SEXUAL BELIEFS AND REPRODUCTIVE HEALTH OF INDIGENOUS FILIPINOS: THE HIGAONON OF BUKIDNON AND THE ATA MANOBO OF DAVAO

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The indigenous peoples (IP) of the Philippines face great disadvantage in terms of social and health services, particularly in reproductive health (RH). The Higaonon community of Bukidnon and Ata-Manobo of Davao reflect this disparity. A participatory action research guided by grounded theory, post-modern and feminist frameworks validated that there is lack of awareness and understanding of RH concepts in the two IP communities. Unique traditional practices for contraception and sexual beliefs across generations have been described. Amid the changing social milieu, some traditional contraceptive practices and sexual traditions are now generally unaccepted in the communities. Misconceptions on family planning modalities and sexual abuse by husbands were reported to interfere with sustainability of RH programs implemented by both local government and nongovernmental groups. These conditions reflect the two IP communities' paternal culture and the men's and community leaders' desire to have big families—compensation to the perceived insidious extinction of their culture, tradition and history.

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Introduction. Indigenous peoples represent a rich diversity of cultures, religions, traditions, languages and histories; yet they continue to be among the world's mostmarginalized population groups[1].This statement runs true for many indigenous people (IP) and communities in the Philippines[2,3]. Representing 10-14% of the country's population[4,5], most Filipino IP or *lumad* remain among the poorest and most disadvantaged group: illiteracy and unemployment are higher; they have been subject to historical discrimination and marginalization from political processes and economic benefit; they often face exclusion, loss of ancestral lands, displacement, pressures to and destruction of traditional ways of life and practices, and loss of identity and culture[3].

Rooting from this complex social dynamics[6] and "invisibility"[7], the fundamental right of the *lumad* to health has suffered. Access to basic health services is more difficult due to remote settlement and lack of health infrastructures, thus characterizing higher morbidity and mortality[5, 8, 9].Economic exploitation, income insecurity, powerlessness, inaccessibility to government services, persisting culture of discrimination and lack of security of tenure have been attributed to as barriers towards achieving health[9].The health of women and children are particularly vulnerable[10].

For the IP, the concept of health is acomplex one; not only does it consider anindividual's physical and mental well-being but alsohis or her balance with nature, with the collectivitiesof which he or she is a part and with the rich andcomplex spiritual realm to which he or she is connected[11]. Consequently, the IP's concept of reproductive health (RH) is intertwined with health needs in respect to social and cultural contexts. However, despite recent strides in the equality of IPs through international and national programs, reproductive health has largely been neglected[12,13].

The indicators of RH in the general population and IP communities reflect these adverse life conditions in indigenous communities, especially the gender dimension of IP issues. The Philippines has one of the highest total fertility rates in Southeast Asiaand throughout the years, has only minimallydeclined[14, 15, 16].The maternal mortality ratio is among the highest in SEA and maternal deaths account for 12% of all deaths of women of reproductive age[17]. About half of the pregnancies each year are unintended[18]. A major factor in the high incidence of unintended pregnancies in the Philippines is the unmet need for contraception among Filipino women[19]. There is also a political context in family planning (FP) and the issue of unwanted pregnancies[20].

While Article II Section 15 of the Constitution mandates that "[T]he State shall protect and promote the right to health of the people and instill health consciousness among them,"[21] the decentralization of the government (i.e., transfer of power from the central government to the local levels) has prevented the comprehensive provision of FP services[19].These issues in the provision of FP are more prominent among IPwith adverse social conditions aggravating poor RH outcomes such as maternal and infant mortality rates[9, 11, 13]. Despite as well that the State is mandated to recognize and promote the rights of indigenous cultural communities"[22], reproductive health rightshave

been largely neglected.[13]Studies have consistently shown that understanding and utilization of FP and RH practices is rooted to socioeconomic and educational status[18, 19, 22]; it should be noted that these indicators are starker among IPs. Studies on unwanted pregnancies and abortion, likewise, have demonstrated a complex interplay of factors that affects a woman's decision-making with an unwanted pregnancy[23, 24, 25].

