Predictors of the Health-Seeking Behavior of Predominantly Christian and Muslim Communities in Lanao del Norte

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W. I. Thomas, a symbolic interactionist, states that a person's definitions will lead him to behave in a particular way, or as he puts it himself, "if men define situations as real they are real in their consequences". In the case of health and illness, for example, being brought up in a culture which considers evil spirits as the cause of ill-health may destine one to hold such a belief for his whole lifetime and accordingly look for a "babaylan" to provide relief from his affliction. This may remain true till one's dying day unless the intrusions of modern medicine's germ theory are made manifest.

Reality, however, does not paint a bivariate relationship between health-related definitions and health-seeking behavior. At best, there are some factors that weaken or strengthen or somehow make a difference in their relationships, if any. Examples of these factors are age, income, ethnic affiliation, education, sex and religion.

Statement of the Problem

This study aims to seek answers to the following: What is the relationship of definitions of health and ill-health, definitions of efficacy and relevance of curative resorts, and etiology of illness (independent variables) with the health-seeking behavior of residents of Christian and Muslim communities (dependent variables) within the context of factors like age, income, ethnic affiliation, education, and religion of respondents?

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Conceptual Framework

Health-seeking behavior is the manifested behavior of the sick toward traditional and/or modern health practitioners as they seek relief from their illnesses. This is operationalized as the *priority curative resort* and the *frequency of recourse/visit* with a particular curative resort. Preliminary statistics show that the latter has very little promise, so that it is dropped from complicated statistical applications.

Curative resorts are treatment choices available to an individual upon the onset of illness, e.g. traditional curers (i.e., hilot, babaylan), modern curers (i.e., doctors, nurses and paramedics like the barangay/community health worker), or self-medication (referring to stock knowledge, either traditional or modern), which a person availed of without benefit of consultation with a specialist, either traditional or modern. *Priority curative resort* refers to the first curative resort used by the individual at the onset of an illness.

Etiology of illnesses are culturally constructed beliefs about the cause of diseases or illnesses as held by individuals.

The **definitions of health, illness, relevance of curative resort** and **efficacy of curative resort** were measured by coming up with a scale for each concept. Each scale consisted of statements derived from the qualitative answers of first phase respondents and were subjected to item and intercorrelation analyses as reliability checks for internal consistency. For bivariate and multivariate analyses, the overall **mean** of each respondent's answer on the scales were used as the operationalization of illness (health as an independent variable was dropped because of its equivalence with illness as shown by canonical correlation results), as well as efficacy and relevance of curative resorts definitions.

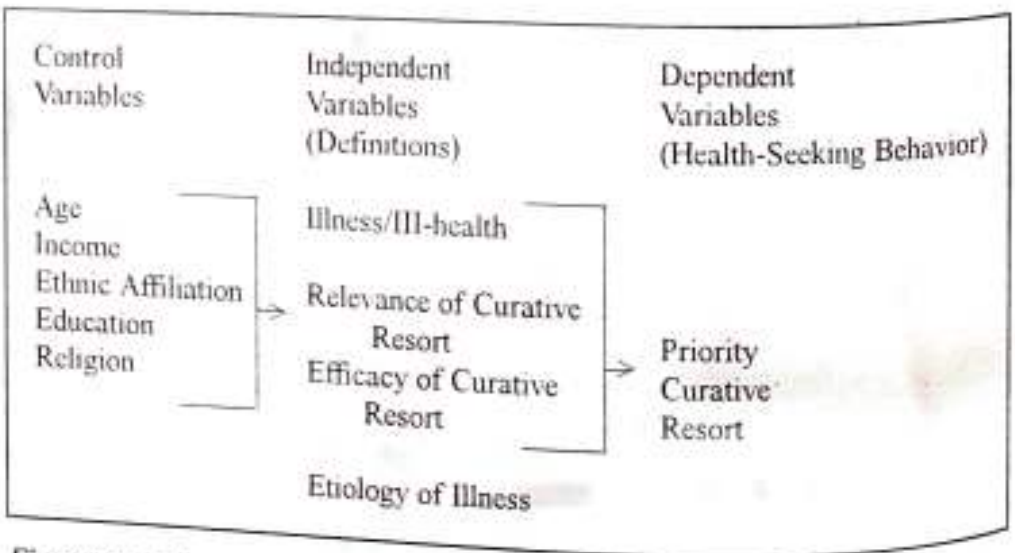

Figure 1. Schematic Diagram

In the previous page is a heuristic presentation of the relationships predicted to be existing between the independent variables (definitions) and the dependent variable (health-seeking behavior), including control variables.

