood is done by male adolescents. The men plow and prepare the fields while it is mainly the women who take care of the planting and harvesting. The female adolescents help in planting rice while both men and women harvest.

Roles and Responsibilities of the *Bumalbalalo/Bumalbalasang*

Young women have more responsibilities than their male counterparts. Their household chores range from *aglaba* or washing clothes, *aglinis/ agdalus ti balay* or cleaning the house, *agaw-awir* or taking care of younger siblings and disciplining them, *agluto* or cooking, *agbayo* or pounding rice, taking care of the house, *aglubo* or cooking food for the pigs, *ag-garden* or gardening, *agkali ti camote/ luktu* or digging for *camote*, planting *camote* and other vegetables, weeding the garden, and *mangayo* or gathering firewood. Although female and male roles are valued equally, sexual division of labor begins to surface at this stage.

The *bumalbalalo*'s or the male adolescent's usual obligations include plowing the fields, planting rice, and doing contractual jobs like carrying goods for people to and from Badeo. Carpentry work, riprapping, and other construction jobs are also common.

Shared tasks between young men and women are: taking care of siblings, cooking, cleaning, pounding rice, fetching water, and gathering firewood. Other communal obligations include acting as couriers of the elders for meetings and other gatherings.

Sexuality is rarely discussed by the people of Badeo. Asked whether sexuality is consciously discussed by the parents with their children, one father states:

I don't think the parents discuss sex with their children. What parents would mostly say is "Don't rush into marriage.

Sexuality is highly associated with marriage such that another respondent asked on matters of his children's sexuality responded:

In my experience as a father, during the time when my son was about to get married, you could sense his apprehension as a young adult. When you talk to the child, he becomes afraid and leaves the house. So you ask for the help of an intermediary.

Common Illnesses of the *Bumalbalo/Bumalbalasang*

Common illnesses among women are related with menarche and menstruation. Remembering that the onset of menstruation is a sign that young women are ready for marriage, menstruation and its manifestations are handled with great caution. Ladies who complain of *nasakit nga panagregla* or dysmenorrhea are massaged in the abdomen. Sometimes, rituals are performed as in cases of delayed onset of menstruation. In profuse menstruation or *napigsa nga panagregla*, the assistance of the midwife who dispenses medicines is sought.

Certain taboos are also strictly followed. Certain foods and strenuous activities like lifting heavy things that elders believe may aggravate menstruation are avoided. *Langka* or jackfruit, squash, including its fruit, leaves and flowers, vinegar and other sour items are prohibited. *Napait* or bitter and *naalsem* or sour food items are avoided during menstruation because the elders believe these foods cause the blood to become foul-smelling.

Taking a bath during menstruation, especially with cold water, is prohibited because according to elders, it reduces blood levels. They also advise women to eat more nutritious food to replace lost blood during their monthly period. The young women are also advised against working under the intense heat of the sun.

However, no scientific basis for the avoidance of any type of food during menstruation exists. The effect of bathing during the menstrual period on blood flow has not yet been established. In fact, modern medicine advocates strict hygiene during menstruation, including bathing everyday, to prevent urinary tract infection and pelvic inflammatory disease. Werner (1994) has a simple prescription for menstruating women saying that “during the period—as at all times—a woman should take care to keep clean, get enough sleep, and eat a well-balanced diet. She can eat everything she normally eats and can continue to do her usual work.”

The onset of menstruation is frequently indicated, according to the older women of Badeo, by the following signs and symptoms: *agsasadut/agmamayo* or lethargy, *panag-ulaw* or dizziness, *nasakit nga tabo/pus-on* or abdominal cramps, and *panagsarwa* or vomiting.

A remedy prescribed for weak menstrual flow is to drink *tafey* or rice wine. Alcohol may have a relaxing effect on uterine muscles thus increasing

blood flow. However, the women were quick to admit that while this remedy has proven to be effective for some, not all had the same positive results.

Following the onset of menstruation, *kamudo/kamuro* or pimples start to appear. Older people of Badeo say that the solution for this is, "*peselen tapno rumar amin diay bagas na*" or to press the pimple until all its content are out. This, however, is unsafe. The skin acts as the body's protective barrier against the outside environment and squeezing pimples necessarily damages the skin. A break in the skin becomes a convenient entry point of microbes that may cause skin infections such as *acne vulgaris*.

Kedked ti ulo or headache is ordinarily cured by using the leaves of a certain plant called *tepnag* or popularly known as *kataka-taka*. It is used as a poultice after being pounded or bruised. It is placed over the head and the cooling effect of the plant relieves the pain. The leaves of the *Subusob* [*Blumea balsamifera*] are likewise used as a remedy for headache. The leaves are boiled and then drunk. Co (1989) says that *subusob*, also known as *sambong*, can be used as treatment for headache by rubbing the pounded fresh leaves mixed with coconut oil on the forehead. The volatile oil and glycosides have been documented to dilate blood vessels and to depress the sympathetic nervous system in animal experiments.

SUMEKSEKDE OR ADULthood

This stage, referred to as *kabanbanwagan* in Ilocano, may roughly be translated to the term adulthood in English. Customarily, this stage is informally categorized into two sub-stages. The first stage is from 17 to 25 years old, when the person is considered as *dumakdakkal pay* or still growing up. The second stage, usually at the age of 25 to 35 years old, is considered as *pinagpatingga ti panagdakkal* or dawn of growth. During this stage, the person is described as *kumethet-eng* or maturing.

Roles and Responsibilities of the *Sumeksekde*

This life stage is characterized as the stage of *kapigbigsaan nga panagtrabaho* or prime of life for work. Persons who are *sumeksekde* are described as having remarkable endurance in work and so most of them find

the initiative to *tumulong nga agbirok* or help sustain the family. It is also during this stage when the person starts to have a sense of morality. This is the onset of the realization of right and wrong, according to the interviewees. It is further explained as the period of *kapihigsaan ti panag-asawa ken panag-anak* or when the adult desires more than ever to get married and to have children.

The female and male *sumeksekde* have certain differences in their tasks and responsibilities to the family and community. A male *sumeksekde* is expected to go with other community folk in the fields, while the female is supposed to carry *camote* or sweet potato in her *kayaba*. She is also expected to cook for the household. The unmarried woman usually helps gather firewood for cooking.

The community, as earlier mentioned, gives equal value to the roles of men and women. However, the sexual division of labor that started to take shape during the *bumalbaló/bumalbalasang* takes on a more pronounced role as economic structures become male-dominated and domestic structures become female-dominated. This corroborates Lewis and Bernstein's (1996) assertion that, "International studies of time use among men and women reveal that women consistently spend more hours in food gathering, family care, and economic-survival activity. Men spend majority of their time in economic-gain activities."

Courtship and Marriage

Matchmaking for marriage is traditionally done through the *kalon* and *kaising*. In one of the focus group discussions of 25 married women, only five married on the basis of personal choice. Seven were married through parental arrangement, while 10 were married based on the choice of their elders. Three were married based on a neighbor's intercession. The practice of *kalon* and *kaising*, however, is being undermined as the young people take the initiative in courtship and choose their marriage partners.