Despite the political and academic interest in the *lumad*, the knowledge, beliefs and attitudes of the Filipino IP on sexual and reproductive healthand FP have been largely undocumented. There is a lack of awareness and understanding of RH concepts among policy makers, executives, managers, providers and the public health[13, 26]. Consequently, while rural health units continue to advocate for FP, health workers and policy makers have executed a generic approach and have left traditional or indigenous tenets on RH unconsidered.The documentation of the practices and beliefs of Higaonon of Bukidnon and the Ata-Manobo of Davao on RH is pioneering and provides baseline knowledge on indigenous culture which can be used to guide more effective policy development and implementation on RH and FP.

Methodology. The study utilized purposive sampling of communities based on: economic profile, community type, ethnicity and language, sectoral categories and selected RH indicators such as contraceptive prevalence rate, total fertility rate, population growth rate and maternal mortality ratios. A Higaonon community in the barangay (i.e., town political sub-unit) of Mauswagon, municipality of Maayos, Bukidnon province and an Ata-Manobo community in barangay Marayaw, municipality of Kapalong, Davao del Norte province were chosen as study sites.

The municipality of Maayoswas recommended by experts as a "typical" Higaonon community and was documented to have high maternal mortality, high infant mortality and low contraception-use.Of the municipalities in the central district of Bukidnon, Maayo had the highest population growth rate of 4.49 (2007), with a population of 35,563.The barangay of Mauswagon was chosen because of the reported greater degree of success in FP programs. The Ata-Manobo community in Marayaw, Kapalong was chosen for the greater concentration of the Ata-Manobo compared to contiguous areas. Seventy percent of the population of Marayaw is Ata-Manobo. This criterion was chosen with support of RH indicators.

Extensive desk reviews and consultation were conducted with experts on Higaonon, Ata-Manobo and *lumad* (indigenous Filipino) culture from various institutions such as the Research Institute of Mindano Culture at Xavier University and the Philippine Social Science Association. These reviews and consultations guided the development of the questionnaires.

Field visits and works were conducted with the assistance of a local guide. Focus group discussions and key informant interviews were conducted among different groups: formal men and women leaders, informal men and women leaders, young men and women, healthcare providers and the tribal council and women members. Per IPcommunity, a total of 16 men and 26 women

participated in the focus group discussions. In the key informant interviews, six men and five women participated.The interviews and discussions were conducted in the Higaononand Ata-Manobo language with an interpreter.

The grounded theory method was applied in the analysis of data from both Higaonon of Bukidnon and Ata-Manobo of Davao. The focus group discussions and key informant interviews were audiotaped and transcribed *verbatim*. The themes and sub-themes for each discussion and interview were coded and subjected to meta-analysis. Triangulation of data was done by comparing commonalities and variations among the case studies.Validation of data was conducted with barangay health workers (i.e., community volunteer health workers), the community midwife, the barangay council, couples-educators (for the Higaonon only), youth women and elders.

Permissions from the National Commission on Indigenous Peoples (NCIP) were secured and courtesy calls to community leaders were made prior to field visits and field data gathering. Written voluntary consent was taken before interviews and translated in the language spoken in the community. The consents were distributed prior to the interviews. Confidentiality, anonymity and respect for persons were assured. Identifiable information were coded and data were stored in a secure system. The participants were reimbursed for their transportation expenses and no monetary payment was made. Capacity building seminars among research assistants were conducted to ensure unity, harmonization and leveling-off of ideas, beliefs, ethics, strategies and ideologies.

The results of this study are detailed in the next page, et seq.

The Higaonon *Lumad* of Bukidnon

Profile of a Higaonon Community

The Higaonon community was generally of low-income, agricultural, had low educational attainment, of poor sanitary conditions, lacked livelihood diversification and consequently, alternative sources of income, and had a mixed population of indigenous Higaonon and Dumagat.

Fifty-nine percent of the population relied solely on their farms as source of income. Some 14% work as laborers (i.e., agricultural workers in commercial farms). Other off-farm activities were carpentry, *sari-sari* store (i.e., home-based and small-scale retail groceries), flower gardening and driving (i.e., transportation services). The major crop, representing 95% of local agricultural produce, was corn. Farmers also planted vegetables, root crops, fruits, coffee, rice and banana.

