# The Health Perceptions and Practices of *Lumads* in Southern Philippines

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**ABSTRACT**

The *Lumads* or non-Islamized indigenous peoples (IPs) of Mindanao, specifically in Maramag, Bukidnon, have demonstrated a high level of awareness of the right to health. The results of the study conducted in 2006 revealed majority of the 200 IP respondents interviewed have basic knowledge and understanding of concepts like the universality of the right to health across economic status, sex, and religion; and equality of the right to health of Christians and *Lumads*. Factors like exposure to the mass media and influence of the barangay health center have contributed to the high level of knowledge of IPs on the right to health, also a reflection of their assimilation into mainstream society. However, they continue to hold on to their indigenous health and treatment beliefs, practices and rituals like patronizing the services of the *baylan* or traditional healer, using herbal plants and medicines, and utilizing traditional structures in the community when confronted by serious health problems, and performing rituals such as the *pamuhat*, *patawalan* and *talotho*. Promoting the IPs' right to health requires political will and commitment on the part of the State to fulfill its obligations to these sections of the population who have continuously been marginalized and discriminated by mainstream society. The active participation of the IPs and their organizations is likewise critical in the development of specific and culturally-appropriate health plans, programs and services.

*Key Words: indigenous peoples, health beliefs and practices, right to health*

## Introduction

An acceptable explanation of the concept "indigenous peoples" (IPs), although not considered its formal definition, is that put forward by Martinez Cobo, the Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities, in his work, *Study on the Problem of Discrimination against Indigenous Populations* (1986), to wit:

> *Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and 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 system.*[1]

In the Philippine Indigenous Peoples Rights Act of 1997, IPs are referred to as:

> "*a group of people or homogenous societies identified by self-ascription and ascription by other*[sic], *who have continuously lived as organized community on communally bounded and defined territory, and who have, under claims of ownership since time immemorial, occupied, possessed customs, tradition and other distinctive cultural traits, or who have, through resistance to political, social and cultural inroads of colonization, non-indigenous religions and culture, became* [sic] *historically differentiated from the majority of Filipinos,*" [2]

Implicit in both descriptions of IPs are their being a distinct collective whose historical experience and cultural background set them apart from the rest of mainstream society. Their close attachment to their land and the natural environment influences and affects their ways of living, social relations, customs and interpretations of events. Moreover, their relationship and interaction with the various forces of nature, most especially their ancestral land, shape and re-shape their worldviews and perceptions, consequently their behavior.

Health beliefs, concepts and practices of IPs are components of their social life that are closely tied to their

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deep relationship with the land and their recognition that the land is the source of life. To the IPs, land is sacred since they are able to get "everything they need to live and to have good health: healing plants, animals, berries for food, clean water, clean air" from Mother Earth.[3] Thus, it is not surprising why IPs view health as the "harmonious coexistence of human beings with nature, with themselves, and with others, aimed at integral well-being, in spiritual, individual, and social wholeness and tranquillity".[4]

Unlike the official definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[5] formulated by the World Health Organization (WHO, 1946), the IPs' concept of health is more wide-ranging and holistic in scope. To them, good health is equated with having a harmonious and balanced relationship with the physical environment, spiritual world, oneself and with members of the community; good health means "balance between mind, body, spirit, culture and earth".[3] To the IPs, "health or wellbeing is directly related to the land they live on"[3] and to the collective ethos that guides their relationship with nature and with others. However, colonialism, exposure to Western influences and the gradual integration of IPs into mainstream society have had its impact on indigenous culture including health. Among the major western influences and developments which have seriously undermined indigenous culture, specifically the "concept of community and interconnectedness", were the "commodification of land" and the "individualization of human life".[3]

The mainstreaming of human rights post-World War II has resulted in a paradigm shift in the view and treatment of health as an aspect of social life. Health as an individual and as a collective right has acquired international recognition with the formulation of international human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (1966) and the United Nations Declaration on the Rights of Indigenous Peoples (2007). In the Philippines, there is the Indigenous Peoples Rights Act of 1997.

As stipulated in human rights laws, health is a right that all peoples, including indigenous peoples, are entitled to enjoy. However, with the development paradigm being implemented by the national government, the individual and collective right to health of IPs has been seriously undermined. Development and infrastructure projects like dam and hydroelectric power plant construction, large-scale mining operations, and logging activities, have resulted, not only in the physical displacement of IP communities, but also in their economic, social and cultural dislocation and annihilation.[6,7] Destruction of their ancestral domains and the plunder of their ancestral lands by governments and multinational corporations have denied IPs the fundamental right to life.[8,9] Consequently, other civil and political rights, economic, social and cultural rights have been placed under attack. These include the rights to participate in decision-making processes, their culture, health, education, freedom from discrimination, and freedom of expression.

The right to health of IPs is one such right which the State is obligated to respect, protect and fulfill. The right to health constitutes having access to a variety of goods, services and facilities, that will enable them to realize the highest standard of health,[10] including information, healthcare, and other underlying determinants of health like food, shelter, education, employment, etc. Moreover, the right to health of IPs entails recognizing their traditional and indigenous health norms, practices and beliefs, and enhancing their capability to further develop and take control of resources that will enable them to enjoy that right.[11]

Awareness of health as a right is a necessary condition for people to claim this right. Being armed with the knowledge of what constitutes the right to health becomes doubly important for IPs who have indigenous health beliefs and practices to protect and preserve in the midst of attempts and efforts to undermine indigenous health systems, generally perceived as backward and unscientific.

This study, which was undertaken during the second half of 2006, explores the perspectives of a group of *Lumads*, a term referring to the non-Islamized indigenous peoples in the Island of Mindanao, on the right to health; how this is exercised and how it relates to indigenous health beliefs and practices.

## Study Objectives

The research aimed to describe the state of the right to health of IPs in the Municipality of Maramag, Province of Bukidnon, Mindanao, particularly among the Manobos, Talaandigs and a mixed group of indigenous people. Specifically, the study had the following objectives:

1. to describe the concepts of and views/perceptions of health and illness of the indigenous peoples in the study sites,
2. to determine their knowledge and practice of the right to health,
3. to describe their awareness of, nature of utilization of, and attitudes toward public health services in the community, and
4. to explain the mechanisms of the indigenous communities in addressing their health problems and concerns.

## Study Methodology

*A. Data-Collection Technique*

The descriptive study conducted among the Manobos, Talaandigs and a mixed group of IPs in Maramag relied on the survey method using a pretested structured interview

schedule in the collection of data. Review of materials and records from both the Municipal and Provincial Development Offices was also done. Moreover, the study results were validated and enriched through focus group discussions (FGDs) conducted among some of the study respondents in each of the five barangays.

A 13-page interview schedule translated into Cebuano, a local dialect used by the study participants, was employed in the survey conducted by two (2) locally trained interviewers who are known to the IPs and familiar with their language.