In the past, courtship was totally unheard of. Marrying couples were paired either by the *kalon* or through the employment of an intermediary or *kaising* or parental agreement. In *kalon*, a man asks an intermediary to express his intentions to marry a woman. If the woman consents, they immediately marry. However, it is usually the parents that give the consent. On either

occasion, marriage enters the picture. Often, the woman accepts the marriage proposal for fear of the *udoy* or the belief that a refusal will subsequently leave her a spinster. And so it is not unusual to hear of a young woman marrying a much older man. Further investigation confirms the fact that only men are able to initiate the *kalon*. One woman relates her marriage through the *kalon*:

In 1964, when I was in grade 4, two old men came to our house to arrange a *kalon*. I did not know then that they were mediating for my marriage. The following morning, my mother told me that I was no longer their responsibility since I was soon to be married, that my marriage had been arranged. I did not say anything then. I just kept quiet. In 1965, they had a sort of feast for the *kalon*. A pig was butchered. The bile of the pig was read. The *mambunong* predicted that our marriage would be good. I was only in grade 5 when they arranged my *kalon*. I wanted to continue my studies but we did not have the money. I wrote to my husband to help me continue with my studies. I was able to finish my fifth grade. My husband helped me so that I could buy paper (school supplies) and clothes. At the end of the school year, I was told to go home to my in-laws. My grandfather told me to proceed to the house of my in-laws which I did. I helped work the swidden farm, growing sweet potato. They taught me how, since I did not know how. They (in-laws) would say to me, "Sleep together, you are married..". I was nervous and they told me to go ahead to our bed and that my husband will follow later.. Since my husband was older than me, he knew that I was shy. I wrapped a blanket around me so that he wouldn't be able to touch me. [That was] the first night. On the second night, I asked one of my siblings to sleep with us so there would be three of us. But she said, "Don't be afraid because he is your husband." During that time, he was very patient not to touch me. After one week, he knew that I was then feeling comfortable with him. He then tried to initiate sex. After that first time, I overcame my inhibitions and felt more at ease with him.

The *kaising* is a parental agreement to marry their children. The children being paired may not even be born yet. Should the children not marry as planned, the *kaising* would still be in effect throughout the generations until it is accomplished.

In the choice for marriage partners, the men choose women who they perceive as industrious and knowledgeable in productive activities, such as growing sweet potato, working in the swidden, basket-making, etc.

It is notable that the men's criteria for choosing a marriage partner are rooted in their concern for everyday survival and food security.

Two men, for example, describe what they consider to be an ideal wife: If I were to choose/love a woman, it would be somebody who is good in growing sweet potato, who knows how to work in the swidden farm. My wife could make baskets (*kayabang* and *bigao*) and she can even give haircuts.

With my wife, it is the same. When I saw her, I saw that she knew how to grow *camote*. Since I do not know how to cultivate sweet potato, I wanted to marry somebody who knew how to grow it.

As in many other cultures, it is the husband that is expected to initiate sex. While some women have learned to be more transparent in terms of sexuality with their partners, two mothers exemplify the general view on the act of initiating sex learned from childhood and assimilated to adulthood:

It is always the men who initiate sex. If I don't want to, I can also say "no." I cannot take the initiative because it would be too embarrassing on my part.

Once married, *lalaki ti mangiturong ti pamilya ken pang-alikamen kas iti daga, ayep ken talon* or the man manages the family and properties like their land, animals, and fields, while *babai ti aghuto, agtaraken ti baboy ken dadduma pay nga pagbiyagan*, or the woman cooks, takes care of pigs, and other means of livelihood. Unlike in some societies, *lalaki ti aggigem ti kuarta, ikkan na ni baket na ti kuarta no agpalengke*, or the husband keeps their money, he gives his

wife money when she goes to market. The husband also reviews the children *for their school homework and disciplines them. One father relates:*

Both the father and mother discipline the children but it is primarily the father who takes care of disciplining them. He talks to the children and gives them advice so that the children will not grow up hardheaded. When necessary, parents resort to spanking their children. It is the father who primarily disciplines the son because they fear the father more than the mother.

Children are generally valued by the people of Badeo. The average family has around 6-7 children. Of course, children are seen as additional hand in agricultural activities. Asked how many they wanted, one respondent said that he would like many children who would *mangisiwat* or work in the field. There would be more to whom he could entrust the land and who would provide support when he grows old. He is also assured that someone will take care of his burial when he dies. Experiences of losing children during epidemics like measles when immunization rounds have not reached the community (i.e. 1960's to 1990's) have also caused parents to consider having more children.

Child delivery is a community duty so that both the male and female adults take responsibility in extending whatever assistance they can provide to the family of the woman who is about to deliver. Females however are more involved with the actual birthing of other females in their community. In addition, they offer *luktu/ camote* to their neighbors while giving a hand in feeding the animals whenever necessary.

In the community, both the male and female *sumeksekde* are expected to help in their barangay and to cast their votes during elections. However, males enjoy better political positioning in the community. Culture dictates that the leaders of the community listen to the words and wisdom of the elders "because they can understand." Mostly, these elders are male. Males dominate the community and so when we collected data, we noticed that the females in focused group discussions kept quiet and allowed the males in the group to monopolize the discussion. This was identified as one of the limitations of the study during the earlier field visits.

Pregnancy

To the woman, the *sumeksekde* stage is when she undergoes various experiences like pregnancy, childbirth, and motherhood—all of which provide her with additional roles and functions to fulfill.

Pregnancy is determined by the physical and physiologic changes observed in the body. Female *sumeksekde* say that they know they are pregnant when their *kadawyan* or menstruation stops. Other signs would be either *panagkuttong* or weight loss or *panaglukmeg* or weight gain. They also notice that their facial appearance either becomes *napintas* or beautiful or *naalas* or unsightly. The skin color is either *nangisit wenno napudaw* or darker or fairer. All these, however, may be categorized as presumptive diagnoses for pregnancy.

Women in this phase continue their usual tasks at home or in the fields. They believe that indulging in work facilitates child delivery. In other places, many women also continue to work during pregnancy (Jansen and Bobak 1985). Moderate exercise is often encouraged. Caution, however, is given to pregnant women to avoid working and doing activities that will exhaust them, as these will compromise uterine perfusion and fetoplacental oxygenation.

In the fields, pregnant women prefer to work in slopes rather than in flat areas. Women believe that working in flat lands causes pregnant women to be nauseous and the baby to be cramped. No specific scientific or medical explanation about this can be found, although nausea and vomiting in pregnancy is often said to be caused by many factors like allergy, high gonadotropin level produced by the trophoblasts, decreased liver glycogen reserve, lack of pyridoxine, diminished gastric motility, which may be aggravated by emotional disturbances (Lerch 1975). Women should be careful, however, while working in the fields. Over exposure to the sun may cause heat stress and endanger the fetus or cause fetal damage.

Panangginaw is a stage in pregnancy where the woman starts to feel changes in her body as well as in her moods and preferences. This takes about a month or more starting from conception. In Badeo, the pregnant woman's craving always needs to be satisfied to avoid a miscarriage. Because of this belief, a conceiving woman is afforded the rare opportunity of being pampered, heard, and satisfied by her husband. Some relate experiences where they craved for *sungo ti baboy* or pig's snout, *tumeng ti baka* or knees of

cow, *alsem ken sili* or sour food and hot pepper, and *lidang* or fish. An interviewee reveals:

For a craving woman, what she wants to eat, they (husbands) have to go and get it for her. If she wants mango, then they have to get it. If she wants pork, then they have to go to the market to buy it. If a woman's craving is not satisfied, she will become thin. She will not eat. That is for craving. In *langgi* or aversions, she cannot eat, even if they say that it is only rice, it still smells bad to her.

Another woman affirms the bodily changes that occurs in pregnant women:

My mother told me if I miss my menstruation, it means I am pregnant. Then there are foods that you want to eat but there are also foods that you do not like to eat. But for the 10 children that I gave birth to, I experienced different things from each pregnancy. Most often I wanted to eat sour fruits like *baokok digway* or unripe pineapple with chili.