A Strength-Weakness/Liabilities-Opportunities-Threats (SWOT) analysis, reflected in the Barangay Centennial Plan (a guiding framework used by the barangay council to guide policies presentingcurrent social indicator baselines and targets), showed that the strength of the barangay derived from their observance of the *binukid* (mountain) culture, one of which is *pamuhat* or their ability to follow the good work of others. The weaknesses cited in the analysis included low income, low wage for labor, non-adoption of diversified farming technologies orlack of technology in farming systems, few livestock, absence of "good price" for their produce and lack of storage warehouse for their products.

Mauswagon is a low-income barangay despite the presence of private commercial plantations. Educational attainment was low (only 2.88% of community members entered tertiary education, 21.03% reached secondary education and 50% completed primary education). Only 1.72% had water-sealed toilet and 83% of the people use the *antipolo* (i.e., latrine) system. The monthly income of 73% of the population ranged from ₱1,000 to ₱3,000. With below subsistence-level incomes, most people had to rely on loans from traders and farmers cooperatives.

Reproductive Health among the Higaonon

The barangay has a health center being serviced by a midwife and barangay health workers. Its services included immunization and maternal childcare. The availability of medicines for basic ailments was believed by most to largely affect the health conditions of the residents.

Inadequacies in the FP services exist. One community member shared that "today, there are no more pills [contraceptive pills] and pregnancies have doubled, or increased by at least 50%." A midwife estimated that pregnancy did increase but only by 20-30%. Accordingly, women had started to buy pills themselves, although "those without money were certainly unable to do so."

Reportedly lacking were monthly consultations for intrauterine device (IUD) and contraceptive pill users complaining of side-effects ("aches and pains,"

“especially those who do heavy work”). Prenatal services were lacking and according to a community woman leader, maternal deaths still occurred. A midwife reported that she is handling a big catchment area of several barangays and she can only give mothers’ classes once a month. She added that when she was around for routine check-ups, people did not always come,“they tended to be shy” and “those who did not come were actually those who needed the check-ups the most.”

The formal Higaonon leader assessed the FP situation as being “inconsistent”, as there were cases of unplanned or unwanted pregnancies. With “life so little”, he feared “things would get worse: drugs, criminality and unchecked population.” With more people starving than ever before, he feared that people, especially the youth, “will resort to crime or drugs, and soon, everything will get out of control.”

In contrast, according to an informal Higaonon woman leader, the FP situation is “good, okay and doing better.” The local government was acknowledged as supplying contraceptives to the municipality and actively promoting FP education alongside the distribution of contraceptives. The barangay health workers report that 13 training sessions on the necklace method (i.e., a natural FP method) and seminars for couples were given by a non-governmental organization (NGO).

This NGO has worked with the barangay to put together a development plan and introduced the idea of couple-educator. Some formal women leaders reported that several couples were chosen but only few participated, adding that “they [the NGO] always had meetings but only about 20-30% of people listened. They brought necklaces [a natural FP method using the woman’s ovulation pattern] for the couples. But these were useless if there was no coordination between husband and wife. The husbands were always drunk.” In fact, according to the formal male leaders, all trainees got pregnant after two years.

In a previous survey (for the barangay’s centennial development plan) that included 80 respondents, or 30% of the total households, it was noted that 76% of the population had children aged 1-4 years old, 15% had five to six children, while another 10% had seven to eight children.People cited the following reasons for engaging in FP: 42% wanted to control the number of their children, 10% cited “economic crises” and 4% mentioned difficulty in giving birth. On the other hand, those who did not engage in family planning said they wanted to have a child (19%), contraceptive use was not advisable (11.53%), while fear of side effects, problem with breast milk and husbands disagreeing with using contraceptionwere mentioned with one respondent each.The FP methods favored were pills (49%), followed by natural methods (21.6%), ligation (8%), IUD (12%) and condom (6%).

Concepts of Family and Family Planning among the Higaonon

Families tend to be big, causingconcomitant problems for the family. Participants acknowledged that their family size tended to get bigger, causing problems such as inability to feed, clothe and educate the children. A woman community leader lamented, "All we have for breakfast and dinner are bananas and *kinilaw*[a fish and vinegar dish]."