*B. Study Sites*

The study was conducted in five (5) barangays in the Municipality of Maramag, Bukidnon. These areas were chosen not only because these had the highest concentration of *Lumads*, primarily Manobos and Talaandigs, but because the study was necessary to enhance and provide credence to the health project being implemented by the Medical Action Group Inc. (MAG) among the IPs in the municipality. The five barangays were Dagumbaan, Danggawan, La Roxas, Panadtalan and Panalsalan.[12]

Maramag is one of the twenty municipalities in the Province of Bukidnon, home to different cultural communities of the Manobo groups, namely the Bukidnon, Higgonon, Matissalug, Talaandig, Tigwahanon, and Umayamnon. The Arumanen is another sub-group.[13]

As of the 2000 census, Maramag had a population of 75,233 individuals constituting 7.1% of the total population of Bukidnon. In terms of population size, Maramag ranks second among the municipalities of Bukidnon.[14]

*C. Study Respondents*

A total of 200 IP respondents belonging primarily to the Manobo and Talaandig tribes in Maramag, Bukidnon, were interviewed for the study. Meanwhile, 12.5 percent of the respondents belonged to a mixed group of IPs like Manobo–Talaandig, Higaonon and Bagobo, and IPs who married Christians like the Cebuanos, Boholanos and Ilonggos. The total number of respondents was pre-determined due to budget constraints.

Following the indigenous practice of the *Lumads*, the selection of the study respondents was supervised and decided by the tribal chieftains of each barangay after a Memorandum of Agreement (MOA) was forged between the Medical Action Group, Inc. (MAG) and the tribal leaders of the barangays. The latter believed they would be in a better position to identify the *Lumad* respondents who would be competent to participate in the interviews.

Before the interviews started, a ritual called *pamuhat* led by the *baylan* or indigenous healer, was held in each of the study sites to ask permission from the gods or spirits of the tribe to allow the entry of outsiders and the holding of activities outside the regular activities of the *Lumads* in the village. It included the recitation of prayers and offering of a live chicken which was later killed, boiled without spices, and eaten with rice by those participating in the ritual. The holding of the *pamuhat* signified the consent of the *Lumads* and their tribal leaders to proceed with and participate in the study.

Based on the estimated total IP population per barangay, a proportional sampling technique was used to determine the number of respondents for each barangay. Out of the pre-determined 200 study respondents, 22% belong to the Manobo tribe, 65.5% to the Talaandigs, and the remaining 12.5% to a mixture of small tribes in the study sites.

**The *Lumads* of Mindanao**

*Lumad* is the term used to refer to the non-Islamized indigenous peoples in Mindanao. It is a Visayan word for native or indigenous "of the land".[15]

Government estimates put the total population of IPs in the country from 15 to 20 million or about 15 to 20 percent of the total Philippine population. About 61 percent of the total IP population is concentrated in Mindanao, the second biggest island of the archipelago.[16]

A recent report of the UN Development Programme in the Philippines (UNDP) revealed that "about 15 million of the IPs suffer from poverty and human rights violations and their life expectancy is 20 years shorter than that of the rest of the population." Moreover, they constantly experience hunger and cultural degradation, and "have no access to basic social services such as education and health care", according to Jacqueline Badcock, United Nations (UN) coordinator in the Philippines.[17]

Even the Episcopal Commission for Indigenous Groups of the Catholic Bishops Conference of the Philippines (CBCP) recognizes the marginalized and impoverished conditions of IPs in the country. As stated by Msgr. Sergio Lasam Utleg, Bishop of Laoag and Head of the Episcopal Commission for Indigenous Groups, "The government must devote more resources to indigenous people—especially in education, health and preservation of their cultural identity. Often local governments are not interested in their needs and force them to live on the margins of society."[17]

Yet, the Philippine government is cognizant of its obligations to promote and protect the rights of IPs as evidenced by its commitments to several international human rights laws such as the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), and the UN Declaration on the Rights of Indigenous Peoples.

Domestically, the rights of indigenous peoples are legally recognized in the 1997 Indigenous Peoples Rights Act

(IPRA) and enshrined in the 1987 Philippine Constitution which stipulates:

> Article XII, Section 5: *The State, subject to the provisions of this Constitution and national development policies and programs, shall protect the rights of indigenous cultural communities to their ancestral lands to ensure their economic, social, and cultural well-being.*
>
> Article XIV, Section 17: *The State shall recognize, respect, and protect the rights of indigenous cultural communities to preserve and develop their cultures, traditions, and institutions. It shall consider these rights in the formulation of national plans and policies.*[18]

However, despite these legal bases, human rights violations continue to be perpetrated against IPs as illustrated in the report of the former Special Rapporteur on the Rights of IPs, Rodolfo Stavenhagen.[2]

The Indigenous Peoples Rights Act of 1997 states:

> Sec. 25. *Basic Services.- The ICC/IP have the right to special measures for the immediate, effective and continuing improvement of their economic and social conditions, including in the areas of employment, vocational training and retraining, housing, sanitation, health and social security. Particular attention shall be paid to the rights and special needs of indigenous women, elderly, youth, children and differently-abled persons. Accordingly, the State shall guarantee the right of ICCs/IPs to government's basic services which shall include, but [are] not limited to water and electrical facilities, education, health and infrastructure.*[16]

Yet, the report of Mr. Stavenhagen revealed the difficulty of IP groups and communities to access and avail of basic social services like health, education, water and sanitation facilities.[2] Moreover, according to the report, "human development indicators are lower and poverty indicators are much higher" in IP communities compared to the rest of the population.[16]

In Mindanao, particularly in the Municipality of San Luis, Agusan del Sur, where the Manobo, Banwaon and Talaandig tribes are found, the Special Rapporteur identified these indigenous peoples as among the poorest in the country. They are said to suffer from the effects of poverty as evidenced by "periods of hunger, high morbidity and infant mortality rates, illiteracy, and a serious lack of basic social and other services."[16]

Deprivation and destruction of ancestral domains have likewise been a major form of economic, social and cultural rights' violations in IP communities. Confronted by so-called development projects, militarization, large-scale mining and logging operations, IPs have lost their ancestral lands, consequently their sources of livelihoods.[16] They have also been forced to abandon their sacred grounds and indigenous knowledge systems and practices in health, arts, and literature due to massive environmental destruction.

In addition to the miserable state of economic, social and cultural rights, the Special Rapporteur revealed that the IPs also experience violations of their civil and political rights. These include arbitrary arrest and detention, displacements, hamletting, destruction of property, summary executions, enforced disappearances, coercion and rape, commonly perpetrated by the military, police and paramilitary forces.[16]

The dismal state of IP rights particularly in Mindanao indicates a weakness on the part of the State and its agencies to fulfill its human rights obligations as duty-bearers. The Philippine government as a State Party to key human rights treaties recognizing the rights of indigenous peoples is mandated to take all the necessary measures and devote the maximum available resources to realize its duties to its citizens. This entails having a strong political will and commitment to create an enabling environment that will redound to human rights promotion and advancement. Specifically, these include the setting-up of appropriate structures and mechanisms, allocation of sufficient funds for projects and programs, training of competent and skilled personnel, and formulation of laws and policies, consistent with human rights standards and principles.