In Western medicine, no rationale explains this unusual craving that usually accompanies pregnancy. No association between physiologic changes and craving is yet established. Reeder, Martin, and Koniak (1992) claim that:

Food choices are a common combination of heritage, superstition, custom, knowledge, and opportunity. Subtle cravings are passed along from one generation to the next by the process of training and imitation ... Women crave or reject certain foods, due more to symbolic meanings of the food than to any physiological factors.

Respondents likewise expressed the importance of trying to understand women regarding their cravings and to explore the possible underlying psychological roots of these cravings. Nevertheless, no mention of the relationship between the cravings and the occurrence of miscarriage was mentioned.

Martes Papsa-as, a 50-year-old *mammadto* and *mambunong* says a pregnant woman usually suffers from nausea, headache, *panagsarwa* or vomiting, and is usually *masadsadot* or in a state of lassitude. Aside from these discomforts, pregnant women also often have aversions that they refer to as *panaglanggi*. People, scents, places, and taste may become offensive to pregnant women. This may be brought about by the physiological changes occurring in their bodies. Excessive or persistent feelings of discomfort, like uncontrolled vomiting, however, require professional attention.

Another belief they have during pregnancy is the avoidance of unusual or unsightly things. Among these are people who are: *duling* or cross-eyed, *natey* or dead, and *lawlawaaay* or other unsightly objects or things like *bakes* or monkey and people with *gusing* or hare lip. They are also prohibited from eating foods such as *singin nga saba* or twin bananas in the belief that they will bear twins, and *nasam-it nga makan* or eating sweet food because the baby may get too big making delivery difficult.

Older women suggest the following food as “musts” in a pregnant woman’s diet: *natnateng* or vegetables, *bukbukel* or legumes, *inapoy* or rice, *camote/ luktu* or sweet potato, fruits like avocado and bananas, and *sida* or fish. However, carbohydrates, including sweets, must be moderately taken to prevent the increase of glucose levels in the blood that can lead to diabetes.

Health practitioners often provide pregnant women with a prescribed diet. De Guzman, *et al.* (1988) suggest protein as the chief source of energy for pregnant women to aid in tissue formation in the fetus. Legumes are common and inexpensive yet are rich sources of protein that aid in rapid fetal tissue growth and are an important component of the amniotic fluid (Jensen and Bobak 1985). It is also useful since its iron content is stored in the fetus’ liver during the third trimester of pregnancy. Protein from legumes also helps in maternal tissue growth essential for the changes in the breasts and the uterus. Since the circulating blood volume during pregnancy increases, protein is important in increasing plasma protein together with the increase in hemoglobin. Furthermore, protein functions as maternal energy reserves needed during labor, delivery, and lactation. Legumes also contain thiamin that work as a coenzyme for energy metabolism.

Fruits, just like vegetables, are rich sources of vitamins and minerals. Vitamins help in the formation and maintenance of tissue, cement connective and vascular tissues and increase iron absorption. Other fruits and

vegetables also contain varying amounts of minerals essential in regulating body processes. *Lukto/ camote* is a grain product which provides a good supply of thiamin, riboflavin, iron, phosphorous, and zinc. These vitamins and minerals improve oxygenation, promote proper body functioning, and increase the body's ability to fight diseases.

Childbirth and Child Delivery

All of the women interviewed preferred to give birth at home. Giving birth in the hospital is done only when they feel and think they will have a difficult time. The mothers continue to go on with their activities in the field even if they are aware that they are about to give birth. It is not surprising to hear stories of mothers delivering their babies while in the field.

Some mothers prefer to give birth at home because they are afraid of the stories they have heard about *makartib diay mabagbagim* or episiotomy, where the vaginal opening is cut open to give way to the infant's head. Others cite practical reasons like the distance of Badeo from hospital facilities. Other reasons include: the ease of delivering in an environment they are familiar with and comfortable in, where they can give birth on their own or with their husband or immediate family. One woman candidly said:

I prefer to deliver on my own. I know when the baby is coming out. I just call my husband or mother when I have difficulty delivering or when the baby is already out.

Most women value privacy, whether they are from Badeo or from elsewhere. The process of labor and delivery is an experience a woman would like to undergo by herself or with her family. It is also considered a normal process that is part of the growth cycle.

Panag-anak or child delivery is divided into two phases. The first phase is *panagpasikal/ manpalpaligat* or labor where a woman awaits the birth of her baby. While undergoing labor, the woman is advised to untie her hair. Also, all uncompleted sewing is completed four days before delivery. They also untie the material used to secure the cover of the jar of *tafey* in the house. All these are done believing these will ease the delivery of the child. They also believe that there are certain actions that can complicate birthing. They say, *maiparit*

ti garaw nga garaw, agposposipos ken maiparit ti agtugaw ti nangato or incessant movement and sitting on a high chair is prohibited because it will be difficult for the woman's uterus to go back to its normal position. For the uterus to regain its normal position, the woman is allowed to sit only on low benches or chairs. Women who undergo labor are likewise advised to *manbakket* or wear a binder they believe will relieve the labor pains. Alegre's study (1999) also says that a binder using old clothes or baby diapers may be applied to help the mother in the childbirth. However, in western medicine, wearing loose, light clothing which does not restrict the body is recommended, especially for pregnant women. This is for the comfort of the woman and for better circulation.

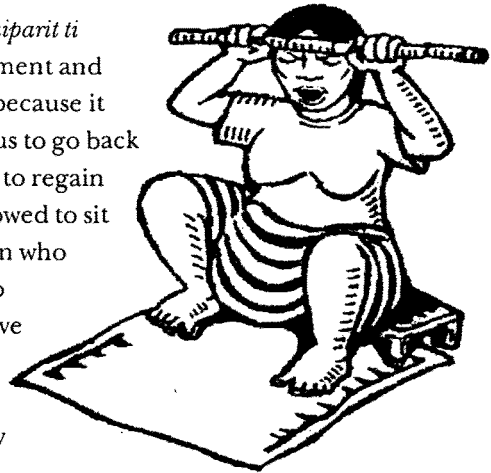


Figure 5
The woman holds on to a horizontal pole as she pushes out the baby.

Maxilina Padilla, who was the main resource person on birthing, demonstrated the different positions assumed by the woman while giving birth. Having 12 children—each of whom she claims she delivered in a different position—Maxiliana exemplifies indigenous creativity in meeting



Figure 6
The husband supports the woman's back as she gives birth.

their health needs. Based on these, it is evident that the birthing positions that the women assume are very different from the birthing position done in the lowlands, especially in the hospitals. The birthing positions of the women are designed to facilitate bearing down or pushing the baby out from the womb. The birthing position in hospitals or the lithotomy position, where the