Today, they recognize that "they would have had fewer children." One female worker already had ten children and she "wished that she only had six" because of "poverty and the difficulties of life."Another had nine children and she wished she "had less" since her children "turned out to be drunkards and she had so many of them to look after." But on second thought, she shared, "it was okay to have many children, as long as they turned out nice." A woman community leader admitted that while there were pills and IUDs before, she was influenced by her friends, "a Catholic priest and a nun", not to use any of those methods.

Traditional beliefs and customs form part of the reason for the non-adoption of family planning and for big families. Most Higaonon community members desired to have many children. There has been a prevailing belief among them that there was no need to plan families, rather "nature and God's plan should take their course." In one focus group discussion, one woman said, "you will stop giving birth when nature stops, so why meddle or interfere with nature." In one focus group discussion with barangay health workers, one said, "we even pray to be blessed with more children."

The traditional leaders, who were men, explained this fatalistic concept in this manner:

> "The woman's body decides whether to have another child or not. The woman's body keeps on going till no more. It just stops when the ovaries dry up. The same is true for men. We can't stop ourselves when we are young; no limits. If it be possible, I'd want to keep on doing it [sexual intercourse or having children], but now I can't do it anymore. Slow down; it is time to control."

Changes in beliefs and practices can be seen among the younger generation. According to formal woman leaders, there is a change in the beliefs of the community members on conception. These changes are attributed to interventions by the government and NGOs and also because "*lumad* practices are no longer being followed, especially by the young." It was noted that "life's difficulties and crises forced couples to limit the number of their children. Work in the plantations and the desire to keep their jobs encouraged them to plan their family."

The community elders refrain from forcing their adviceon the young "who have turned to the more modern ways." The older generations of Higaonon are cognizant of "life's difficulties" and "would advocate the modern methods of family planning." The traditional leaders said that "God has stopped making lands, but people have not ceased from making babies." They added:

> "Jobs will be rare in the years to come. There will be no more land or farm to work on. It will be difficult for parents to raise their children. It is important for the population to be controlled; never mind losing your family name in the process. Stop thinking about the yet unconceived, and mind more, and raise well, the ones who had been born. The youth should be educated, joint seminars, so that instead of affording only a peso[']s worth] of salt, they could afford themselves enough and more."

Knowledge, Attitude and Practice of Reproductive Health among Higaonon

Reproductive health as a concept is not known. Nowhere was "reproductive health"mentioned in any focus group discussions and key informant interviews, except with the NGOs. The concept has yet to be disseminated and applied, although some of its elements may be discerned in some of the activities, especially by NGOs.

Traditional practices were not as accepted as before. In the interviews, the traditional leaders said that they were no longer listened to [for consultations] as much nowadays. Although they would counsel against the use of the contraceptive pill, they "grudgingly accepted the fact that its use depended on whether a person agrees or not with the modern method, and they cannot tell a couple what to do or what their limits should be." A woman worker, a member of the younger generation, said, "I would rather run to the [health] center than to a tree to extract some roots." The younger generation would rationalize the use of contraceptive pills by saying that there is no harm in trying, and that, "anyway, the elders do not insist [against it] anymore." One informal women leader did try *panaktan*, a flower soaked and taken with "fighter wine" for contraception, but "she did not like it much."

Family planning methods are practiced to a varying extent. The most popular family planning method was the contraceptive pill. One of the community women said, "It is more convenient to use pills; you only have to take it regularly, unlike using the calendar method. Our husbands are always drunk and they usually see bold [sexually explicit] films." Some talked of using a combination of methods, like "withdrawal" (i.e., coitus interruptus) and "rhythm" (i.e., calendar method).Tubal ligation was mentioned by one participant, although one formal woman leader claimed that one adverse reaction to ligation was that it causes one to be a "maniac" (i.e., lustful): "one woman tried it out with several men to find out the effects of ligation and she have her husband much shame." Rhythm was "used successfully" by one respondent, claiming that "it strengthens a couple's relationship". The respondent further added, "drunk or not, a wife can always say we have a plan and I am fertile these days".