## Study Results

*Socio-demographic profile of respondents*

Majority (58%) of the respondents were 41 years or younger at the time of the interview and the mean age was 40 years. Among the Manobo tribe, the mean age was 39 years while it was 40.7 years among the Talaandigs and 39.5 years among the mixed group. More than three-fourths (79.5%) are females, while 88.5% are married. (Table 1)

In terms of educational attainment, most of the IP respondents reached elementary education. There was only one respondent belonging to the Talaandig tribe who completed college education. (Table 1)

Data on religious affiliation indicates that more than three-fourths (78%) of the study participants have been converted to Christianity. (Table 1)

Close to nine out of 10 (87.5%) of the IP respondents were earning an estimated monthly income of less than Php5,000 (Table 1). This means that more than four-fifths (87.5%) of the study participants were living below the poverty threshold, considering that, in 2006, a family of five at the national level and in the rural areas had to earn Php 6,211 and Php5,885 a month, respectively, to meet their minimum basic food and non-food needs.[19]

**Table 1.** Sociodemographic profile of IP respondents, 2006

| Variables | Manobo (n=44) | | Talaandig (n=131) | | Mixed (n=25) | | Total (n=200) | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| **Age:** | | | | | | | | |
| 18-23 yrs. | 5 | 11.4 | 4 | 3.0 | 0 | 0 | 9 | 4.5 |
| 24-29 | 5 | 11.4 | 25 | 19.1 | 6 | 24.0 | 36 | 18.0 |
| 30-35 | 10 | 22.7 | 19 | 14.5 | 8 | 32.0 | 37 | 18.5 |
| 36-41 | 8 | 18.2 | 23 | 17.6 | 3 | 12.0 | 34 | 17.0 |
| 42-47 | 6 | 13.6 | 21 | 16.0 | 1 | 4.0 | 28 | 14.0 |
| 48-53 | 3 | 6.8 | 20 | 15.3 | 2 | 8.0 | 25 | 12.5 |
| 54-59 | 1 | 2.3 | 9 | 6.9 | 1 | 4.0 | 11 | 5.5 |
| 60-65 | 6 | 13.6 | 10 | 7.6 | 4 | 16.0 | 20 | 10.0 |
| **Mean age** | **39 years** | | **40.7 years** | | **39.5 years** | | **40 years** | |
| **Sex:** | | | | | | | | |
| Male | 7 | 16.0% | 28 | 21.4% | 6 | 24.0% | 41 | 20.5% |
| Female | 37 | 84.0 | 103 | 78.6 | 19 | 76.0 | 159 | 79.5 |
| **Civil Status:** | | | | | | | | |
| Single | 1 | 2.3% | 2 | 1.5% | 0 | 0 % | 3 | 1.5% |
| Married | 36 | 81.8 | 118 | 90.1 | 23 | 92.0 | 177 | 88.5 |
| Live-in | 1 | 2.3 | 3 | 2.3 | 0 | 0 | 4 | 2.0 |
| Widow/er | 5 | 11.4 | 5 | 3.8 | 2 | 8.0 | 12 | 6.0 |
| Separated | 1 | 2.3 | 3 | 2.3 | 0 | 0 | 4 | 2.0 |
| **Education:** | | | | | | | | |
| No education | 2 | 4.5% | 2 | 1.5% | 1 | 4.0% | 5 | 2.5% |
| Elementary | 25 | 56.8 | 53 | 40.4 | 10 | 40.0 | 88 | 44.0 |
| Elementary Grad | 9 | 20.4 | 35 | 26.7 | 4 | 16.0 | 48 | 24.0 |
| High School | 7 | 16.0 | 21 | 16.0 | 7 | 28.0 | 35 | 17.5 |
| High School Grad | 0 | 0 | 12 | 9.2 | 1 | 4.0 | 13 | 6.5 |
| College | 1 | 2.3 | 5 | 3.8 | 1 | 4.0 | 7 | 3.5 |
| College Grad | 0 | 0 | 1 | 0.8 | 0 | 0 | 1 | 0.5 |
| Voc/Tech | 0 | 0 | 2 | 1.5 | 1 | 4.0 | 3 | 1.5 |
| **Religion:** | | | | | | | | |
| Catholic | 40 | 91.0% | 97 | 74.0% | 19 | 76.0% | 156 | 78.0% |
| Protestant | 0 | 0 | 2 | 1.5 | 1 | 4.0 | 3 | 1.5 |
| 7th Day Adventist | 0 | 0 | 7 | 5.3 | 3 | 12.0 | 10 | 5.0 |
| No religion | 2 | 4.5 | 1 | 0.8 | 0 | 0 | 3 | 1.5 |
| Others | 2 | 4.5 | 24 | 18.3 | 2 | 8.0 | 28 | 14.0 |
| **Estimated Monthly Family Income:** | | | | | | | | |
| Below 500 | 2 | 4.5% | 1 | 0.8% | 0 | 0 % | 3 | 1.5% |
| 500-999 | 3 | 6.8 | 6.0 | 4.6 | 1 | 4.0 | 10 | 5.0 |
| 1,000-2,999 | 29 | 66.0 | 64 | 48.8 | 14 | 56.0 | 107 | 53.5 |
| 3,000-4,999 | 9 | 20.4 | 37 | 28.2 | 9 | 36.0 | 55 | 27.5 |
| 5,000-6,999 | 0 | 0 | 13 | 10.0 | 0 | 0 | 13 | 6.5 |
| 7,000-8,999 | 0 | 0 | 3 | 2.3 | 0 | 0 | 3 | 1.5 |
| 9,000- up | 0 | 0 | 4 | 3.0 | 0 | 0 | 4 | 2.0 |
| Others | 1 | 2.3 | 3 | 2.3 | 1 | 4.0 | 5 | 2.5 |
| **Household Size:** | | | | | | | | |
| 1-3 | 11 | 25.0% | 19 | 14.5% | 4 | 16.0% | 34 | 17.0% |
| 4-6 | 18 | 41.0 | 67 | 51.1 | 18 | 72.0 | 103 | 51.5 |
| 7-9 | 13 | 29.5 | 38 | 29.0 | 3 | 12.0 | 54 | 27.0 |
| 10-13 | 2 | 4.5 | 7 | 5.3 | 0 | 0 | 9 | 4.5 |
| **Sex of HH Head:** | | | | | | | | |
| Male | 40 | 90.9% | 121 | 92.4% | 24 | 96.0% | 185 | 92.5% |
| Female | 4 | 9.1 | 10 | 7.6 | 1 | 4.0 | 15 | 7.5 |
| **Age of HH Head:** | | | | | | | | |
| 20-30 | 8 | 18.2% | 19 | 14.5% | 6 | 24.0% | 33 | 16.5% |
| 31-41 | 15 | 34.1 | 40 | 30.5 | 10 | 40.0 | 65 | 32.5 |
| 42-52 | 10 | 22.7 | 43 | 32.8 | 2 | 8.0 | 55 | 27.5 |
| 53-63 | 6 | 13.6 | 19 | 14.5 | 3 | 12.0 | 28 | 14.0 |
| 64-74 | 4 | 9.1 | 9 | 6.9 | 4 | 16.0 | 17 | 8.5 |
| 75-up | 1 | 2.3 | 1 | 0.8 | 0 | 0 | 2 | 1.0 |
| **Educ of HH Head** | | | | | | | | |
| No education | 2 | 4.5% | 3 | 2.3% | 2 | 8.0% | 7 | 3.5% |
| Some elementary | 34 | 77.3 | 66 | 50.4 | 14 | 56.0 | 114 | 57.0 |
| Elementary Grad | 5 | 11.4 | 26 | 19.8 | 2 | 8.0 | 33 | 16.5 |
| Some HS | 3 | 6.8 | 14 | 10.7 | 6 | 24.0 | 23 | 11.5 |
| HS Grad | 0 | 0 | 19 | 14.5 | 1 | 4.0 | 20 | 10.0 |
| Some college | 0 | 0 | 1 | 0.8 | 0 | 0 | 1 | 0.5 |
| College Grad | 0 | 0 | 2 | 1.5 | 0 | 0 | 2 | 1.0 |