Methodology

The researcher made us of stratified multi-stage random sampling. The predominatly Muslim communities (PMCs) were grouped separately from the predominantly Christian communities (PCCs) based on statistics from the NCSO office in Iligan City. Two PMCs were drawn by lottery to represent all the PMCs and three PCCs were drawn to represent all the PCCs in Lanao del Norte. A total of 21 barangays were randomly chosen, which generated 253 resepondents for the PCCs and 148 respondents for the PMCs.

Factory analysis was used, preceded by a principal component analysis for a first pass through the data to characterize the concepts of health, illness and relevance and efficacy of curative resorts of the respondents. The orthogonal factors were obtained by varimax rotation.

Logistic regression was used to predict the relationship of health-seeking behavior and the different definitions.

Limitation

The survey design utilized in this study made use of probability (random) sampling, which ensured the representativeness of the respondents. However, this has resulted in one major deficiency in relation to the use of logistic regression. With probability sampling, the researcher was not free to plan in advance for the exact number of samples (n) for each of the three curative resorts. Consequently, the n that have resulted out of the so-called multi-stage attrition have produced statistical models with unbalanced designs. As a result, no model of significance could be garnered with respect to traditional and modern curative resorts for each of the illnesses considered like cough, fever, gastric pains, toothache, "piang", skin diseases and backache. Although a few significant models came out in the statistical runs, still the n for each illenss among those who self-medicated in the PCCs and PMCs for each of the illnesses considered was not enough to warrant significant relationships in majority of the models for most of the independent and control variables like illness definitions, relevance and efficacy definitions of curative resorts, etiology definition, age, religion, ethnic affiliation, income and education. Sex was eliminated because of lack of variance.

Findings

I. Definitions

a) *Respondents' Definition of Health.* To the PCCs, health consists of three underlying factors: Normal Behavioral State, Normal Psychophysical State, and Normal Psychobehavioral State. According to the PMCs, health consists of four underlying factors, namely: Normal Physical State, Normal Behavioral State, Normal Psychological State and Absence of Symptoms.

b) *Respondent's Definition of Illness.* Respondents in PCCs agree that illness consists of four underlying factors, namely: General State of Ill-being, Abnormal Physical Appearance, and Presence of Internal Symptoms. Respondents in PMCs agree that the four underlying factors of illness are: Abnormal Physical Appearance, Abnormal Psychological State, Presence of Symptoms and Dormant Behavior.

c) *Etiology of Illnesses.* Overall for both the PCCs and the PMCs, illnesses are mainly attributed to natural causes, such as environmental factors, laborious and heavy activities/stressful events and germs/food poisoning, hitting and being hit by objects, negligence and abuse, and offshoot of another medical condition/offshoot of medication of another illness. The rest of the natural causes indentified are: genetic inheritance, old age and cause unknown. A minuscule 3.5 percent of the PCCs and a similar percentage of the PMCs still believe in supernatural causes of illness.

d) *Relevance of curative resorts.* PCC respondents agree the only underlying factor which constitutes relevance of curative resorts is Accessibility. The PMCs partly differ with the PCCs about the underlying factors that constitute relevance of curative resorts, because in addition to Accessibility, they have Sufficiency.

e) *Efficacy of curative resorts.* The three underlying factors that constitute efficacy of curative resorts, according to the PCCs, are: Well-equipped/Well-prepared with Effects Circumscribed by God's will; Superior Effectiveness; and Precise/Exact and Fact Results Whose Effect is Limited by God's Powers. Among the PMCs, the three underlying factors that constitute efficacy of curative resort are similar to those of the PCCs.

Overall, for both communities, one idea that is clear from the results is that rural folk consider traditional curative resorts as relevant while modern curative resorts are considered as efficacious. One implication is that modern curative resorts may be able to make themselves relevant, too, by the inclusion of herbal medications in their pharmacopoiea, which are quite inexpensive and virtually free.