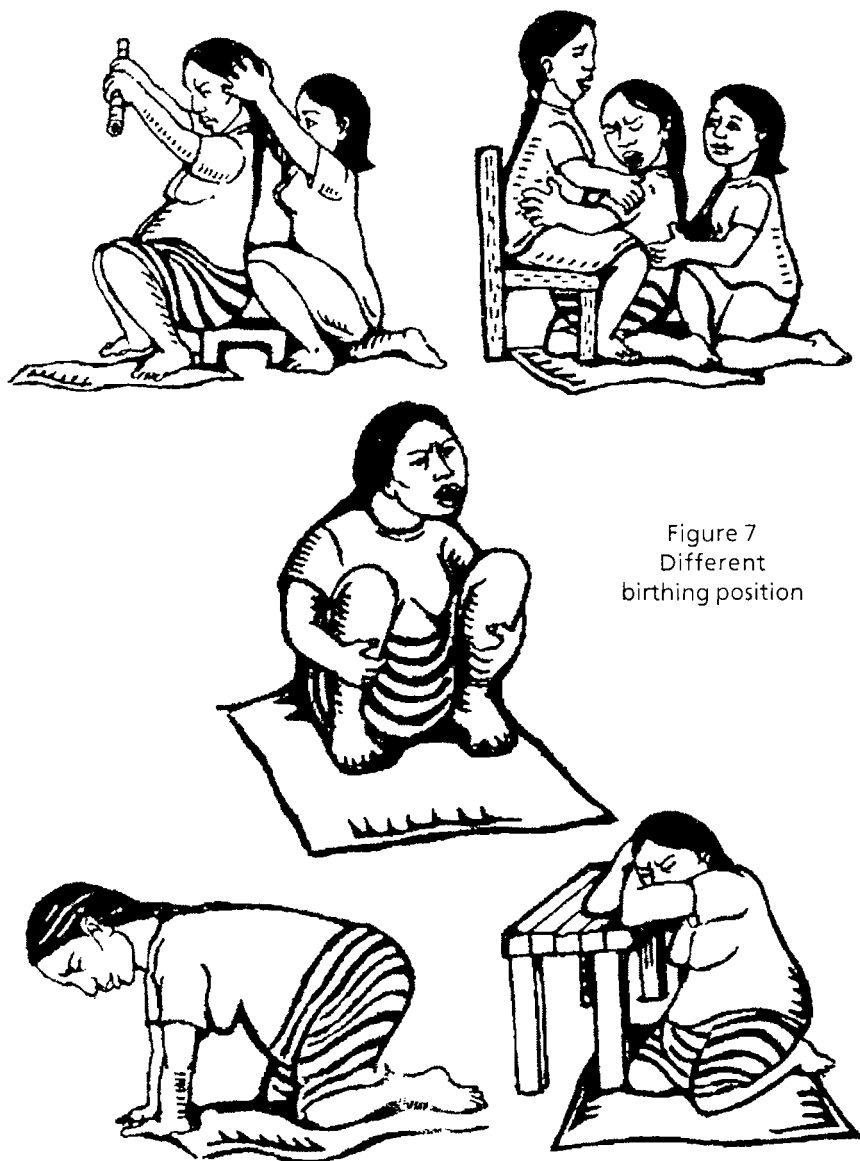


Figure 7
Different
birthing position

woman is lying down with legs spread apart, was designed not so much to facilitate the delivery of the baby but to cater to the comfort of the doctor or whomever is assisting in the delivery of the baby.

Initially, Manang Maxilinda and the other Badeo women could not understand the interest and fascination with their indigenous birthing positions. They assumed the birthing positions they are accustomed to are universal and that all women shared the same experiences with birthing. Describing the lithotomy position, it was difficult for them to imagine how a woman could deliver in such an awkward position. Only after we explained this did they understand our interest in their birthing positions.

Manang Maxilinda reveals that women about to give birth do not lie on their backs. Instead, they usually squat or kneel or half-stand. They make full use of gravity to facilitate the delivery of the baby. One birthing position (Fig. 5) is when the woman squats while holding on to a suspended horizontal pole. The woman holds the pole tightly and uses the pole to support her body while she bears down or pushes the baby out. Blankets are positioned below or near the woman's genitals to catch and cushion the baby's fall.

Another position (Fig. 6) is when the woman sits on her buttocks with her legs folded. Somebody, usually the husband, supports the woman's back and holds the woman's legs to keep them apart while the woman tries to push the baby out.

According to Manang Maxilinda, when the birth pains or contractions start, the woman can explore various positions (Fig. 7)—kneeling, squatting, half-standing, etc—until she finds bearing down the “most comfortable” or *naimas nga ag-edek*. Most comfortable here does not mean the physical comfort of the woman giving birth but rather the positions most conducive to or that would most facilitate the delivery of the baby. In a study by Alegre (1999) among birthing practices in Aeta communities in Pampanga, she narrated that although some *hilots* prescribe certain positions for birthing, it is the mother who determines the position she is most comfortable with.

Western biomedical perspectives do not negate the different birthing positions mentioned. An increasing number of health practitioners advocate the different positions so long as the position during the second stage of labor is such that the presenting part aligns with the axis of the pelvis (Reeder, Martin, and Koniak 1992). In the same book, health workers are advised “to encourage/allow the women to listen to their own bodies. It is

the uterus that decides the amount of effort and the timing of that effort during the second stage."

Another respondent described how she delivered all her children alone inside their own home. She claims that the pain signals to her that she is about to deliver. She says, "*Isaganak amin diay mausar no mariknakon nga agsakit. Ta saan met nga sasta ket aganak ka nga dagus*" (I prepare all that I need for the delivery. You do not deliver at once upon feeling the pain).

During difficult or prolonged labor, women are given raw, fresh eggs to eat to give them additional strength and warmth. A chicken may also be cooked *pinikpikan* style. To prepare this, the chicken is repeatedly beaten with a stick while burning the unplucked feathers without bloodletting. The women believe that the aroma of the chicken would facilitate the labor process.

Abnormal fetal presentation during childbirth is usually referred to the midwife or hospital. Sometimes, matters are left in God's hands, "*Makaammo ni Apo Dios, Manrarag tako en Apo Dio*" (God Almighty will decide, let us pray to God).

Immediately after birth, the woman douches with a decoction of guava leaves to aid her healing. It produces an antiseptic effect on the wound to prevent infection. They continue wearing their *bakket* or belt/binder, believing that this helps in the swift restoration of the uterus to its normal anatomical position.

The women cut the umbilical cord only after the placenta has been expelled. This minimizes the risk of bleeding and infection. The cord is cut using the "*epal*," a sharpened bamboo tool crafted for this sole purpose. While waiting for the placenta to be borne out, the baby is cleansed with clean cloth, rubbed with coconut oil, wrapped in a blanket, and placed beside or on top of the mother's abdomen. In western medical practice, the umbilical cord is cut immediately after the baby is born. The stump is tied with an umbilical clamp or sterile thread. This is to avoid bleeding of the umbilical stump. In Badeo, the umbilical stump is not tied anymore. Interestingly, no cases of bleeding have ever been reported. According to the mothers, infections of the stump are unheard of, except for the babies delivered by the government midwife.

The placenta is buried near the house or placed in a basket that is hung up a tree near the house. The women keep the umbilical cord inside or near

the house to remind children of their roots and kinfolk. This practice indicates the importance of heritage to the Kankana-eyes of Badeo. Having no harmful effects, it should be respected as it reinforces important values.

After childbirth, the woman is given *abusang*, a concoction made up of *laya* or ginger with cooked lentils mixed with pork fat and placed in a coconut shell or *sabut*. They believe that this mixture will help the uterus return to its normal position and help in lactation. According to one interviewee, this is done to *tapno bumayak ti suso* or to make the breasts secrete more milk. The *agayap* or unripe papaya with ginger may also be given to aid milk production. Providing these traditional concoctions for better lactation is a sign of the community's support for the breastfeeding mother.

Bathing is allowed only after the news of the birth of the child is already known in the community. Members of the family who attended the delivery of the baby will have to slice ginger together with a piece of pork fat pierced with fresh *runo*. This is then planted upright near the place where water is fetched. After three days, the mother will bathe then pick the ginger on the stick. This is believed to promote the production of breast milk.