There are mixed reactions and misconceptions to pills and other FPmethods. Contraceptive pills are the easiest and most convenient method for most of the participants. As how they came to choose the pill, the community women said they "just talked among themselves, shared their knowledge and experiences and decided to use it."The use of condom was not preferred for a variety of reason: "they tear easily", "they are too cumbersome

to use", "they are not effective for the younger generations", "the stocks that were distributed lacked lubrication" and "they were painful to use." The following "side effects" of pills were mentioned for the use of pills: "headache", "irritability", "becoming fat" and "constant feeling of being hungry." For ligation, constant hunger was reported to be a common side effect. However, respondents mentioned no side effects for IUD, vasectomy, natural family planning methods, Depo-Povera and condoms.

*Husbands are usually drunk and tend to be uncooperative with FP practices.*For most of the wives, "it is not possible to say 'no' [refuse sexual intercourse] with their husbands". According to a couples-educator, "If they say so, men get what they want when they want it, baby or no baby". It is when men are drunk when most trouble begins, although the respondents "distinguish different kinds and levels of drunkness". According to the respondents, "When a man is very drunk, nothing will happen. It is when a man is slightly drunk that he cannot be restrained in his sexual appetite." However, at least one informal woman leader disagreed, she argued that "it is the woman who says it [decides whether to have intercourse or not] and the man just follows her lead. Men do not have too big a role."

Family planning is known among Higaonon youth. The youth were quite knowledgeable about different family planning methods. They report that they learned this from school and never from their parents who only gave them general admonitions on not getting pregnant or not letting men court them on the streets. However, the youth would rather hear from their parents than their peers "who are bound to teach them wrong things."

For young men, opinions on the value of virginity were divided. However, most did not agree with premarital sex. To them, sex should come with responsibility, when they are already able to build a family and have a source of livelihood. If and when they "forget themselves" (i.e., engage in premarital sex), it is better for them "to control and not get pregnant" (i.e., use contraceptive devices) than to abort a pregnancy. Abortion, most of them note, is a sin. They admit that "times have changed" and since the church (i.e., Roman Catholic) is no longer listened to, they (i.e., priests and religious leaders) "should be more open to modern ideas". The traditions, for example, wherein parents would not allow "kissing in public", or would rather marry off a daughter than see her holding hands with her boyfriend, or returning of the dowry should a woman be no longer a virgin, are "ways of the past." The youth said that the *datu* (community leaders) are no longer being followed.

The Ata-Manobo *Lumad* of Davao

Profile of an Ata-Manobo Community

Marayaw has a population of 16,594 as of 2003, with 70% of the population Ata-Manobo. The Ata-Manobo live by primitive and subsistence farming methods (e.g., swiddening, *kaingin* or slash-and-burn), fishing and wildlife hinting. Income derived from these activities has not been determined. The remoteness of several places is an issue for local health workers and it was reported that "majority of the children in these hard-to-reach places were malnourished."

State of Reproductive Health among the Ata-Manobo

There were 17 live births for every 1,000 population in Marayaw. For the total fertility rate, there were 141 live births for every 1,000 female population of childbearing age. Infant mortality rate was 33/1,000. Only one maternity death was recorded in 2003. The community has one rural health unit that offers prenatal consultations and basic laboratory tests, family planning services such as IUD insertion, oral contraceptive distribution and natural family planning counseling. Due to remote settlement, some pregnant women can only be attended by *hilot* or traditional birth attendants.

Concepts of Family and Family Planning among the Ata-Manobo

Marriage remains rooted to traditional practices. Marriage in the *Ata-Manobo* culture may be characterized by the *buya* and *duoy* or *duway*. *Buya* is apractice wherein the parents determine who their child is going to marry. The Ata-Manobo marries at an early age, usually 12-14 years old. *Duoy* or *duway* is the practice of taking another wife after the first one. There can be many reasons for this practice, the most cited is when the first wife is "incapable of bearing the husband a child." The husband and his wives may live in the same household.

Indigenous traditions are utilized to prevent unwanted pregnancies. Ata-Manobo women who would not want to get pregnant go to the *baylan* (a priest and medicine man or women believed to be infused with a spirit-guide). The *baylan* prescribes selected herbs taken by the woman to prevent pregnancy. Most participants who tried the herbal remedies attest to their effectiveness. Rituals are also conducted after a woman gives birth in order to prevent another pregnancy. Ritual objects are kept by the woman whom she throws into the river if they want to get pregnant again. The participants refused to elaborate on the specific herbs and paraphernalia used by the *baylan*.