II. Illnesses. The PCCs and the PMCs reported having the same most popular illnesses, except that they differ in the magnitude of occurrence. The illnesses used in the logistic regression analysis are cough, fever, toothache, headache, "piang", gastric pains, and skin diseases.

III. Health-seeking behavior. In terms of priority curative resort, for both PCCs and PMCs, the curative resort which is frequently availed of as first recourse is self-medication. For second curative resort, both communities equally have modern curative resorts. They differ in terms of their third curative resorts, because the PCCs have traditional curers while the PMCs still retain the modern ones.

IV. What variables would predict that a respondent in a predominantly Christian community, or predominantly Muslim community, when at the onset of a particular illness, will go to a particular resort?

To be able to answer this question, logistic regression is done on illnesses for which self-medication is used.

For each of the illnesses, the model below

$$\text{Logit } P = b_0 - b_1 X_1 + b_2 X_2 + \ldots + b_k X_k$$

Where P = probability of resorting to self-medication

Xs = independent predictor variables

is investigated for a) validity of fit of the model by maximum likelihood method and b) possible predictors.

Below are seven tables which present the significant predictors of the probability of respondents to self-medicate for seven selected illnesses. One table, however, does not present predictors but simply indicates that no independent variables were found to be significant enough to be predictors for self-medication for a particular illness.

The original predictor variables used in the models, out of which some have failed to predict, are the following: age, etiology of the illness, ethnic

affiliation, illness definition, relevance definition of curative resort, efficacy definition of curative resort, religion, education, sex and income.

Among the PPCs as shown in Table 1, cough is generally defined to be caused by environmental factors.

The etiology of cough is conceived to be a highly significant predictor ($p < 0.01$) of the probability that respondents will self-medicate whenever they have the illness. Among the PCCs, those respondents who consider cough as environmentally-caused are more likely to self-medicate for cough than those who consider the illness as not environmentally-caused. The same general tendency is true among the PMCs, although the likelihood is higher for the PMCs (71 percent probability) than for the PCCs (25 percent probability).

Table 1. A Multiple Classification Analysis Table on the Probability of Self-medication as a First Recourse for Cough

PREDOMINANTLY CHRISTIAN COMMUNITIES			PREDOMINANTLY MUSLIM COMMUNITIES		
Etiology coded (.01)*	n	p'	Etiology coded (0.05) **	n	p'
Environmentally-caused	137	0.2549354	Environmentally-caused	65	0.714129
Not environmentally-caused	5	0.0676065	Not environmentally-caused	4	0.2986217
	142			69	
Relevance of Curative resort (.05) **			Relevance of Curative resort (.039) **		
Disagree	0	0.2253906	Disagree	1	0.2555391
Uncertain	10	0.2858564	Uncertain	2	0.1525334
Agree	70	0.248948	Agree	45	0.3485377
Strongly Agree	59	0.2552797	Strongly Agree	14	0.5155736
	137			65	
			Efficacy of curative resorts (.09) ***		
			Disagree	0	0.5521046
			Uncertain	1	0.7267496
			Agree	55	0.2325416
			Strongly Agree	11	0.2823547

"p" means probability of self-medicating controlling for all other factors in the model.

* Significant at $p < .01$
** Significant at $p < .05$
*** Significant at $p < .10$

Another significant predictor of the probability that respondents will self-medicate for cough is the respondent's agreement with the definition of the relevance of curative resort. To recall, a curative resort is considered relevant by the PCCs if it is accessible (i.e., affordable, accommodating, known and familiar to the people). A respondent's degree of agreement with the definition of the relevance of curative resort is found to be significant at $p < 0.05$. The same table show that those who agree and strongly agree with the definition of relevance of curative resorts are more likely to self-medicate for cough than those who disagree and who are uncertain, although the differences between them are infinitesimal as to render them negligible. Nonetheless, despite this, it could still be said that those who agree/strongly agree consider self-medication as accessible to them.

For the PMCs, etiology is also considered as a significant predictor ($p < 0.05$) of the probability that respondents will self-medicate as a first recourse for cough. Those who consider cough to be caused by environmental factors are more likely to self-medicate for cough than those who believe that this illness is not environmentally-caused.

Still among the PMCs, a person's degree of agreement over the relevance definition is a significant predictor for one to self-medicate for cough. Those who strongly agree are more likely than those who simply agree to self-medicate for cough.