After childbirth, they observe *tanggap*, which is a rest period for the woman. This ranges from one to three months, sometimes even six months. In modern societies, the equivalent of this practice is maternity leave. To the Kankana-eyes of Badeo, *tanggap* gives the woman time to nurture the newborn as well as to regain strength. This rest period exempts the woman from the "more heavy" workload but she continues with her regular duties at home. During this period, the husband takes a more active role and a bigger share of the housework. Moreover, when the woman is nearing the expected date of birth, the husband is expected to stay in the village to make himself readily available if required to assist in the childbirth.

Basig or Infertility

Couples who are unable to have children are dubbed *basig* or infertile. Male infertility is commonly attributed to *kessit ti lalaki ket nangisit* or having black sperm, or one testes is smaller than the other. To females, this is attributed to *bassit nga suso ti babai* or having small breasts. Despite this, the concept of *basig* seems vague to the people of Badeo. Rituals to cure infertility include the *dawdawak*, *sip-ok*, and *bunong*.

Common Illnesses

Usual ailments of adults are: *sakit ti peweg* or knee pains, *sakit ti siket/bakrang* or pain on the waist/hips, and *sakit ti tengnged* or pain over the nape area. These pains particularly of the knee, waist, and hip may be attributed to the inflammation of a joint, coupled with swelling and stiffness. *Masahe* or massage using baby oil, alcohol or *lana* or coconut oil as lubricant usually work to alleviate these pains. One of the oldest healing therapies all over the world, massage, “aside from relieving muscle tension... can also provide better flexibility, improve circulation, lower blood pressure, relieve headaches, improve posture, strengthen the immune system, reduce stress, and much more” (Jager 1998). Other measures to stop or prevent pain include increased intake of calcium, Vitamin D and physical activities such as walking. The above condition maybe attributed to arthritis, based on the symptoms, as well as its response to massage. No statistics however, confirm this condition.

Namospos or Menopause

This stage which is exclusive to women forms a major milestone in the life of a Badeo woman since it marks her exit from one of her more important roles—that of bearing children. *Namospos* is a stage in life that is marked by the cessation of menstruation, which usually happens when she reaches her forties. This phase starts when the interval between her periods lengthens. This short-term amenorrhea lasts typically for a year before the woman stops menstruating altogether.

During this phase, the woman feels *kasla agnginaw manen—aglaladot, naim-imas ti turog* or like infanticipating again—lethargic, sleepy. This phenomenon was also observed by David Werner (1994) who said, “A woman may think she is pregnant. And when she bleeds again in three months, she may think she is having a miscarriage.

The menopausal woman likewise feels *napudot nga rikna nga haan nga gapu ti trabahao* or unusually hot, even in the absence of any strenuous activity. Noticeable, too, is her *maaw-awan nga rikna* or steady loss of sex drive and *awan galis* or loss of lubrication. This stands in contrast to men whose “*rikna*” or sex drive, the womenfolk observe, are *ket haan nga maputed* or never lost. The womenfolk mention the use of coconut oil to help their lubrication problems.

The above description of the Badeo women regarding what they feel during the *namospos* stage is typical of what is medically known as the climacteric process, a state highly ascribed to the changes in the ovaries and the various biological processes associated with its functions (Vander Zanden 1993). All the symptoms felt and described are due to the profound decline in the production of female hormones, particularly estrogens. In Western countries, "symptoms that may have commonly been attributed to menopause include hot flushes (the flushing of the skin; feelings of extreme heat), episodes of profuse sweating, fatigue, dizziness, headaches, insomnia, nervousness, and depression" (Vander Zanden, 1993). The substantial reduction of estrogen also results in skin, vaginal, and clitoral changes (Poorman 1988).

The *namospos* is plagued with *naut-ot nga siket* or back pains. Again, the womenfolk cite coconut oil as a common remedy used in massaging the ailing body part. While no confirmative diagnosis can be made as to the cause of back pains, one possibility is osteoporosis, a condition where bone matrix is lost. This is common to the elderly, particularly the postmenopausal woman (Brunner and Suddarth 1986). Usually manifested by lower back pains, osteoporosis must be treated with supplementary calcium in the diet.

Lewis and Bernstein (1996) claim that although bone density decreases as part of the aging process, "calcium is constantly being exchanged within bones to provide the needed amount of cellular exchanges. Estrogen acts to delay the resorption of calcium, promoting bone density." Therefore, health workers should emphasize the value of adequate calcium intake among menopausal women.

While recent medical books now mention a menopausal counterpart in men, the men of Badeo do not express any knowledge or awareness of any change in their life that they can consciously associate with women's menopause.

LAKAY/BAKET OR OLD AGE

An interviewee reveals, "*Lakay o baket kan nu haan ka nga makatrabahun*" or roughly translated, "You are already old when you can no longer work." This reflects the community's definition of old age. To the community, this phase also means *nganngani nga matayen ti tao* or death is approaching.

A *lakay/baket* is characterized by episodes of *kabaw*, *kasla agtagtaginep* or forgetfulness, dream-like state, *umap-apos* or proneness to self-pity, and *maup-upay* or melancholia. The physical changes a *lakay/ baket* exhibits include *uban* or the growth of white hair, and *haan nga makabaklayen* or weakness of body as to be unable to carry objects anymore.

The *lakay/ baket* is perceived as *kasla nga ubing nga maay-aywanan ken matartaraken* or like a child needing care and monitoring. To meet their needs, a caregiver role is usually ascribed to a daughter or a grandchild, usually a granddaughter. This includes bathing the *lakay/ baket*, feeding them, and—to ward off self-pity and melancholy—keeping them company.

Despite all these, the *lallakays/ babbakets* are held in high esteem. Their experiences in life are well associated with wisdom and insight. It is then not surprising that part of the *lakay's akem* or the elderly male's responsibilities is to be the *taga-mandar iti balay ken ili* or the manager of the household and community. The *baket* or the elderly female, on the other hand, is expected to *taga-urnos ti pamilya* or to maintain harmony in the household. They both take care of *pammagbaga ti ubbing/ apokuk* or instructing and enlightening the youth. Still, the *lallakays* and *babbakets* are free to attend to any tasks that they are capable of doing to sustain the family. One old woman says:

I still go to the *uma* even if I am already old. You need to work in order to have something to live by. If you don't, how will you live? So you need to be patient and endure farming, growing *camote* and vegetables.

Another woman relates how her weak body has limited her work but she continues to help out in the household:

I just sit around the house because now that I am thin, I don't want to work. I only work when I prepare the food of the children. I take care of five children. Sometimes I still go to the swidden, I go to see how it is. I look for vegetables or anything that I can get as food. I don't carry heavy loads anymore. I can only carry small containers of water. It's the only thing which I can bring up the house. The children are big enough, they pound rice and so all I have to do is cook.. Yes, I can still see the rice grains that I am cleaning. God is merciful...

Common Sicknesses of the *Lakay/Baket*

Most, if not all, of the sicknesses and ailments experienced by the *lallakays* and *babbakets* are age-related or degenerative disorders common to the elderly of many societies. The *lallakay/babbaket*'s usual complaint is *sakit ti tumeng* or knee joint pains which they treat with *laya nga nilibek* or pounded ginger and *gipas*, a local herb. There have been reports linking ginger to relief of many pains, including rheumatoid arthritis and muscle plus joint pains (Co 1989; WB 1998). *Gipas* is also a proven effective treatment for rheumatoid arthritis. In Co's book (1989), *gipas*' fresh leaves and stems are said to be effective as a poultice for arthritis when pounded and mixed with a small amount of wine.

Another common ailment is *sakit ti pag-ew/barukong gapu ti bannugor* chest pain due to exhaustion or fatigue. They decoct and drink *gaon/pan-aw* or *cogon*, a kind of grass, for this.

