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Emic Definitions of Health and Illness in Rural Muslim and Christian Communities of Lanao del Norte

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Abstract

Selected predominantly Christian and predominantly Muslim rural communities in Lanao del Norte were surveyed to determine the rural folks definitions of health and illness. In-depth interviews guided by a structural interview schedule, were conducted among 401 respondents selected through stratified multi-stage random sampling. Two hundred fifty three (253) respondent were selected from three (Bacolod, Kapatagan, & Magsaysay) predominantly Christian communities (PCCS), and 148 from two (Balo-I & Pantao-Ragat) predominantly Muslim communities (PMCs).

Majority of the respondents are mothers and housekeepers with household incomes below the poverty line identified by NEDA. Data reveals that the **emic** *(culture-specific concepts) indicators for health identified by both PCC's and PMC's respondents generally correspond with medical science's* **etic** *(predetermined general concepts) indicators. Both sets of respondents* **emically** *defines health as composed of factors like positive behavior, positive psychological state & positive physical appearance. While illness is composed of factors like abnormal physical appearance, presence of symptoms and the like. There are some specific instances wherein the* **emic** *definition of respondents demote from the* **etic**. *Some illness indicators of modern medicine like distended abdomen to indicate parasitic infection are considered by rural folks as without medical significance. Majority of the two types of communities*

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(PCC's-69%; PMC's 71%) have the fatalistic attitude and belief that diseases could not be avoided. Findings of this research would be useful to the policy and decision-makers particularly the DOH and Local Government Units (LGU's) in their intervention program for the maintenance and attainment of health of the populace.

Health has been defined by the World Health Organization (1978) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Another definition says that health "...in a sense, is defined by what does not constitute health, namely disease" (Risse 1978:579). Disease, on the other hand, has been defined as a "biological abnormality" or distress and disability that is based on abnormal processes and structural alterations of the human organism. These biological deviations have had, for the most part, a universal validity (Risse 1978:579). In other words, the syndrome sequences in categorized illnesses like tuberculosis or asthma are considered to be true whether one is in frigid Alaska, temperate America or torrid Africa. All the above definitions constitute what medical anthropologists term as **etic** definitions or "...descriptions of...behavioral phenomena considered in isolation from a particular system or in relation to predetermined general concepts..." (Mish 1990).

The other side of the coin shows contrasting **emic** definitions which are culture-specific because these are replete with variable social and behavioral factors. In some instances phenomena considered to be symptoms of disease by some groups may be regarded as signs of health or without medical significance by others. A good local example cited by Dr. Olano, former Provincial Health Officer of Lanao del Norte, is the schistosomiatic conditions in endemic areas in Lanao del Norte, which have been regarded by residents as a normal part of their agricultural life. From the researcher's own impressions in the Philipines, people even from the cities regard young children with Buddha-like fatness as an indicator of health and well-being and not of obesity. In the barrios, children with distended stomachs due to intestinal worms are considered normal since almost every other child has a big stomach. Diarrhea during the teething period is no cause for alarm, the reason being that teething is always accompanied by loose bowel movement. A documented study on leprosy reports that the respondents tend to equate the symptoms of leprosy with a skin disease. (Valencia et al. 1979)

We see in the contrasting etic and emic definitions above two different ways of looking at two related phenomena, health and disease. An important thing to keep

in mind here is that these definitions lead to different behaviors on the part of people subscribing to them. One man may generally subscribe to the etic definitions and consequently, may go to a professional doctor of medicine, who has been trained to combat germs in appropriately scientific ways. Another man may generally subscribe to the emic definitions and consequently, may seek no professional help at all or go to a hilot, a herbolario, or a babaylan. Thus, knowing a people's definitions may be the first important step towards better planning for their health. This can occur insofar as the planning and implementation of health care delivery may have accounted for etic definitions only when in fact the target clientele has emic definitions of their state of being.

Objective

The present article aims to describe the varying definitions of health and illness held by predominantly Christian and Muslim rural communities in Lanao del Norte, including beliefs on illness avoidance.

Research Site

The province of Lanao del Norte was the chosen research site. It is located on the northern coast of Mindanao . It comprises one of the five provinces in Region XII or Central Mindanao. The other provinces are Lanao del Sur, Maguindanao, North Cotabato, and Sultan Kudarat.