Majority (51.5%) of the IP respondents belong to relatively big households with four to six members. Close to one-third (31.5%) of the participants have at least seven to nine household members. (Table 1)

Most of the IP respondents (92.5%) belong to households headed by males. Close to one-third (32.5%) of all the male household heads were between 31 to 41 years of age. Among the Manobos, 34.1 percent of the male household heads belonged to the age range 31 to 41 years while it was 30.5 percent among the Talaandigs. The heads of the mixed tribes aged from 31 to 41 years were 40 percent. (Table 1)

More than half (57%) of the household heads had some elementary education (Table 1).

*Views on the Right to Health*

There are no distinct differences in the concepts of a healthy person and the reasons cited for having good health among the three groups of IP tribes from the five barangays. The top three concepts of a healthy person of the IPs were: 1) one who has no illness; 2) one with a strong, robust and right body/physique; and 3) one who is active and fat, and has the correct weight. Meanwhile, the top three most common reasons cited for having good health were: 1) body is properly taken care of, 2) eating the right kinds of food, and 3) having good family relations and being cared for by the family. The reasons cited for having good health indicate that for the IP respondents, good health involves satisfying both the physical and social needs of the individual with the importance given to good family relations.

No differences in the concepts of a sick person and the reasons for getting ill have been observed among the IP groups from the five study areas. To them, a sick person is one who 1) feels pain in his/her body; 2) is lethargic, pale and thin; and 3) sad. These top three concepts of a sick person were the exact opposite of the concepts of a healthy person given by the respondents.

Meanwhile, the most common reasons cited for why a person gets sick in the community were the following: 1) does not take sufficient food and/or water; 2) changes in the weather or climate, and because of problems; and 3) abuse/neglect one's body, and being unkempt.

Most of the IP respondents (91.5%) had heard of the right to health: Manobos - 93.3%, Talaandigs - 92.4%, and mixed tribes - 84%. The most common sources of information on the right to health were the barangay health center (BHC), mass media and non-government organizations (NGOs). More than half of the respondents had heard of the Philippine Constitution (73%) and the Indigenous Peoples Rights Act (IPRA) (64%). However, a large majority of the respondents had not heard of the Universal Declaration of Human Rights (UDHR) (93.5%).

To further investigate the level of awareness and understanding of the respondents on the right to health, 25 statements were presented to them. The responses of the study participants from the three groups indicate a high level of knowledge and understanding on the right to health as evidenced by the preferred responses given by more than half of the respondents to 22 out of the 25 statements presented to them. (Table 2)

**Table 2.** Percentage distribution (%) of the level of knowledge and understanding of the IP respondents on the right to health, 2006

| | YES / AGREE (%) | NO / DISAGREE (%) | DK (%) |
|---|---|---|---|
| **1. Health is a human right that is important in the enjoyment of other rights.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 99.2 | 0 | 0.8 |
| Mixed | 100 | 0 | 0 |
| Total | 99.5 | 0 | 0.5 |
| **2. The enjoyment of the right to health is essential in living a life in dignity.** | | | |
| Manobos | 97.7 | 2.3 | 0 |
| Talaandigs | 100 | 0 | 0 |
| Mixed | 100 | 0 | 0 |
| Total | 99.5 | 0.5 | 0 |
| **3. A good patient is one who does not ask questions and opposes what the doctor says.** | | | |
| Manobos | 20.5 | 79.5 | 0 |
| Talaandigs | 16.0 | 84.0 | 0 |
| Mixed | 20.0 | 76.0 | 4.0 |
| Total | 17.5 | 82.0 | 0.5 |
| **4. The right to health of a person without a decent job is affected.** | | | |
| Manobos | 97.7 | 2.3 | 0 |
| Talaandigs | 93.1 | 6.9 | 0 |
| Mixed | 96.0 | 4.0 | 0 |
| Total | 94.5 | 5.5 | 0 |
| **5. Education is important in the enjoyment and assertion of the right to health.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 98.5 | 1.5 | 0 |
| Mixed | 100 | 0 | 0 |
| Total | 99.0 | 1.0 | 0 |
| **6. The right to health of Christians and natives should be equal.** | | | |
| Manobos | 97.7 | 2.3 | 0 |
| Talaandigs | 97.7 | 2.3 | 0 |
| Mixed | 92.0 | 8.0 | 0 |
| Total | 97.0 | 3.0 | 0 |
| **7. The setting-up of barangay health centers is an obligation of the government to promote the people's right to health.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 100 | 0 | 0 |
| Mixed | 100 | 0 | 0 |
| Total | 100 | 0 | 0 |
| **8. The health services provided by the government in our barangay/community are sufficient.** | | | |
| Manobos | 86.4 | 13.6 | 0 |
| Talaandigs | 74.8 | 22.1 | 3.1 |
| Mixed | 56.0 | 44.0 | 0 |
| Total | 75.0 | 23.0 | 2.0 |
| **9. The right to health enjoyed and possessed by the rich should be different from the poor.** | | | |
| Manobos | 20.5 | 79.5 | 0 |
| Talaandigs | 28.2 | 70.2 | 1.5 |
| Mixed | 36.0 | 64.0 | 0 |
| Total | 27.5 | 71.5 | 1.0 |