Hypertension, popularly known to them as high blood, is believed to be caused by *kanayon nga panag-inom ken kanayon nga panangan ti aso* or frequent alcohol intake and frequent eating of dog meat. One remedy they use is *panangan ti napitpit nga bawang* or eating crushed garlic. Co (1985) documented *bawang* or garlic as an effective treatment for hypertension. Treatment using garlic is done by eating fresh cloves or leaves of garlic during meals. They also eat *tunsoy* or watercress and schedule their bathing only in the afternoons. The afternoon baths are done as a conscious effort to ensure relaxation which cannot be done during the cold mornings and nights at Badeo.

Ulcer, another common ailment, is popularly believed to be caused by *naladaw nga pannangan aglalo no nadagsen to obra* or delayed meals especially during heavy work. *Sabeng* and *uggot ti runo* are used to manage the condition.

Goiter is ascribed to drinking water fetched near a giant fern called *tibbawang*. Such effects of the *tibbawang*, however, may be countered by eating *engwad* tops. Although no scientific rationale can be drawn regarding the relationship between the giant fern and hyperthyroidism, *engwad*, more commonly known as *burburtak*, has been thought to also contain levels of iodine, the key mineral ingredient whose lack or absence causes goiter.

Matagudab or cataract, *matulleng* or deafness, and *maballa* or mental derangement are common to the *lallakays* and *babbakets*, but the people of Badeo do not know any cure for any of these health problems.

PESE OR DEATH

The final phase is described by the people as *patingga ti biag nga nangapitan ni Apo Dios* or the end of life that comes from God. Its advent is heralded by telltale signs like sunken eyes and the inability or refusal to eat.

Once *pese* is confirmed, the *iyun-a* or deceased is bathed then wiped dry. A piece of cloth is tied around the forehead. The wealthy use *salibubo*, *kundiman*, or *kambayaddo*, cloths from Bontok. When the *iyun-a* is poor, the piece of cloth used is called *lunas*. The *iyun-a*'s knees are tied together and then the entire body is wrapped with blanket. For the *baknang*, the blanket of Bontok called *pinagpagan* or *kuwabe* or *bay-ong* is used, while the poor use the *bendala*. The choice of clothing is dictated by the deceased's social status. The poor, using only the *bendala* and *lunas*, also butcher less animals as compared to the wealthy, who butcher numerous animals for the occasion.

Numerous rituals mark this phase. Each child of the *iyun-a* is expected to *manlawit* or butcher an animal during the wake. The animal may be a carabao, pig, chicken, or dog. The bones of the animals are hung outside the *iyun-a*'s house as a sign that death has visited the household. The *iyun-a*'s spouse is given a share of the butchered animal, a practice called *siling*. *Tafey* is also served at the wake.

The spouse of the *iyun-a* is expected to observe *ngilin* or fasting. In addition, the spouse is asked to refrain from traveling and using the deceased spouse's clothes. The widow/widower is also expected to eat alone at the wake. The surviving spouse is prohibited from eating the *siling ti asawa na* or meat of the butchered animal at the wake in order to prevent *magudab* or blindness, *mawelwel* or nausea, and *matay nga sumaruno* or dying after the spouse.

The *kiwkiw* must be observed, where ginger, *tabtaba* or fats, and water are used, so that *haan nga maisiding idiay nabalo* or the widow/widower will not be too affected by the loss. Remarriage is allowed after six months to one year.

The rest of the *iyun-a*'s family must likewise observe *ngilin*, though, in other ways. The men folk are prohibited from cutting trees and the female members from cutting firewood. Everyone is similarly restrained from doing *makitegged* or work for pay. Sexual relationships are prohibited. When caught under the rain, they must take care that they do not get wet. Conversing and

roaming around are discouraged. And so are sleeping in a house other than one's home, passing by a river, and having a haircut. Certain foods must not be eaten, such as pepper, *patani* or peas, anything slimy, shells from the ricefields, chicken, squash, and any animal that died for no apparent reason. This period of *ngilin* lasts for a month.

At the wake, the community helps out in kind, usually by donating rice or by doing manual labor. Whenever possible, monetary donations may also be made. This form of communal assistance is called *deng-aw*. The wake can last up to nine days, depending on the finances of the bereaved. In the past, the period also depended on the number of children of the deceased.

Burial may be under the ground or in a *liang* or cave. Should a rat be seen as the burial party is making preparations, they must delay setting out for the burial grounds by about 30 minutes. Sneezing and passing gas are to be avoided. Before the *iyun-a* is carried out of the house, his forehead is washed so "he can find his way."

As the *iyun-a* is brought out of the house, fire is kindled and its heat spread on the place he was laid. A chicken is brought to the burial site as *balon ti natay* or food for the dead. The burial party brings food which is eaten halfway to the burial site. If on the way they see a bird called *kositi* or a rainbow bird, this is taken as an ill omen. To counter this, the family must butcher a pig and the *mambunong* should offer prayers.

After the burial, the group goes back to the bereaved family's house taking care to bring a handful of the soil called *eka* in which the *iyun-a* was buried. Once home, the burial participants wash their hair or observe *gulgol*, after which they partake of the chicken that was intended as *balon ti natay*. The *eka* is also the object of the chanting that ensues at this point.

After eight days from the burial or the number of days prescribed by the elders, the bereaved family once again gathers together with relatives. They will again butcher an animal. This is also the time when debts incurred during the wake are discussed. A debt settlement, called *guod*, must be undertaken, otherwise their debts would haunt them, rendering *panagbiag* or life difficult.

The death and burial of a family member burdens the family not only by having one less member contributing to the family's income; they are also burdened in their effort to satisfy the call of tradition. One elder woman's experience, whose husband died eight years ago, dramatizes the fading practicality of the death rituals. She describes the dying process of her

husband who refused to be brought to the doctor and preferred to be treated by the *mambunong*. Asked what interventions the *mambunong* performed, she relates:

Our traditional way that we call the *dilos*. But still he did not live. They play gongs..butcher animals like pigs..around five. But it didn't work. He did not survive but it's all right, he knows that I followed his wishes. I did not disobey him. He won't be able to complain since we observed the rituals even if I had to borrow money.

Despite her observance of the rituals for the death and burial of her husband, the same woman, however, exhibited more flexibility. Asked if she would require the same from her family when her time comes, she responds with such practicality:

Of course I would, if that is what my children like. If they prefer mere prayers, then let it be. I will not have hurt feelings if they would not follow the rituals. Everything is expensive nowadays.

FINAL REMARKS

The concept of health of the people of Badeo is integrally related to their belief system. They believe in the existence of unseen beings and spirits, which possess the power to grant good fortune or inflict evil such as diseases. To prevent or reverse ill health and diseases, people appease the spirits by way of rituals and the sacrificial offering of ritual animals such as pigs and chickens. But more than this, the people of Badeo maintain good health by avoiding sicknesses and treating diseases through their own knowledge of health. Their use of herbs to prevent or cure ailments and sicknesses, for example, illustrates their knowledge of the curative qualities of plants. These indigenous knowledge and practices continue to persist despite the incursions made by modern medicine.

Progressive health practitioners and researchers (NEHCC 1989) remind us that most of these beliefs are of great value while some may be harmful. However, they also point out that it would be useful for researchers

and health practitioners to be judicious in assessing the value of these indigenous health knowledge and practices. Indeed, many traditional beliefs are valuable and beneficial and thus should be promoted. Harmful practices, on the other hand, should be corrected. Practices that do not necessarily harm should be respected because they often fulfill other health needs such as psychological support.