*Indigenous prenatal and postnatal practices are still being followed.*The Ata-Manobo women are involved in *kaingin* or swiddening, fetching water and fetching logs even when pregnant. Carrying heavy logs during pregnancy were considered beneficial because it is "a form of exercise." This exercise is thought to ease delivery. Herbal remedies are also used to facilitate easy delivery and stop post-partal bleeding. According to some participants, birthing to them is "so easy" that they proceed to work just after delivery.

The Ata-Manobo family is patriarchal. The husband of the household makes most of the decisions for the family. The wife performs much of the chores. The women are accorded some respect and honor, they can participate in community assemblies with men and share their ideas on matters of discussion.

Knowledge, Attitude and Practice of Reproductive Health among Ata-Manobo

The Ata-Manobo community is not conscious of RH. The Ata-Manobo equate reproductive health with personal hygiene and eating vegetables. When asked about the government programs on reproductive health in the area, participants pointed to the government's agricultural programs, animal breeding and farming.

FP is perceived to be essential because of poverty. The participants recognize that there is a need to plan family size because of poverty or "because life is hard." Many share that it is not easy having a lot of children especially if they sick because they could not afford to bring the child to a hospital. They also do not have enough food to give to their children.

FP is not actively or widely practiced. Many shared that "only God knows how many children we will have," and that "God will give us and if the wife will not get pregnant anymore, then that it is." Because of this concept, most continue to "make happiness" [engage in sexual intercourse, usually unprotected] every night "for as long as they want". Informants estimate that only one of four Ata-Manobo couples was practicing FP. Most are interested and willing to avail of FP services, but they feel that they have to be educated first. Some are willing to accept the FP services, "provided that the medicine used are traditional." Many believe that traditional remedies are "more effective than modern ones."Only a few are using modern FP methods and most utilize the traditional practices described. The most commonly used modern FP method was Depo-Povera, followed by tubal ligation.

Misconceptions hinder the practice of modern FP methods. Some of the Ata-Manobo believes that since Depo-Povera stops menstruation, "the blood would stay in the body and [make the body] explode." A lot are also suspicious of tubal ligation due to an incidence wherein "a ligated woman still gave birth to four more children." The community women are afraid of injections and do not want to show their genital to health practitioners (i.e., for tubal ligation). Husbands, on the other hand, fear that if a woman is using contraceptives, she would flirt with other men.

Decision-making on FP is not shared by the couple. Some wives no longer consulted their husbands on their FP method of choice, especially on ligation. Some husbands "get angry anger learning that their wives were ligated." To the men of the community, "it is the men who should decide on the FP," "it is the man's role to talk and discuss FP and the family would just listen."

*Barriers to FP service provision are not adequately addressed.*Lack of education on the part of the Ata-Manobo makes it harder to explain the FP program of the government, according to one informant. The *lumad*, on the other hand, say that there is lack of adequate explanation on the part of the healthcare providers. In addition, some of the areas in the community suffer from inaccessibility. A midwife reports that lack of contraceptive supplies further burden the "already difficult" problem of effective FP service provision. Several strategies have been used to promote FP. An informant admitted to "brainwashing" the Ata-Manobo, telling them that "Christians, too are using depo [Depo-Povera], so it is safe." The rural health unit is also "actively campaigning for tubal ligation."

Discussions and Conclusion. The study looked into two ethnic groups in the Philippines, representing contrasting community settings and unique cultural backgrounds but similar circumstances of poverty and marginalization.[1]Both the Higaonon of Bukidnon and the Ata-Manobo of Davao face the same issues of disadvantage in RH servicing and sustainability, reflecting a gender dynamics at play within a greater collective struggle against changing social, political and even, traditional settings and conditions.

Major themes that emerged validated that there is a lack of or inadequacy in both skills and knowledge or awareness RH concepts in the IP communities.There are numerous misconceptions on common FP practices that hinder participation to FP programs launched by the government and NGOs. In the case of the Higaonon, initial success was reported due to a comprehensive information dissemination campaign of an NGO regarding FP and RH. However, the sustainability of the program was hampered by persistent negative attitudes, unsustained funding and decline in the participation of community members. The same negative attitudes to FP measures are observable in the Ata-Manobo communities.