Table 2. A Multiple Classification Analysis Table on the Probability of Self-medicating for Fever

PREDOMINANTLY CHRISTIAN COMMUNITIES			PREDOMINANTLY MUSLIM COMMUNITIES		
Illness Definition (0.06) *	*n*	*p*	*Ethnic Affiliation (0.03)* **	*n*	*p*
Disagree	12	0.010496	Visayan	15	0.5250442
Uncertain	34	0.0096728	Non-Visayan	36	0.8115725
Agree	48	0.00873		51	
Strongly Agree	0	0.0079609			
	94		*Efficacy of curative resort (0.03)* **		
			Disagree	0	0.0448894
			Uncertain	0	0.2002516
			Agree	38	0.5703251
			Strongly Agree	13	0.8768495
			Education (.09)		
			Low Education	22	0.6114576
			Medium Education (09) **	10	0.3552636
			High Education	13	0.6212174

Similarly, a person's degree of agreement with the definition of efficacy (which is met by modern medicine) is a significant predictor for self-medication for cough. Those who disagree with the efficacy definition are greatly likely at 92 percent to self-medicate for cough; at the other extreme, those who strongly agree with the efficacy definition are least likely at 9 percent to self-medicate for cough. To those who disagree, perhaps the perception is that self medication would be appropriate enough for the treatment of cough, the reverse could be the line of thinking of those who strongly agree with the efficacy definition.

Table 2 shows that definition of illness is a significant predictor over the probability of the PCCs to self-medicate for fever. It could be observed, however, that the probability values are infinitesimal as to render them negligible.

Among the PMCs, the same table shows that ethnic affiliation and the definition of the efficacy of curative resorts (all items of low correlation have been eliminated) have come out as very significant predictors for the use of self-medication as a first recourse for fever. In fact, the Visayans are less likely to self-medicate for fever than the non-Visayans. Also, those who agree and strongly agree with the definition of efficacy of curative resorts are more likely to self-medicate thatn those who disagree with or are uncertain about it. To recall, respondents consider modern medication as efficacious. Within this context, it could be interpreted that those who agree and strongly agree with the efficacy definition and who have a high probability of self-medicating are involved in some kind of dissonance. Thus, we have a situation wherein what one professes is not consonant with one's actions.

Education has turned out to be a significant predictor for the PMCs wherein those with high and low education are more likely to self-medicate for fever than those with medium education.

As evident in Table 3, income is a significant predictor for self-medication for gastric pains in the PCCs. The probability is that as the income goes higher, the greater is the probability that a resident in the PCCs will self-medicate for gastric pains.

Thus, those with a class mean income of P750 have a 61 percent probability of self-medicating while those with a class mean income of P21,350 have a 96 percent probability of self-medicating. One possible explanation for this tendency of the higher income is that having known the appropriate medication for a chronic non-incapacitating disorder as gastric pain from previous consultations with doctors, these high income people just reach out for the same prophylaxis when attacks come. For the low-income earners, chances are they have utilized the traditional curer more in the past, and whatever knowledge they have gained from this encounter could have been appropriately effected for subsequent similar occurrences of gastric pains.

Table 3. Probability of Self-medicating for Gastric Pains

PREDOMINANTLY CHRISTIAN COMMUNITIES			PREDOMINANTLY MUSLIM COMMUNITIES		
Income (0.05) ***	n	p	Ethnic Affiliation (0.0029) *		
750	32	0.6097861	Visayan	16	0.3611214
2250	35	0.6548694	Non-Visayan	11	0.8421084
3750	18	0.6973294		27	
5250	7	0.7366563			
6750	7	0.7725582			
8250	3	0.804854			
9750	0	0.833552			
11250	2	0.8567702			
17250	1	0.9296523			
21750	2	0.9594495			
	105				

Among the PMCs in the same table, ethnic affiliation has been found to be a very significant predictor for self-medication as first recourse for gastric pains at $p < 0.01$. In fact, the Visayans are less likely to self-medicate as first recourse for gastric pains than do the non-Visayans (Maranaos).

From Tables 2 and 3, it looks like ethnic affiliation is a good predictor for self-medication in two particular illnesses among the PMCs, namely gastric pains and fever. In fact, the non-Visayans consistently show that they are more likely to self-medicate for fever and gastric pains.