| | | | |
|---|---|---|---|
| **10. The patient should hand over and follow all decisions of the doctor with regard his/her health because he/she knows best.** | | | |
| Manobos | 75.0 | 25.0 | 0 |
| Talaandigs | 78.6 | 19.8 | 1.2 |
| Mixed | 68.0 | 32.0 | 0 |
| Total | 76.5 | 22.5 | 1.0 |
| **11. The people have no right to complain about the services they receive from the barangay health center because these are free.** | | | |
| Manobos | 13.6 | 84.1 | 2.3 |
| Talaandigs | 8.4 | 90.8 | 0.8 |
| Mixed | 8.0 | 92.0 | 0 |
| Total | 9.5 | 89.5 | 1.0 |
| **12. The beliefs and practices on treatment of the natives/tribes should be changed with modern treatment methods.** | | | |
| Manobos | 2.3 | 97.7 | 0 |
| Talaandigs | 9.2 | 90.8 | 0 |
| Mixed | 8.0 | 88.0 | 4.0 |
| Total | 7.5 | 92.0 | 0.5 |
| **13. Health services with higher value are better or of higher quality.** | | | |
| Manobos | 6.8 | 86.4 | 6.8 |
| Talaandigs | 8.4 | 89.3 | 2.3 |
| Mixed | 28.0 | 72.0 | 0 |
| Total | 10.5 | 86.5 | 3.0 |
| **14. Women should have the right and freedom to decide on matters affecting their health.** | | | |
| Manobos | 86.4 | 13.6 | 0 |
| Talaandigs | 84.7 | 13.7 | 1.5 |
| Mixed | 80.0 | 20.0 | 0 |
| Total | 84.5 | 14.5 | 1.0 |
| **15. All people have the right to health no matter what their position is in society.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 99.2 | 0.8 | 0 |
| Mixed | 100 | 0 | 0 |
| Total | 99.5 | 0.5 | 0 |
| **16. The people should participate in making decisions/policies related to health.** | | | |
| Manobos | 97.7 | 2.3 | 0 |
| Talaandigs | 99.2 | 0.8 | 0 |
| Mixed | 96.0 | 0 | 4.0 |
| Total | 98.5 | 1.0 | 0.5 |
| **17. The people's capacity to pay should be considered when determining the prices of health goods and services.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 98.5 | 0.8 | 0.8 |
| Mixed | 96.0 | 4.0 | 0 |
| Total | 98.5 | 1.0 | 0.5 |
| **18. People have the right to access, receive and look for information that will promote their health.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 99.2 | 0.8 | 0 |
| Mixed | 100 | 0 | 0 |
| Total | 99.5 | 0.5 | 0 |
| **19. The views and opinions of the doctor about the situation or state of a patient should always prevail.** | | | |
| Manobos | 77.3 | 22.7 | 0 |
| Talaandigs | 81.7 | 18.3 | 0 |
| Mixed | 64.0 | 36.0 | 0 |
| Total | 78.5 | 21.5 | 0 |
| **20. The culture and traditions of the natives/tribes should not be considered in promoting their health because these are outmoded.** | | | |
| Manobos | 0 | 100 | 0 |
| Talaandigs | 3.1 | 96.9 | 0 |
| Mixed | 8.0 | 88.0 | 4.0 |
| Total | 3.0 | 96.5 | 0.5 |
| **21. Fathers have the sole right to decide on matters related to the health of the family.** | | | |
| Manobos | 29.5 | 70.5 | 0 |
| Talaandigs | 17.6 | 81.7 | 0.8 |
| Mixed | 16.0 | 84.0 | 0 |
| Total | 20.0 | 79.5 | 0.5 |
| **22. The government does not have anything to do with people having good health.** | | | |
| Manobos | 2.3 | 97.7 | 0 |
| Talaandigs | 6.1 | 93.1 | 0.8 |
| Mixed | 8.0 | 92.0 | 0 |
| Total | 5.5 | 94.0 | 0.5 |
| **23. Greater attention/value should be given to the health of men because they are the ones earning a living for the family.** | | | |
| Manobos | 29.5 | 68.2 | 2.3 |
| Talaandigs | 28.2 | 71.8 | 0 |
| Mixed | 24.0 | 76.0 | 0 |
| Total | 28.0 | 71.5 | 0.5 |
| **24. Having access to nutritious food, clean water and decent housing is important in the enjoyment of the right to health.** | | | |
| Manobos | 100 | 0 | 0 |
| Talaandigs | 99.2 | 0.8 | 0 |
| Mixed | 100 | 0 | 0 |
| Total | 99.5 | 0.5 | 0 |
| **25. The enjoyment of the right to health is not connected with the land problem of natives.** | | | |
| Manobos | 11.4 | 88.6 | 0 |
| Talaandigs | 9.2 | 90.8 | 0 |
| Mixed | 20.0 | 80.0 | 0 |
| Total | 11.0 | 89.0 | 0 |

Majority of respondents agreed with the statement that the health services provided by the government in their barangay are sufficient. (Table 2)

On patient-physician relations, most of the participants across the three tribes in the study areas demonstrated a high regard and full trust in doctors as illustrated by their responses to Statements 10 and 19. More than two thirds of the respondents in all three groups believed that "the patient should hand over and follow all decisions of the doctor with regard to his/her health because he/she knows best" (Statement 10), while most of them agreed that "the views and opinions of the doctor about the situation or state of a patient should always prevail" (Statement 19). (Table 2)

On gender-related matters, more than two thirds of the respondents in all three groups disagreed that "fathers have the sole right to decide on matters related to the health of the family" (Statement 21) and that "greater attention/value should be given to the health of men because they are the ones earning a living for the family" (Statement 23). However, more than one fourth of the Manobo respondents (29.5%) and less than one fifth of the Talaandig interviewees (17.6%) and mixed tribes (16%) agreed that "fathers have the sole right to decide on matters related to the health of the family" (Statement 21). On the other hand, more than one fourth of the respondents from both the Manobo (29.5%) and Talaandig (28.2%) tribes, and 24% of those belonging to the mixed tribes, agreed "greater attention/value should be given to the health of men because they are the ones earning a living for the family" (Statement 23). (Table 2)

The respondents in all the three groups were almost unanimous in valuing indigenous beliefs, traditions and practices on treatment in promoting their health. They disagreed with the statement "the beliefs and practices on

treatment of the natives/tribes should be changed with modern treatment methods" (Statement 12). They also disagreed with the statement "the culture and traditions of the natives/tribes should not be considered in promoting their health because these are outmoded (Statement 20). (Table 2) They were almost unanimous in disagreeing that their treatment beliefs and practices are outmoded and should be changed with modern methods. This would explain why despite the presence of the barangay health center, the IPs continue to patronize the services of the *baylan*; use herbal and medicinal plants and roots such as *lagundi* and *sambong* leaves for cough, *tawa-tawa* and *busikad* plants for fever, and *hagonoy* leaves for wounds; and hold rituals and ceremonies led by the *baylan* like the *pamuhat* or *panubad*, *patawalan* or *tawal*[i], *talotho*[ii], and *tayhop*[iii]

*Health Perceptions and Practices*

More than half (55%) of the study respondents said a sick member of the family is first brought to the *baylan*. Close to three fourths (72.7%) of the Manobo respondents first bring a sick family member to the *baylan*, followed by 18.2% who bring their sick member to the barangay health center (BHC). For the Talaandig respondents, 52.7% and 34.3% bring a sick family member to the *baylan* and BHC, respectively. For those belonging to the mixed tribes, 36% bring their sick first to the *baylan*, while 24% to the BHC. (Table 3)