The lifestyles of the two IP groups are markedly different. The Higaonon are mostly farmers employed in commercial plantationswhereas the Ata-Manobo are subsistence farmers utilizing slash-and-burn techniques and hunting. The differences in their social setting impact both practices and beliefs of the IPs. It is observable that traditional practices are more accepted in the Ata-Manobo communities. This is validated by intergenerational interviews in both IP communities. For the Higaonon youth, for example, traditional practices on contraception were generally not accepted and perceived to be outmoded. In contrast, most of the Ata-Manobo young women utilize described traditional FP practices. Apart from this, it was mentioned that although they were willing to utilize "modern" FP measures, they would only do so if herbal remedies were prescribed.

The intergenerational shift in paradigms over RH and FP is more apparent among the Higaonon and can be attributed to the exposure to improved living conditions. The integration of the Higaonon community into a more modern lifestyle provides a unique opportunity to validate concerns on the collective mentality of the Higaonon on cultural identity. Although traditional practices in FP represent only a portion of the cultural identity of the Higaonon, it is noteworthy to point that the younger generation's rejection to these practices represents what the United Nations Development Programme called

[1]The representation of various sectors permitted an extensive and generalizable range of data. The juxtaposition of policy makers and formal and informal community leaders in the key informant interviews with the accounts of the community members provided depth, validation and triangulation. The larger study (Galvez Tan, Castillo, Tayag et al, 2008) utilized a broader participatory action research not described in the paper. The Higaonon community was profiled in Tayag JG. (2008). "Community Leadership in Population and Reproductive Health: The *Higaonons* of Bukidnon Case Study".*Ibid.*:129-152. The Ata-Manobo community was profiled in Arcenal X, Marinez A, Onan JM, Megarbo M. (2008). "Community Leadership in Population and Reproductive Health: The *Ata-Manobos*of Davao Case Study".*Ibid*.: 153-170.

"pressures to and destruction of traditional ways of life and practices, and loss of identity and culture"[3].

The older Higaonon community members themselves believe that it is important to consider present circumstances of poverty and that modern contraceptive techniques should be employed for the sustainable use of natural resources, sharing that "God has stopped making land but men continues to have babies." Despite this partial acceptance to RH and FP measures in the Higaonon community, both IP communities demonstrated a fatalistic nature when it comes to FP. Several community members shared the notion of "nature's course" or "God's will" and cautioned against interfering with a cosmic status quo. For the Higaonon, this reflects the Catholic Church's strong stance against contraception. For the Ata-Manobo, this appears to be intrinsic to the naturalistic and animist beliefs integrated in the mixed Muslim and Christian community.

This fatalistic notion on FP runs parallel with the negative attitude of both IP communities to modern FP measures, despite perceived benefits. This attitude, however, is not expressed by most of the population. Patriarchy appears to be another factor for this attitude. The indigenous culture of the Higaonon and Ata-Manobo share a patriarchal family structure. This system has been shown to affect decision-making and use of FP measures among women. In the Higaonon community, husbands who are chronically alcoholic sometimes force their wife to sexual intercourse and this sexual abuse has beenreported by many women. In the Ata-Manobo community, although there is a degree of independence for women, the men relay concerns of an emasculation, that they "should be the ones to decide for the family." This machismo dynamics in FP decision-making among couples have been observed in Metropolitan Manila[26, 27]and case studies of other IPs in both rural and urban settings[28-31]. The patriarchy is consistent with the defined gender roles and the stereotyping of gender in the two IP communities.

In respect to the challenge of identity survival that the IP communities face, especially the Higaonon, paternalism is seen as a buffer or compensatory. The *lumad* prefer big families partly because of the high infant mortality, a trend common among Filipino IPs[13].Apart from this, the aspect of lineage has surfaced. The men are preferred leaders in the community and even though there has been no reported preference in children's gender,the fact that men hold more authority in many aspects of community and tribal life is antecedent to the disadvantage of women.This system has resulted into the lack of power of women over decision-making, especially in FP. The positive association between participation in decision-making and unmet need for FP has been documented in Filipino families[16].The resulting large family sizes in respect to resources have contributed to food insecurity which has been documented in both Higaonon and Ata-Manobo children.

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