The province of Lanao del Norte has a total land area of 13,092 square kms. and is considered a first class province. It has a total population of 614,092 as of 1990. It consists of 22 municipalities and one city, Iligan City, which also serves as its capital *(National Statistics Office 1990)*.

The Philippine Almanac sets the estimates for the crude death rate (CDR) in Central Mindanao (where Lanao Norte is one of the provinces) at 10.94 deaths per thousand. This figure means that the region has the second highest (following Western Mindanao) death rate in the country. The high death rate contrasts with the national figure of 7.85 as well as with the estimated CDR of the national capital region (NCR) which is pegged at 4.74 per thousand.

As of 1990, the male life expectancy in the region of Central Mindanao stood at 59.1 years, making this region only twelfth in rank throughout the country in terms of this measure. (Regions with even less favorable mortality conditions were Eastern Visayas, Cordillera Administrative Region and the ARMM.) Similar re-

sults were also found for female life expectancy although in this case, a slightly more favorable situation was found, with Central Mindanao ranking tenth in terms of life expectancy (Flieger and Cabigon 1994, Table B). Clearly, the health situation in this region needs more improvement.

All towns of Lanao del Norte, with the exception of Iligan City, have been considered as rural for the purpose of this research. This is so because although some towns definitely fitted the National Census and Statistics Office (NCSO) definition of urban, they did not display the kind of ambience exuded by an honest-to-goodness urban area.

The five municipalities sampled using the multi-stage sampling procedures for this study were Bacolod, Kapatagan, and Magsaysay as the predominantly Christian communities and Balo-i and Pantao-Ragat as the predominantly Muslim communities.

Related Literature

Health and Disease Definitions. In a sense, health is defined by what does not constitute health, namely disease or "the absence of symptoms"(Wilson 1970:3). Health, therefore, becomes a residual category, the opposite of disease. According to Wilson, though, this definition begs several questions. Firstly, it excludes from the category of illness those subtle and latent disturbances that go unremarked by the subject or which are not apparent to the observer. By fixing attention on familiar signs of malfunction, the definition of health as non-disease tends to exclude analysis of the well-functioning individual. Lastly, symptoms themselves are rarely unambiguous: physicians may disagree on the appropriate scope or severity of symptoms for a given diagnosis, and many of the most important symptoms cannot be observed at all but must be inferred from the patient's report.

Another definition of health revolves around the conception of "normalcy", a state from which the deviations commonly leading to a classification of the individual as ill may be measured. Gauging departures from the norm is difficult in itself bacause normalcy may take many guises. The idea of normalcy as a statistical artifact can be useful to modern medicine; however, this may bring about some problems if used among human groups in which conditions that modern medicine has clearly identified as pathologic are endemic but are considered acceptable and not sick because persons free from the disease are statistically rarer than persons having it (Wilson 1970: 4-5).

The World Health Organization has defined health as a state of complete

physical, mental and social well-being and not merely the absence of disease or infirmity (Sills 1968:330).

Aubrey Lewis (1980) has considered the WHO definition of health as meaningless because this definition reverts to an ancient formula of unattainable wholeness of body, mind and soul, realized in the Golden Age but long since forfeited.

Bonifacio (1979), however, thinks that the WHO's definition is a good one because any health organization, when being planned, should be designed in such a way that it addresses the three components of the well-being of man.

Disease, a term which reflects a series of value judgments regarding psychobiological characteristics considered to be deviant or pathological, has been defined as person-centered, discontinuous, and undesirable — this is the organismic view of disease. This notion reflects three explanatory frameworks that have been used for disease: (1) as a biological abnormality; (2) as a behavioral discontinuity; and (3) as a phenomenological occurrence (Risse 1978: 579).

The first category is rooted in the idea that distress and disability are based on abnormal processes and structural alterations of the human organism. These biological deviations have had, for the most part, a universal validity, in contrast with variable social and behavioral factors.

The second category, disease as a behavioral discontinuity, comprises the full range of behavioral responses to pain and dysfunction as determined by social, psychological, and cultural factors.

The third category, disease as a phenomenological occurrence, is perceived as a completely altered state of being for the affected person, often as a result of supernatural possession or invasion.

All the three categories, which can coexist in any given culture, stress the discontinuity of health and disease (Risse 1978: 579).

According to Wijeyanake (1988), a disease or illness as perceived by Vietnamese refugees at the Philippine Refugee Processing Center in Morong, Bataan, is closely associated with discomfort or uncomfortable feeling, which is considered as a first symptom of any illness. During the course of illness, discomforts are accompanied by a slow pulse, muscle pain and low grade fever before a person is pronounced sick.