Medium education is a significant predictor for self medication when skin diseases appear; in fact, those with this level of education have a 74 percent probability of self-medicating for a skin disease. Low education and hgih education are not significant predictors.

Table 4. Probability of Self-medicating for skin diseases

PREDOMINANTLY CHRISTIAN COMMUNITIES			PREDOMINANTLY MUSLIM COMMUNITIES		
Education	n	p	Ethnic affiliation (0.0063) *		
Low Education	31	0.6458324	Disagree	0	0.9992063
Medium Education (.07) ***	25	0.7352977	Uncertain	0	0.9648473
High Education	7	0.466887	Agree	12	0.3716114
	53		Strongly Agree	3	0.0126544
			Age (0.09) **	n	p
			Young	12	0.7342571
			Old	3	0.7427563

For skin diseases among the PMCs as shown in Table 4, the definition of efficacy of curative resort has been found to be significant at P<0.01. Those who simply agree and strongly agree with the efficacy definition are less likely to self-medicate as first recourse for skin diseases than those who disagree and are uncertain about it. It will be recalled that the respondents consider modern medication as efficacious. However, those who disagree with this perception certainly think that skin diseases could be better dealt with by self-medication than by modern medication.

With regards to age, the old and the young are almost equally likely to self-medicate skin diseases. Whatever difference they have in terms to tendency to self-medicate is negligible.

Table 5. Probability of Self-medication for Toothache

PREDOMINANTLY CHRISTIAN COMMUNITIES	PREDOMINANTLY MUSLIM COMMUNITIES
(problematic model because entire model is significant but not significant predictors within model)	(Problematic Model)

Table 5 shows that for both PCCs and PMCs, none of the independent variables are predictors of the probability of the respondents' use of self-medication for toothache.

Among the PCCs, Table 6 shows that relevance definition is a significant predictor of subscription to traditional medication for "piang". However, as the probabilities will show, the respondents for each level of agreement are equally likely to self-medicate (99 percent) for "piang". This is one unique instance when a disease/illness prompts people of whatever persuasion (i.e., level of agreement over the relevance of curative resorts definition) to go traditional. Perhaps this is so because "piang" describes a whole continuum of disorders from pinched nerves to broken bones which are perceived to be treatable only by the traditional way.

Table 6. Probability of traditional medication for piang

PREDOMINANTLY CHRISTIAN COMMUNITIES			PREDOMINANTLY MUSLIM COMMUNITIES		
Relevance of Curative Resort (0.07)**	n	p	Age (0.02) **		
Disagree					0.4070669
Uncertain	0	0.9954849	Young	26	0.4915479
Agree	14	0.9976005	Old	9	
Strongly Agree	67	0.9989884		35	
	34	0.9989211			
	115		Education		
					0.4330977
			Low Education	13	0.4530665
			Medium Education (0.04)**	12	0.4150663
			High Education	10	

In the same table, among the PMCs, age is a significant factor ($p<0.05$) of the probability to use traditional medication as first recourse for "piang". The young ones are less likely than the older ones to go traditional for "piang", but actually, the difference is very small at 0.042 percent.

Medium education is a significant predictor ($p>0.05$) also. The respondents with medium education are less likely than the respondents with high education to go traditional as a first recourse for "piang", further, the respondents with medium education are also less likely than the respondents with low education to go traditional for "piang".

Among the PCCs, Table 7 shows that no independent variable was good enough as predictor for the probability that respondents will self-medicate for backache. The same observation is true for the PMCs.

Table 7. Probability of Self-medication for backache

PREDOMINANTLY CHRISTIAN COMMUNITIES	PREDOMINANTLY MUSLIM COMMUNITIES
(No significant predictors within model)	(No significant predictors)

Discussion

The main hypothesis of concern in this research is: Are the respondents influenced by their definitions of illness, relevance and efficacy of curative resorts and etiology of illnesses in their subcription to a particular curative resort? In general, do definitions influence the respondent's health-seeking behavior?

One very important finding on the health-seeking behavior of respondent is that 64 percent of the PCCs and 52 percent of the PMCs self-medicate for cough, fever, gastric pain, toothache, backache and skin diseases, but not for "piang".