**Table 3.** Percentage distribution of respondents on where sick family member is first brought, 2006

| First consultation when family member is sick | Manobos (%) | Talaandigs (%) | Mixed (%) | Total (n=200) (%) |
|---|---|---|---|---|
| *Baylan*/traditional/indigenous healer | 72.7 | 52.7 | 36.0 | 55.0 |
| Datu/tribal leader | 0 | 0.8 | 8.0 | 1.5 |
| Midwife | 0 | 0.8 | 8.0 | 1.5 |
| Parent/relative | 0 | 0.8 | 4.0 | 1.0 |
| Neighbor | 4.5 | 1.5 | 0 | 2.0 |
| Barangay health center (BHC) | 18.2 | 34.3 | 24.0 | 29.5 |
| Private clinic/hospital | 0 | 0.8 | 0 | 0.5 |
| No one/house remedy | 4.5 | 7.6 | 16.0 | 8.0 |
| Others | 0 | 0.8 | 4.1 | 1.0 |
| Total | 99.9 | 100 | 100 | 100 |

The majority of the respondents (96%) utilized services at the BHC. Also, more than half of the respondents (53%) last visited the BHC at least six months prior to the survey. (Table 4)

**Table 4.** Percentage distribution of respondents on last visit to the barangay health center, 2006

| Last visit to the BHC | Manobos (%) | Talaandigs (%) | Mixed (%) | Total (%) |
|---|---|---|---|---|
| This week | 2.3 | 10.0 | 12.0 | 8.5 |
| 1-3 weeks ago | 13.6 | 10.7 | 4.0 | 10.5 |
| 1 month ago | 27.3 | 22.1 | 28.0 | 24.0 |
| 3 months ago | 0 | 10.0 | 12.0 | 8.0 |
| 6 months ago | 4.5 | 1.5 | 0 | 2.0 |
| 1 year ago | 18.2 | 10.0 | 16.0 | 12.5 |
| Long time | 15.9 | 19.8 | 8.0 | 17.5 |
| Can't remember | 2.3 | 1.5 | 4.0 | 2.0 |
| Never visited the BHC | 4.5 | 6.9 | 8.0 | 6.5 |
| Others | 11.4 | 7.6 | 8.0 | 8.5 |
| Total | 100 | 100 | 100 | 100 |

The top five services of the BHC utilized by the IPs from the five barangays were:

1. Consultation/treatment
2. Vaccination
3. Prenatal consultation
4. Free medicines and
5. Well-baby consultation

Having good staff and services were the most frequent responses given by the respondents when asked about their views and observations on the services/programs of the health center. However, they were also quick to say that the health center lacked medicine, a situation which according to the IPs makes it a waste of time to go to the health center because you will be given a prescription instead of free medicines.

Aside from the services/programs of the health center, the Manobos said that other things being done by the government related to the health of the IPs are call meetings on health matters and distribute Philippine Health Insurance (Philhealth) cards. Meanwhile, both the Talaandigs and the mixed tribes shared that the local government carries out health projects/campaigns like weighing and feeding of children in the village, constructing and/or repairing the health center and deep well, and distributing Philhealth cards. However, less than one fifth (19.1%) of the Talaandig respondents and almost one third of both the Manobos and mixed tribes claimed that the local government does nothing in relation to the health of the IPs in the community.

More than four fifths (88%) of the interviewees said they attend meetings/consultations on health matters organized by the health center/local government unit (barangay/municipal). However, for the small number of respondents who do not attend meetings/consultations called by the local government unit (LGU), the most frequent reason given was "they have no time".

[i] A rite which involves burning the bark of tree or plant accompanied by prayers while letting the smoke envelope the patient's body to drive out the "engkanto" or "bad spirit" which has entered the patient's body and caused him/her to get sick.

[ii] A practice where the *baylan* chews guava leaves or fresh ginger and places the chewed guava leaves or ginger on the crown or top of the head (*bumbunan)* or part of the body of the patient that is in pain as a way of dispelling the "engkanto" or "bad spirit"

[iii] A rite where the *baylan* blows the crown or top of the head (*bumbunan)* of the patient accompanied by prayers to drive out the "bad spirit" causing the pain

The health matters discussed during meetings/consultations called by the LGU were similar in the five barangays. The most common ones identified by the IP respondents were 1) health problems like cleanliness of the surroundings and sanitation in the community, and lack of medicines at the BHC; 2) health plans/projects of the government; and 3) income-related matters of the barangay.

On the question of what the government should do to improve and/or develop the health situation of the IPs in the community, the three most common answers given by the respondents in the three groups were: 1) provide jobs or capital for business; 2) solve the ancestral land problem; and 3) provide free and/or more medicines, basic services particularly electricity, water and health center.

*Mechanisms in Solving Health Problems*

More than four fifths (82%) of the IP respondents identified the council of elders/tribal leaders as the structure in the community where health problems are discussed and solved (Table 5). These include problems like environmental sanitation, malnutrition, lack of medicines in the health center, and increasing cases of pulmonary tuberculosis (PTB) among the IPs. More than two thirds (71%) said they had approached the organization on problems pertaining to health.

**Table 5.** Percentage distribution of respondents on type of organization in barangay, 2006

| Type of organization | Manobos (%) | Talaandigs (%) | Mixed (%) | Total (%) |
|---|---|---|---|---|
| Council of Elders/Tribal Leaders | 86.4 | 80.2 | 84.0 | 82.0 |
| Barangay Council | 0 | 4.6 | 0 | 3.0 |
| None | 4.5 | 9.9 | 8.0 | 8.5 |
| Others | 9.1 | 5.3 | 8.0 | 6.5 |

In addition to health problems, the council of elders/tribal leaders is also approached to discuss and solve other important issues and concerns of the community with consequences to the people's health status. Problems pertaining to their ancestral domain claim where the IPs are restricted, if not allowed, by *hacienderos* or landlords to cultivate the land, problems regarding very limited sources of income, and poor roads which make it difficult for them to market their products to the nearest town center, are among those addressed by the council of elders.

At least two thirds (77%) of the respondents acknowledged having participated in decision-making discussions of the organization.

When the community is faced with a serious health problem like an epidemic, more than half (63.5%) of the respondents identified the council of elders/tribal leaders as the mechanism used in solving the problem (Table 6).

**Table 6.** Percentage distribution of interviewees on how serious health problems are solved, 2006

| How serious health problems are solved | Manobos (%) | Talaandigs (%) | Mixed (%) | Total (%) |
|---|---|---|---|---|
| Present to proper government agency | 13.6 | 15.3 | 24.0 | 16.0 |
| Council of Elders/Tribal leaders | 61.4 | 64.9 | 60.0 | 63.5 |
| Barangay Council/Captain | 4.5 | 6.1 | 4.0 | 5.5 |
| *Baylan*/Traditional healer | 15.9 | 6.1 | 4.0 | 8.0 |
| Pray to spirits/God | 0 | 2.3 | 0 | 1.5 |
| Others | 4.5 | 5.3 | 8.0 | 5.5 |

*Indigenous health laws and practices*

The respondents from the three tribes were almost unanimous in saying that there are existing customary/indigenous laws and practices in the community related to health. They were also almost unanimous in admitting that these customary laws and practices continue to be followed in the community, and that these are useful in addressing health and other problems in the tribe. For instance, the *Lumads* continue to perform rituals and ceremonies like the *pamuhat, patawalan* and *talotho* for health problems or conditions including *buyag*, a condition where the bad energy of a person is transmitted to another person as evidenced by vomiting, fever, paleness, generalized body malaise, and swelling of a body part, and *barang*, intentionally inflicting or punishing a person by the use of evil power and characterized by abdominal enlargement and the presence of "crabs" seen moving out of the patient's abdomen during treatment; and when a person's body is possessed by an "engkanto" or "bad spirit".