The Vietnamese refugees consider being healthy as synonymous with being fat or strong and happy. They consider being thin as weak and unhealthy. Health is described by refugees as fitness in the person's body or his physical well-being.

Among Laguna de Bay residents, health implies freedom from illness (Campos 1975:55-58). It is a state of physical, emotional and mental well-being. The concept of sickness encompasses "almost all phenomena that give discomfort to a

person- from simple skin irritations and tiny wounds to complex biological disorder and supernaturally caused afflictions." The popular concept of illness was quite functional: one is sick if one is bedridden and unable to work. Very few respondents, mostly those belonging to the upper income and educational levels, mentioned morbidity. The lower income households appeared to report only those cases which were incapacitating, and left out minor ailments.

Methodology

Four hundred one (401) respondents were selected from three predominantly Christian communities (PCCs) and two predominantly Muslim communities (PMCs) in Lanao del Norte through the stratified multi-stage random sampling procedure. Of the total sample, 253 are from the PCCs (Bacolod, Kapatagan and Magsaysay) and 148 (Balo-i and Pantao Ragat) are from the PMCs.

This study involved two phases. The first phase concerned itself with the development of the scale instruments for the different concepts in the study, namely health and illness. The main data gathering technique for the first phase of the study was the in-depth interview guided by a structured interview schedule. Sample questions were:

> When do you say that a person is healthy? Explain. (Delve deeper into responses through appropriate follow-up questions.)
> When do you say that a person is sick? Explain. (Follow-up questions.)

The responses arrived at during the first phase subsequently became the basis for making the second phase survey instrument. In the translation from English to the dialects, three Maranaos and three Visayans were asked to translate the material.

For the study of the concepts of health and illness, statements were derived from actual responses given by respondents during the preliminary phase. A total of 217 translated statements were arrived at which were apportioned as follows:

Health ———— 96 statements
Illness ———— 121 statements

These statements were subjected to item and intercorrelation analyses as reliability checks. Questionnaires for pre-testing were given to twenty-five respondents in Maigo, a predominantly Christian community, and a neighbor of Bacolod, along with another twenty-five respondents in Pantar, a predominantly Muslim community and a neighbor of Balo-i. After the item analysis, the statements for each concept were reduced to more or less one-half of the original number. The exact figures were:

Health	46
Illness	62
	108

Not all of the statements have been used . For example, out of 46 health statements, only 14 statements (those on general conception/definition of health) were used, while the remaining 32 statements which were about specific conceptions of health of male, of female and of a child were dropped from the present endeavor. The same conditions were true to illness, wherein out of 62 statements, only 13 statements (those on general conception of illness) were used, while the remaining statements which were about specific conceptions of illness of male, of female and of a child were similarly dropped.

Reviewing the scale construction process (for definitions of health and illness), the researcher believes that each scale has face validity as the statements have been extracted from the people themselves; this , in effect, gives us the people's own definitions from their own point of view. As mentioned by Kidder, evaluating validity is a subjective process while Kerlinger said that it is a judgmental one.

Thus, it is concluded that the scales themselves constitute the definition of the health-related concepts of interest in this study, and when used for data-gathering, these were able to get the respondents' level of agreement to the definition that they (the scales) represent. However, it was only through factor analysis that the different dimensions of the definition of each concept were culled . The following quotation aptly describes the construction process that the scales in this study went through: "Earlier social science research sought to create scales that tapped single dimensions; more recently there has emerged a realization of the multidimensional nature of most scales." (Kidder 1981)

As an additional information, in the interpretation of data in both the first and second phases of both study when the emic definitions had to be evaluated against

the etic definitions of medical science, the researcher consulted a doctor of medicine for this purpose.

Findings

(A.)Majority of the respondents in both the PCCs and the PMCs are mothers and are housekeepers. The mean household income in the PCCs is P3,215.48 per month, while in the PMCs, it is P3,361.23, both below the poverty line identified by the NEDA. The PCCs have less children (average of 4.67) than the PMCs (average of 5.53). In terms of child mortality, the PMCs have a bit more incidence of death than among the PCCs.

(B.)This section presents the means, the correlations and the factor analyses for health and illness including results on illness avoidance.