Life in Badeo is difficult and the people cling to many traditions they consider important for their survival. Amidst the rapid changes in the socio-economic and political environment, the people of Badeo rely on customs and practices passed on by their ancestors to help them survive. While mostly dependent on indigenous knowledge and practices, the need for modern medicine is also acknowledged and sought. Indeed, the lack of access to medical services should be properly addressed.

As the research findings confirm, there are many variables that impact greatly on disease patterns, health behavior, and the overall health situation in Badeo. Economic and social factors such as class, educational attainment, gender, and being an indigenous people, most of all, affect health. The remoteness of Badeo, its inaccessibility, and the dearth of government health services give us more reason to preserve the indigenous healing practices of the people of Badeo. The integration of indigenous and modern medicine can be a tool to meet the challenges to create a better life in Badeo.

Chapter 6

SUMMARY AND RECOMMENDATIONS

The indigenous peoples of the Grand Cordilleras of Northern Philippines, collectively known as Igorots, are among the most marginalized sectors of Philippine society. Marginalization here is associated with the political, economic, and sociocultural situation of these people. They are a group of peoples who have successfully resisted colonial integration and later, the assimilationist attempts of the different Philippine political administrations. Unfortunately, the failure to assimilate them in mainstream Philippine society has brought on a deeply entrenched bias against these indigenous peoples. Sadly, they have long been denied their rights to their ancestral domain which is not only the source of their subsistence but an integral part of their life and culture. They have long been victims of government apathy and neglect.

They continue to receive attention from the government which they would rather not have. Generally, the people of the Cordilleras been victimized by government programs and projects that exploit their rich natural resources. These have displaced many of them from their ancestral lands. They also suffer from government neglect, specifically in terms of social services and social and hard infrastructure.

In terms of health, many continue to suffer from malnutrition; a high incidence of preventable and communicable diseases; lack of health personnel, services, and facilities; and the prohibitive cost and inaccessibility of health care. The low levels of education and the people's harsh living conditions all contribute to and compound their health problems.

The inadequate health delivery system of the Philippine government underscores the value of nurturing and propagating the medically sound indigenous health knowledge and practices of indigenous peoples. The primary health care approach, the concept of democratic health service, and an integrated health care program recognize and affirm the importance of indigenous health care knowledge and practices.

As recipients of first hand information and as witnesses to the medically sound indigenous health knowledge and practices of the people of Badeo, we would be the last persons to undervalue their health knowledge. However,

we also recognize that identifying, validating, and propagating such indigenous health knowledge and practices alone would have a limited contribution towards achieving "people's health."

In the course of the study, we have found out that:

- (1) The Kankana-eyes of Badeo have an internally consistent, highly integrated, and ecologically harmonious knowledge system that revolves around life cycles, major life events, and health issues. This knowledge places health in a holistic psycho-socio-spiritual perspective. However, we contend that the integration of the more biologically based Western interventions being presented by the government or NGO programs are beneficial and imperative.
- (2) The people of Badeo have many beneficial health practices. Some of them may have no scientific basis but are beneficial for the psychological and spiritual support individuals need. These are also important in transmitting important cultural values necessary for ensuring tribal welfare and identity. Although there are practices frowned upon by Western medical practice, many of their beliefs can be validated by western scientific knowledge. These beliefs (e.g. the use of guava leaves as a general antiseptic) should be preserved, promoted, and defended against equally effective but less ecologically sound western alternatives
- (3) The following practices and concepts should be integrated into and strengthened in GO and NGO programs:
 - a. Strengthen the propagation and use of medicinal plants, not only because they are alternatives to costly western drugs, but because they are scientifically proven, accessible, and available.
 - b. Improve sanitary conditions emphasizing the proper disposal of garbage (e.g. composting or burying garbage); proper channeling of used or dirty water from kitchen and bathroom drainage to a covered pit or blind drainage to prevent mosquitoes, flies, and other insects from breeding; and proper disposal of human waste through properly constructed sanitary toilets. This will prevent the spread of microbes that can contaminate the soil, water, and air. Sanitary human waste disposal also prevents the spreading of microbes by flies, cockroaches, and other pests.
 - c. Provide safe water through regular inspection of water source and examination of water, especially during rainy season or

- when incidence of gastrointestinal tract infections like diarrhea and dysentery are on the rise.
 - d. Vigorously promote immunization of children before they reach the age of one.
 - e. Assess and improve practices related to pregnancy like pre-natal care, home delivery, and post-natal care.
 - f. Assess and promote the nutritional value of the food intake of the community, and identify ways to improve current nutritional intake.
 - g. Promote mental health throughout the life cycle.
 - h. Promote dental hygiene, particularly among children
- (4) Like any other community, there is a need to introduce other health promoting practices and to provide information that would help people stop some practices that the researchers believe are harmful.
- a. The value of breast-feeding up to six months needs to be strengthened among the women of Badeo. This practice does not only promote LAM as a contraceptive method but offers and guarantees the child the benefit of good nutrition.
 - b. The introduction of food supplements at a very early age of three weeks should be further tested.
 - c. Early weaning of the child from breast-feeding at age four months or earlier should be discouraged.
 - d. Misconceptions should be addressed such as forbidding women to bathe and eat certain foods during menstruation; bathing the baby only once the umbilical stump falls off; chewing certain parts of herbs used as poultice for wounds; rubbing the mother's nipples with ginger or chili pepper to wean the child; wrapping the sick in blankets, especially fever stricken infants; women with large breasts produce more breast milk than women with small breasts; deformities at birth are related to encounters with unsightly objects, animals or persons during the pregnancy period.
 - e. Sex education among adolescents should be encouraged and not considered as taboo. Women and men both have sexual desires, and as such, women must be able to express such

- desires without being reproached by men and society-at-large.
- f. Stereotyped roles of men and women should be a focus of health promotion activities as part of a comprehensive and gender-sensitive reproductive health program. Gender issues should be tackled during trainings.
 - g. Child spacing must also be emphasized in health promotion activities.
- (5) The following are considered either beneficial or detrimental aspects of the cultural constructions of health, the life cycle, and events in Badeo *vis-à-vis* the framework of the study.
- a. Although the spiritual dimension of the concept of health is important, the biological should also be given premium.
 - b. It is recognized that religious functionaries play significant roles in their effort to maintain health; however, the people of Badeo must be made to understand that there are cases that require medical attention to prevent complications or to avoid aggravating the condition.
 - c. The stereotyping of adolescents and their lack of sexual knowledge is a practice that needs to be transformed. Adolescents need accurate information and reproductive health services.
 - d. The practice of women dominating the labor and delivery process promotes empowerment and must be encouraged. It should also be pointed out *vis-à-vis* other roles they play in the home and in the community.
 - e. Acknowledging that pregnancy, labor, and delivery are natural processes is positive. This perception leads to preparing for these events and considering the home as the best birthing place. However, the signs and symptoms of a high-risk pregnancy and hospitalization, if the need arises, must be acknowledged.
 - f. The labor and delivery process is one stage in the life of the women of Badeo that depict their control over their bodies. This is manifested in their ability to make choices: from choosing the desired birthing position to selecting the birth attendant.
 - g. The sexual division of labor that begins during adolescence and is passed on to adulthood does not promote gender sensitivity.

This reinforces the “naturalness” of the idea of a male-dominated economic structure and a female-dominated domestic structure. Even the men’s criteria for choosing a marriage partner are rooted in their concern for food security.