More than half of the Manobo (65.9%) and Talaandig respondents (55.7%) said the health center/local government recognizes the health-related activities of the *baylan* in the community. Less than one third (32%) of the respondents from the mixed tribes gave this response.

When asked if the health center/local government extends support/assistance to the *baylan*, more than one third (36.4%) of the Manobos and 48.8% of the Talaandigs said no support is given. Meanwhile, more than two thirds (72%) of the respondents from the mixed tribes gave the same response. (Table 7)

On the other hand, of those who admitted that support is extended by the health center/local government to the traditional healers, 34.1% and 29% of the Manobo and Talaandig interviewees, respectively, said this is done through the promotion of traditional healing methods like the use of herbal plants and medicines. Allowing the *baylan* to practice in the community was also considered by 16% of the respondents from the mixed tribes as a form of support extended by the health center to the traditional healers of the tribes. (Table 7)

**Table7.** Percentage distribution of respondents on forms of support/assistance to *baylan*, 2006

| Forms of support/assistance to *baylan* by health center/LGU | Manobos (%) | Talaandigs (%) | Mixed (%) | Total (%) |
|---|---|---|---|---|
| No support given | 36.4 | 48.8 | 72.0 | 49.0 |
| Refer patients to them | 20.5 | 7.6 | 8.0 | 10.5 |
| Provide trainings/seminars | 9.1 | 3.1 | 0 | 4.0 |
| Promote their healing methods like use of herbal medicines, massage, etc. | 34.1 | 29.0 | 16.0 | 28.5 |
| Others | 0 | 11.5 | 4.0 | 8.0 |

## Discussion

The study results reveal that the concepts and perceptions of good health and illness of the *Lumads* of Bukidnon, particularly the Manobos, Talaandigs and a mixed group of IPs, have a lot of similarities. To these groups of IPs, health and illness are closely associated with their physical and emotional state since health is generally perceived as related to having no illness, having a strong and right physique, having the correct weight, and being fat and active. Illness, on the other hand, is defined as experiencing pain, being lethargic, pale and thin, and being sad.

The state of good health is commonly attributed by the IPs to proper care of the body, eating the right kinds of food, and to good family relations and family care. Meanwhile, ill health is perceived to be caused by insufficient food and water intake, changes in the weather and to problems, and abuse/neglect of one's body including lack of cleanliness. The reasons commonly cited by the IP respondents explaining good health and illness indicate that aside from the requirements of the body like food, rest and cleanliness, health and illness are viewed to be related to the nature of relations within the family. To the IP respondents, the nature or state of family relations has a bearing on health and illness.

It is important to note that the dominant views on health and illness of the IP respondents differ from what IPs consider health, which would cover not only the absence of illness but a comprehensive "state of spiritual, communal, and ecosystem equilibrium and wellbeing"[20] or the "balance between mind, body, spirit, culture and earth".[3] Moreover, historically, IPs view health as "the harmonious coexistence of human beings with nature, with themselves and with others, aimed at integral well-being, in spiritual, individual and social wholeness and tranquility".[21]

The interconnectedness between health and/or illness with their land, environment and gods/spirits did not appear in the responses of the IP participants in the three groups indicating the impact of modern medicine and mainstream society on their current health views and behaviors. Except for the inclusion of family relations, the dominant concept of health of the IP respondents is no different from what most non-IPs believe with emphasis on the physical and mental state of the individual.

The dominant views on health and illness of the IP respondents have been, to a large extent, shaped and influenced by their interaction with and assimilation into, mainstream society, and exposure and practice of Western medicine, which have reached their communities through the barangay health center. A significant percentage of the IP respondents acknowledged utilizing the services of the barangay health center and recognized these services to be valuable although deficient. The influence of the mass media is likewise responsible for changes in the concepts of health and illness of the IPs.

The influence of the barangay health center on the IP communities is manifested in the high level of awareness of the right to health of the respondents.

As reflected in the study results, most of the participants are aware of the universality of human rights regardless of economic status, religion and sex; interrelationship of the right to health with other human rights such as the rights to work, food, housing, and access to information; the equality of the right to health of Christians and IPs; and the role of the government in the promotion of health. However, knowledge is not translated into practice as in the case of patient–health provider relationship. The IP respondents' high regard and trust in doctors and their perceptions of people with authority have prevented them from being able to assert their rights like the rights to information, humane treatment, choice of medical treatment, and freedom from discrimination. Most of the IPs believe that patients should allow doctors to make decisions for them because they know best and the views of the doctor should always prevail. Like many Christians, the IPs look up to doctors who are placed on a pedestal and treated as gods. Thus, they are viewed as beings who are infallible and would do no harm to their patients.

Although the IPs are aware of the right to ask questions or ask for explanations from doctors about their health conditions, they are hesitant, if not afraid, to do so when face-to-face with a physician. As shared during the validation activity of the study, the IP respondents' hesitation to ask questions emanates from the fear that such behavior might be misinterpreted by doctors as doubt in their knowledge and competency.

The perception and attitude toward doctors may have been acquired in the course of their interaction with people at the health center. The many years of education and training acquired by doctors and other health center staff are given much weight and importance by the IP respondents to the extent of entrusting their lives to these individuals.

The gap between knowing their rights and exercising their rights as exemplified in the situation of the IP respondents is a predicament commonly observed when

those involved have unequal power relations and when the relationship is markedly hierarchical in nature.

The value of indigenous health and treatment beliefs, traditions and practices in promoting their health and well-being has been recognized by the IPs. They did not believe these beliefs and practices were outmoded and needed to be replaced by modern treatment methods. Their experiences have shown that indigenous health and treatment beliefs and practices continue to be relevant and useful in solving health problems in the community. These beliefs and practices make sense of the world around them, remaining integral components of their worldviews which direct their everyday life.[3] This is why the Manobos and Talaandigs persist in patronizing the services of the *baylan*, who is usually the first person consulted when there is a sick member of the family: using herbal and medicinal plants and roots in the treatment of common illnesses and other health problems; and holding indigenous rituals and ceremonies.