To determine the level or degree of agreement of the respondents, precoded responses with 1 = strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree and 5 = strongly agree, have been utilized. Therefore, the higher the mean score, the greater is the tendency to agree with the statement, and vice-versa. The response 3 is the midpoint; therefore, scores below 3 would mean more disagreement than agreement.

The factor analysis is a method for determining the number and nature of the underlying factors among larger numbers of variables that constitute the definition of concepts like health, and illness. More succinctly, it is a method for determining **k** underlying (factors) from **n** sets of variables, **k** being less than **n** (Kerlinger 1973: 659). The factor tables in this section thus present (a) how many factors there are; (2) what variables are loaded on what factors; and (3) the magnitude of the factor loadings.

(1.) Health Concept in Predominantly Christian and Predominantly Muslim Communities

(1.1) Discussion on Means

Table 1 shows that out of fourteen statements, respondents in predominantly Christian communities tend to agree with eleven of these, to be uncertain about two of them and to disagree with one . To the PCCs, the trademark of health are: happiness , equanimty, activity and energy, endurance/stamina, consciousness over health maintenance and being forward-looking.

Table 1. Means and Standard Deviations of Statements on Concept of Health Involving the Predominantly Christian and Muslim Communities

STATEMENTS	PCCs		PMCs	
	Mean	SD	Mean	SD
19 A person who feels pain and discomfort yet continues doing his work is considered healthy.	2.9	1.0	3.8	0.9
20 A healthy person does not get tired wherever he may go.	3.8	0.7	4.1	0.8
21 A person who is active and does not tire easily is healthy.	4.0	0.5	4.1	0.5
22 Fatness indicates health in a person.	3.3	0.9	2.9	1.2
23 A person who industriously earns a living for his family is healthy; conversely, a person who has no enthusiasm for earning a living must be feeling ill.	2.5	0.5	3.3	1.1
24 A person with reddish body complexion and who has no complaint is healthy.	3.4	0.9	4.0	0.7
25 A person who has no ailment is happy.	4.1	0.6	4.1	0.6
26 A healthy person has a good mood, does not make scathing remarks and is not quick to anger.	3.8	0.7	3.9	0.8
27 A healthy person, even if he has a problem, is not readily affected by it. He is still in a good mood.	3.8	0.8	4.0	0.7
28 If a person gives extra care and attention to himself, and he has not been particularly abusive, there is no reason why he could not be healthy.	4.0	0.5	4.1	0.5
29 A healthy person does not have many red veins in the eyes.	3.4	0.8	3.9	0.7
30 A healthy person takes vitamins.	3.5	0.9	3.6	1.0
31 A healthy person makes plans for his life.	3.9	0.6	4.1	0.5
32 A healthy person plays vigorously.	3.9	0.6	4.1	0.5

Respondents are uncertain whether fatness indicates health or not, and whether a person who persists in working despite his ailment is healthy.

The lone statement with which the respondents disagree is that a person's failure to earn a living industriously is not necessarily a valid indicator of poor health.

Still in Table 1, among predominantly Muslim communities (PMCs), respondents agree with twelve out of fourteen statements Among PMCs, stamina and endurance, activeness , equanimity, a happy disposition , consciousness over one's

Table 2. *Highest Loadings of Fourteen Variables of Health Concept on Orthogonal Factors in Predominantly Christian Communities*

Variables	S_1	S_2	S_3	h^2 *
28.) If a person gives extra care and attention to himself, and he has not been particularly abusive, there is no reason why he could not be healthy.	.6884			52
21.) A person who is active and does not tire easily is healthy.	.6802			53
31.) A healthy person makes plans for his life.	.6423			55
20.) A healthy person does not get tired wherever he may go.	.5834			47
24.) A person with reddish body complexion and who has no complaint is healthy.		-.6931		54
22.) Fatness indicates health in a person.		-.5938		39
27.) A healthy person, even if he has a problem, is not readily affected by it. He is still in a good mood.		-.5334		35
29.) A healthy person does not have many red veins in the eyes.		-.5147		59
32.) A healthy person plays hard.			.6041	51
30.) A healthy person takes vitamins.			.5547	48
26.) A healthy person has a good mood, does not make scathing remarks and is not quick to anger.			.5298	47

	Largest Eigenvalue	Variation	Common Variation
Step 1	2.543254991	.181661071	.181661071
2	1.899954915	.135711065	.317372136
3	1.298165504	.092726107	.410098244

* h^2 displays the communality of each variable.

health maintenance , and being forward-looking are unmistakable signs of health. Also, those with asymptomatic diseases, as long as one is not bedridden, could be considered as healthy.