Self-medication has dangers which can lead to abuse of drugs or attenuation of the effects of drugs because of resistant strains. Or if it is the traditional cures used for self-medication, this may prove inefficacous and may cause the illness to become worse. On the other hand, although self-medication could be replete with dangers, it has some advantages. It is inexpensive and readily available. Besides, its use shows people's willingness to take care of their health, a proclivity which dovetails with the DOHs goal of putting health into the hands of the people.

As clearly stated, the modal curative resort of respondents is self-medication. This being so, a logit regression was done on self-medication as dependent variable and particular illnesses as independent variables, holding constant the health-related definitions variables (i.e., definitions of illness, relevance and efficacy of curative resorts, and etiology of illness), including other variables like age, income, education, religion and ethnic affiliation.

Now, to the results of logit regression. To a limited extent, they seem to indicate that respondents' definitions influence them to subsribe to self-medication as their first curative recourse, controlling for all other factors. The definitions that do this are those for the etiology of cough (for both PCCs and PMCs), relevance of curative resorts (for cough among PCCs), and the efficacy of curative resorts definition (fever and skin diseases among the PMCs). The illness definition has not come out as a determining factor in a respondent's decision to self-medicate as first recourse. The variables that is not a health-related definition but is nevertheless found to be a significant predictor of self-medication is ethnic affiliation (cough and gastric pains among PMCs). In the case of "piang", a logit regression was done on traditional medication, and age and education are found to be significant predictors among the PMCs.

What does this make of W.I. Thomas's definition of the situation? In this research, definitions of etiology, relevance and efficacy of curative resorts are found to be significant in nine instances out of the expected fifty-six statements. Could it be concluded that Thomas's concept does not apply in a rural medical situation? Thomas's definition of the situation is a well-accepted explanation of social phenomena and one single research is not enough to discredit it in its well-entrenched position, especially since the present research could be considered exploratory by its ample use of exploratory statistics, meant to draw out implications that could be tested in future researches. Although the harvest is small compared with what is expected, there is an indication that there is more to the theory if perhaps a well-thought out research design is made, especially taking into account the sample for the dependent variables (specific curative resort for specific illness).

One important methdological point has to be raised. A problem that continously bugged this researcher in the use of the logistic regression is its difficulty in coming up with models of good fit. One explanation for this is that the **n** for each sample has suffered from multi-stage attrition because of the nature of the variables involved. For example, the phenomenon being measured is self-medication for a particular illness in two separate communities. Self-medication is only one of three curative resorts - and it is the one chosen for logistic regression because of its relatively big **n** (majority of the respondents self-medicate as first recourse) and this gives the highest possibility of garnering good models, which, as it turned out fell short of expectations. Then, there's the question of the illness. Not everyone got sick of a particular illness one or three months

before the day of the interview. This limitation has brought about unbalanced designs so that consequently, very little models of good fit with significant predictors within have resulted. At its present state, nothing could be done to increase the n as this is a survey, wherein no deliberate attempt is made/could be made to ensure that the samples (n) are big enough for the purpose of coming up with balanced models. For future researches, it is suggested that a field study be made wherein the samples of respondents who subscribe to a particular curative resort for a particular illness are controlled for balance ahead of time.

Implications/Recommendations

1. Findings show that generally, the first curative resort is self-medication, but this is availed of only for a short duration. After self-medication and the illness is not yet cured, a person is confronted with a choice between traditional and modern, and most often, the choice is a traditional curative resort, which (if it is not effective) will be followed by a modern curative resort. However, there are some who first choose the modern curative resort, and, if this is found ineffective, the traditional curative resort is next tried.

We thus have two systems that are seemingly poles apart. Clients are bridging the gap between these by shifting from the traditional to the modern paradigm in their attempts to meet their health needs. Their actions suggest an insistence on some sort of a paradigmatic shift where there is cooperation/synergy between the two competing systems, where the best of both systems may be integreated into a new paradigm. The said paradigm may be more attuned to the needs of the rural folk. It is certain that without innovative approaches, massive rural populations will be left essentially without the benefit of modern medicine, either preventive or curative.