As stipulated in the Indigenous Peoples Rights Act of 1997 (IPRA), it is the duty of the State to provide the necessary support to IPs in the preservation and protection of their culture and traditions including their health beliefs, practices and rituals. States also recognize that IPs have the "right to preserve, practice and transmit their traditional knowledge and to maintain cultural, spiritual and social beliefs and institutions" which is essential in ensuring the health of indigenous communities.[9]

Indigenous medicine and healing concepts and practices offer a rich and valuable body of knowledge beneficial to society. Thus, in 1997, the World Health Organization (WHO) established a program on traditional medicine with the objective of convincing member countries to take concrete action towards the expansion of research on and development of traditional medicine.[9]

Yet, according to the study participants, although the barangay health center staff and local government officials recognize the health-related activities of the *baylan*, specifically by promoting their healing methods like the use of herbal/medicinal plants, and not stopping them from providing services to members of the community, no other efforts are taken by the State to extend support to these indigenous healers. The local government through the health center does not have programs or plans intended to further hone the skills of the *baylan* and to transform them into partners in the promotion of the IPs' right to health.

From the way health concerns are managed in the community, the *baylans* are simply viewed and treated as a "social given" and tolerated to coexist with the mainstream health structure represented by the barangay health center for as long as they do not interfere with the functioning of the health center.

Furthermore, part of the State's obligation to respect the IPs' right to health is the integration of the best of their ancestral wisdom and practices with the benefits of mainstream/modern medicine.[22] This constitutes one of the normative contents of the right to health, i.e., acceptability, which includes making culturally appropriate and responsive health services available to the IPs. However, the experiences of the IPs in Bukidnon indicate a weakness on the part of the State in coming up with concrete plans or programs intended to preserve and further develop the valuable and useful indigenous health beliefs and practices and integrate them into the mainstream health system. The long history of discrimination and marginalization experienced by IPs in society[9] may partly explain the inability of the State to "recognize, respect and protect the rights of indigenous cultural communities/IPs to preserve and develop their cultures, traditions and institutions" including their "traditional medicines and health practices, vital medicinal plants, animals and minerals, indigenous knowledge systems and practices, knowledge of the properties of fauna and flora…".[2] Their isolated and invisible status has likewise contributed to the absence of health programs and services responsive to their needs.

The utilization of the services of the barangay health center, the most common of which are free consultation/treatment, vaccination, prenatal and well-baby consultations, and free medicines, by a significant percentage of the IP respondents demonstrates their assimilation into mainstream society. Yet they have expressed dissatisfaction with the health center, primarily due to the lack of medicines and inadequate services extended to the IP communities. They have likewise expressed the pressing problems which affect their health and need to be urgently addressed by the State. These include the lack of jobs or livelihood opportunities in the community, ancestral land problem, and inadequate provision of basic services particularly electricity, water and health.

Despite their assimilation into the dominant culture, the IPs maintain their traditional structures like the council of elders or tribal leaders. Most of the IP respondents continue to respect and rely on their tribal leaders when confronted with serious health problems. This is the structure, according to most of the respondents, where health problems in the community are discussed and solved.

To the IPs, the elders act as key players in the community. They:

> *...have always played a critical role in maintaining the health of Indigenous nations. They are living libraries, repositories of the oral traditions for their nation. They remember the old ways, old ceremonies, songs to sing for gathering the plants, medicines to use that will cure their people.*[23]

However, outside these indigenous structures, the IPs have no voice in the development of relevant health programs and plans. As far as the health center is concerned, the health problems and needs of the IPs are no different from those of the migrant settlers of the community.

The active and meaningful participation of IPs in matters that concern their lives and culture as a people has not been given attention and encouraged by the local government units as exemplified by the types of health programs and projects typically implemented in the community. The distinct health needs and problems of IPs are not effectively addressed by the local government units through the barangay health centers because venues where these can be presented and discussed are lacking in the community. Local government officials have been remiss in their obligation to create an enabling environment for the active and meaningful participation of IPs in the development and implementation of health programs and services, including their adherence to the principle of free, prior and informed consent.[9] They likewise have not paid serious attention to building the capabilities/competencies of IPs for their effective participation in structures and mechanisms involved in decision-making and program development.

**Conclusions and Recommendations**

The study findings indicate that the IPs' concepts of health and illness are to a large extent comparable to that of mainstream society with emphasis on the physical and emotional dimensions of human experience. Absent in the concept is the holistic and comprehensive character of earlier dominant views on health of IPs which highlights the interconnectedness between the human body, mind, spirit, others and the environment.

Furthermore, the IPs are aware of the right to health and its principles. However, this is restricted to the cognitive level. There is a gap between their recognition of the right to health and taking action as rights-holders, such as claiming the right to have access to relevant and culturally-appropriate health goods and services, the right to preserve, practice and develop their traditional health beliefs and practices, and the right to participate in the formulation and development of health policies, programs and projects.

The study findings also revealed that despite the influence and impact of Western medicine through the barangay health center on their health beliefs and behaviors, the IPs continue to promote and practice aspects of their indigenous health culture. Their reliance on the services of the *baylan*, the use of herbal plants and medicines, and the holding of rituals in the alleviation and/or treatment of certain health problems or conditions, are illustrations of how they combine indigenous with Western medicine.

The State as the primary duty bearer plays a critical role in the overall improvement of the health status of IPs. It requires compliance with its rights obligations including the creation of an enabling environment that will empower IPs and address their health needs and problems. Venues and opportunities have to be created in order for the IPs to develop their knowledge, skills and competencies toward the promotion of their right to health.

Efforts have to be taken by the State, through their representatives and organizations, for IPs to actively participate in the formulation of policies and programs that would affect their right to health. The preservation, development and integration of indigenous health and treatment beliefs and practices into the mainstream healthcare system have to be given due attention.

Consistent with international human rights instruments specifically the International Labour Organization Convention No. 169, Article 25 (1989),[24] the International Covenant on Economic, Social and Cultural Rights, Article 12 (1966),[25] International Convention on the Elimination of All Forms of Racial Discrimination, Article 5 (1965),[26] as well as domestic laws specifically the 1987 Philippine Constitution, Article 13,[27] and the Indigenous Peoples Rights Act of 1997, Sections 2, 16, 21, 25 and 29,[2] the State, as part of its obligations to the IPs' right to health, is compelled to take concrete measures, at the national, local and community levels, to:[22]

1. Create special legislation that will promote the IPs' right to health, including access to comprehensive and culturally-appropriate health services like health education, nutrition and housing,
2. Recognize and integrate indigenous health practices, knowledge and values into the mainstream healthcare system and into policies that affect the IPs,
3. Ensure the right to participation of IPs particularly in the community and in the mainstream health institutions, and their autonomy in the management of their health resources.

Furthermore, the State through the local health units at the community, municipal and provincial levels and in partnership with the IPs and/or their organizations, should decisively address the following concerns in fulfilling its right to health obligations to IPs:

1. Document the best and effective indigenous health knowledge and practices in the community,
2. Develop health programs and services where indigenous health knowledge and practices are integrated and popularized,
3. Launch training programs intended to raise the knowledge and skills of the *baylan* in the community, and
4. Institute health programs and services that specifically address the IPs' health problems and concerns.

The IPs' right to health is critical to the enjoyment of other human rights like the rights to food, education and work. However, unless the State observes its human rights obligations and demonstrates the political will to address structural, financial, geographic and cultural barriers which make it difficult for IPs to access basic health services, human rights violations will persist among the ranks of the IPs and they will continue to be discriminated and marginalized in mainstream Philippine society.

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