- h. The notion that menopause is just a physiological process and considered a deterrent to activities in life is not a healthy outlook. There is also a need to emphasize the implications of such physiologic changes to certain health risks like osteoporosis.
 - i. The community’s association of old age with high esteem (*i.e.* associated with wisdom and insights) and not material things like educational attainment attests to a healthy attitude regarding aging.
 - j. The belief that death is a *gift* of the spirits is extremely beneficial. This is indicative of a positive outlook in life, not only of the individual, but of the family and community as well.
- (6) Understanding the cultural context of the people is a powerful tool to assess and understand relationships and to determine ways to respond to their needs. It leads to a culturally congruent provision of health care, especially if research data are properly utilized.
- (7) Different culturally based indigenous health knowledge and practices were obtained from the women and men of Badeo. We also found different modes of learning and transmitting indigenous health knowledge and practice throughout their life cycle. To better understand the indigenous peoples, not only in Badeo but in the whole world as well, it is important to understand the relationship between indigenous health knowledge and modern health care.

We reiterate, therefore, that indigenous health care knowledge and practices:

- (1) are humanistic and people-centered.
- (2) use practical knowledge in familiar ways to care for others.
- (3) focus on holistic ways, beliefs, values, life experiences, and worldviews of people.
- (4) are delivered by caring individuals at home, using familiar resources.

- (5) rely on lay practices and on the understanding of cultural factors to help people regain health and perform their daily functions.
- (6) focus on preventing illnesses and deaths by observing tried and tested cultural rules and practices, and keeping away from taboos.
- (7) reflect high context modes of communication.
- (8) use cultural rituals to cure and prevent illnesses in favor of technology-based tools and instruments of modern medicine.

Modern health care, on the other hand:

- (1) is scientifically-oriented and patient-illness oriented.
- (2) uses symptoms to arrive at specific diagnoses and employs curative medical treatments.
- (3) is delivered by medical specialists and other caregivers.
- (4) is expensive and often beyond the economic capabilities of many people.
- (5) reflects low cultural context modes of communication.
- (6) uses high tech tools and machines in often alienating hospitals.

There is a need to establish a mechanism to address the decline of indigenous health care practices. Oral tradition, a mechanism that people used to transmit their knowledge on health, is on the decline; hence, the need to develop other mechanisms to successfully preserve their knowledge and skills on health care. Schools are an important venue by which indigenous health knowledge can be disseminated. It would be interesting to incorporate a section in the curriculum that will allow students to learn basic knowledge on indigenous health care and healing. The academe and other health care institutions can also initiate dialogues on indigenous health and can facilitate trainings on identifying, preparing, and preserving herbal cures.

There is a need to sustain the use of indigenous knowledge on health care because of the poor health conditions of people in marginalized areas such as Badeo. The Local Government Code of 1991 calls for the mobilization of local resources. This is an excellent opportunity to integrate indigenous health knowledge and practices to the government delivered health care system.

Further research can be conducted to uncover cultural contexts of indigenous health knowledge and practices since different cultures have

different beliefs, values, and patterns of caring and healing. Caregivers can use the knowledge on this in caring for people across cultures. There is also a need to further explore cultural care values, beliefs, and practices. Furthermore, there is a need to document and to understand the language of the people in the context of health. Exploring indigenous health knowledge and practices will provide valuable data to develop meaningful, competent, congruent, safe, and beneficial health care practices.

The use of qualitative research methods leads to more reflective knowledge and a better understanding of indigenous health knowledge and practices from the people's *emic* worldview, language, ethnohistory, and social structure features (including religion, kinship, education, economics, politics, and cultural values) making health professionals more culturally sensitive.

Health is a complex issue which requires a holistic and integrated approach. The primary health care approach is considered to be a more comprehensive strategy that would not only include a people-centered approach to health services but would also address the social and political factors that influence health. We thus subscribe to the principles engendered by the primary health care approach, and the democratic health service and integrated health care system.

We believe that a more democratic health service necessarily must provide the following elements:

- (1) equitable distribution of food, water, sanitation, preventive health services, and free curative medical care to women, children, and men of all social classes in rural and urban areas;
- (2) support for community-based health care initiatives which give all members of a community control over decisions involving their health and livelihood;
- (3) support for and promotion of food security, in particular, the production of food crops for domestic consumption must be given priority over commercial production of export crops (The redistribution of land is another important component of food security, as a more equitable and appropriate distribution of agricultural services and inputs to small farmers, especially women);
- (4) support programs which would enable groups to overcome poverty such as housing development, literacy training, improved education, and skills development programs for the poor;

- (5) programs to combat family violence and sexual inequality;
- (6) integration of sexual and reproductive health services at the primary care level; and
- (7) research and documentation as an integral part of a comprehensive reproductive health program.

Moreover, we believe that primary health care is still the most holistic and appropriate approach and strategy towards “people’s health.” Thus, we also subscribe to the following principles of primary health care. Primary health care should:

- (1) reflect and evolve from the economic conditions and sociocultural and political characteristics of the country and its communities, and it should be based on the application of the relevant results of social, biomedical, and health services research and public health experience;
- (2) address the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;
- (3) educate people concerning prevailing health problems and the methods of preventing and controlling them; promote food supply and proper nutrition; provide an adequate supply of safe water and basic sanitation; provide maternal and child health care, including family planning and access to contraceptive services and information to menstrual regulation; immunize the public against major infectious diseases; prevent and control locally endemic diseases; provide appropriate treatment for common diseases and injuries; provide essential drugs; prevent and provide information about STDs, HIV/AIDS, and other reproductive tract infections (RTIs); give post-abortion care; reach special populations such as young adults and men; and eliminate sexual violence and coercion;
- (4) involve, in addition to the health sector, all related sectors and aspects of national and community development—in particular, agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors—and coordinate efforts of all those sectors;
- (5) require and promote maximum community and individual self-reliance and participation in planning, organizing, operating, and

- controlling primary health care, making full use of local, national, and other available resources to develop, through appropriate education, the ability of communities to participate;
- (6) sustain health care through integrated functional and mutually-supportive referral systems, to bring about progressive improvement of comprehensive health care, giving priority to those most in need;
 - (7) rely on health workers—including physicians, nurses, midwives, auxiliaries, and community workers at local and referral levels—and suitably trained traditional practitioners, to work as a health team and to respond to the expressed health needs of the community.

Given the complexity of the phenomenon of health, we suggest that health be viewed and analyzed using various analytical lenses, such as: (1) the primary health care approach which is contextualized against the larger backdrop of macro-social structures—the role of multilateral finance and development institutions which impact on the situation of the people, particularly on the health situation and health programs in southern countries; (2) the indigenous peoples and their rights; (3) indigenous health knowledge and practices; (4) gender roles and women's multiple roles; and (5) the life cycle approach.

We believe that our roles as researchers, health advocates, and activists do not end with this research. We are convinced that this research is just the means for the implementing programs that can provide direct services and inspire advocacy. Thus, part of our recommendations is to encourage campaigns on policy and other levels of advocacy that will address the various issues and levels of structures that affect the health situation and the achievement of "people's health."

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MAINSTREAMING INDIGENOUS HEALTH KNOWLEDGE AND PRACTICES was conceived as a response to the urgent need to capture and document indigenous health knowledge and practices before the influx of modernity into indigenous communities undermines and obliterates these practices. The Cordillera communities are among the indigenous communities threatened by modernity.

In the area of health, the national government has instituted a health delivery system that principally purveys a Western medical approach. Unfortunately, government has not been too effective in the delivery of healthcare especially in far-flung communities, delaying the incursion of Western medicine into the Cordillera villages. However, medically sound indigenous health knowledge and practices still face the threat of oblivion as younger generations are secularized and modernized rather than socialized into their indigenous culture.

The study focuses on indigenous notions of health or *kasalun-atan* and women's life cycle with emphasis on women's health.

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