Since there is a wide range of chronic non-incapacitating dysfunctions for which modern medicine can prescribe no specific cure, and since many critical incapacitating dysfunctions may respond to different remedies including the therapy of time, it seems probable that native medicine will continue to thrive in a structure complementary to scientific medicine." [Landy 1977:470]. So why not help traditional curative resorts to lean more in the direction of scientific outlook and practice?[*] In the process, those who try to do this should not make a frontal undermining or underestimating of traditional curative resorts' be-

[*] Incidentally, a DOH sponsored processual evaluation research on Hilot Training was done by Dr. Linda Burton in Bukidnon, Agusan del Norte and Agusan del Sur. The purpose of the training was to teach traditional birth attendants to improve their skills in order for them to become better in their line of work (Burton 1995). The effort is a testimony of the DOH's implementation of its policy of co-opting traditional health workers into the country's modern medical system.)

liefs and practices, but just input scientific knowledge, and let the traditional practitioner undergo a personal psychological process of rationalizing for or against his own paradigm or for or against the scientific paradigm. Hopefully, over time and with intensive training and follow-ups, the traditional curer will have an inclination for the modern. Hopefully, too, the above strategy will allow more time for doctors to concentrate on preventive measures.

Co-opting some traditional curative resorts into the modern medical system, and in the process teaching them preventive measures which they pass on to their clients and more sanitary/sterile procedures and more scientific knowledge about diseases, is a possible avenue. It will be particularly important to begin this process with the thousands of *hilots* in the barangay level found throughout the rural Philippines. Whether we like it or not, rural folk will be going to the traditional curative resorts, pushed more by economic reasons.

2. People must have a clear idea of illness episode data, so that they themselves could recognize the gravity of the situation as it progresses. Most of them self-medicate based on their past experiences about a particular illness or their neighbor's report about some similar condition. These people do not recognize the limitations of self-medication. Why not teach them more about common illnesses and intensify their ability to identify at what point in the progression of a disease that they should bring the patient to a doctor? One of the most common illnesses is cold, which is self-limiting, but with frequency of occurrence, this already needs a doctor's ministration. With other illnesses like cough, we do not know whether the cough is already leading to TB or is an acute respiratory infection (ARI). Only a doctor can tell that with certainty. Anemia, which rural folk dismiss as paleness, could have pregnancy complications for women.

In this regard, a massive information and education campaign about illness episodes and the virtues and limitations of self-medication can be carried out by DOH through the rural health units and barangay health centers. The barangay health personnel, being the frontline workers, should be well-versed on these matters.

3. The mandate of the rural folk seems to be that herbal medication should be used and propagated (instead of synthetic modern medicine), with the modern doctors treating them and dispensing the same. This will surely meet their idea of a relevant and effective curative resort which is efficient, offers fast and accurate results, and which is virtually free.

Maintaining herbal gardens used to be a practice in most barangays in the past, but this has become a rarity these days. Community health workers

can encourage people to revive this practice of backyard or even communal herbal gardens.

More funds must be allocated for the continued testing of other herbal medicines to meet the standards of modern science and in order to expand choices of medicine for a particular disease as well as to expand the range of diseases that could be targetted.

Establishing herbal testing stations at places endemic for medicinal herbals where first level of testing could be done the scientific way is not a remote possibility. Herbals that have passed the test at the first level could be sent to much better equipped laboratories for further testing.

For years now, the testing, production and packaging of herbal medications have been an accepted policy. More attention has to be given by DOH in terms of more fund allocations to support researches.

The DOH should convince doctors to look positively at herbal medication. A policy of national application concerning the inclusion of herbals in doctors' pharmacopeia could be adopted and a massive campaign for its use could be undertaken by the DOH.

3. For further research and for theoretical implications, multivariate analyses could be done on the relationship of illnesses, etiology and curative resorts. To recall, the definition of illness was taken as a single value which is the mean during factor analysis; one suggested angle is to use the statements scoring high on the first factor as the basis for defining illness, relevance and efficacy, and use these in succeeding bivariate and multivariate analyses. Or, further multivariate analysis could be undertaken with the definition of illness as random vector and the four factors as vector components. All of these suggestions have to be taken within the context that as this present research has underscored the importance of the size of samples, a field research can be done, taking special note of the balance of the design to ensure strong and definite conclusions.

4. A qualitative research could be done on the actual medical curing and treatment practices of traditional curative resorts to enable modern medicine to pinpoint areas that scientific medicine could influence.

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