The PMCs are uncertain as to whether industriousness in earning a living may or may not mean that a person is healthy or that whether fatness indicates health in a person.

1.2 Discussion on Factor Analysis on Definition of Health in Predominantly Christian and Muslim Communities

The predominantly Christian communities' definition of health consists of three underlying factors as shown in Table 2.

(Statements 23 and 25 have been eliminated because they do not correlate highly with the other statements. This has been established during the intercorrelation procedures.)

Variables 28, 21, 31 and 20 which constitute Factor 1 are found to be highly intercorrelated with each other and are found to be loaded on Factor 1. The label given in this case is *Normal Behavior.*

Factor 2 is made up of four variables (24, 22, 27 and 29), all endowed with negative loadings, which means that the opposite effect has to be considered. This actually emphasizes the meanings conveyed by the variables. Thus: Thinness indicates illness in a person; a person who has complaints is sick; a sick person is always in a bad mood; and a sick person has many red veins in the eyes. Factor 2 is labeled as *Normal Psychophysical State.*

Variables 32, 30 and 26, mentioned according to the magnitude of their factor loadings, constitute Factor 3, which is labeled as *Normal Psychobehavioral State.*

To summarize, the three factors underlying the PCC's definition of health are: *Normal Behavior, Normal Psychophysical State, and Normal Psychobehavioral State.*

Table 3 shows that four factors underlie the ten variables that indicate health from the viewpoint of respondents in the predominantly Muslim communities.

Factor 1, which is labelled *Normal Physical State,* is constituted by variables 20, 19, 25, 24 and 28.

Factor 2 is labelled *Normal Behavioral State* and variables 30 and 31 are heavily loaded on it.

Factor 3 is *Normal Psychological State,* which is made up of variables 26 and 27.

Table 3. Highest Loadings of Fourteen Variables of Health Concept on Orthogonal Factors in Predominantly Muslim Communities

Variables	S_1	S_2	S_3	S_4	h^2
20.) A healthy person does not get tired wherever he may go.	.7858				.69
19.) A person who feels pain and discomfort yet continues doing his work is considered healthy.	.7711				.72
25.) A person who has no ailment is happy.	.7071				.64
24.) A person with reddish body complexion and who has no complaint is healthy.	.6332				.67
28.) If a person gives extra care and attention to himself, and he has not been particularly abusive, there is no reason why he could not be healthy.	.6283				.71
31.) A healthy person makes plans for his life.		.6827			.65
30.) A healthy person takes vitamins.		.5547			.56
26.) A healthy person has a good mood, does not make scathing remarks and is not quick to anger.			.72788		.77
27.) A healthy person, even if he has a problem, is not readily affected by it. He is still in a good mood.			.6090		.66
29.) A healthy person does not have many red veins in the eyes.				.5583	.67

		Largest Eigenvalue	Variation	Common Variation
Step	1	3.861588245	.275827732	.275827732
	2	1.404985037	.100356074	.509882350
	3	1.139051762	.081360840	.591243190
	4	1.107188388	.079084885	.670328075

Factor 4 , *Absence of Symptoms,* is highly correlated with variable 29.

Statements 21 and 32 have been eliminated as possible items for a fifth factor because although their eigenvalue is greater than one (1.107188388), the factor loading of each is less than .5, i.e., S21 (loading of .4599) and S32 (loading of .4686).

To summarize, the four factors that underlie the health definition by the PMCs are: *Normal Physical State, Normal Behavioral State, Normal Psychological State and Absence of Symptoms.*

(2.) Illness Concept in Predominantly Christian and Muslim Communities

2.1 Discussion on Means

The respondents in the PCCs typically agree with twelve of the statements in Table 4 and strongly agree with one. To them, illness means extreme weakness, progressive loss of weight, gloominess, brooding, yellowing, body growths, fever, blood spitting and indifference to cleanliness.

On the other hand, respondents among the PMCs strongly agree with three of the statements, namely statements 65, 66 and 72. To them, illness is having the presence of indicators lke yellowing of the body, fever and thinness. Earlier in this paper, it was expreessed that PMC respondents are uncertain over fatness as an indicator of health. Thus, while fatness may not in itself always be an indicator of health, the PMC residents do in general strongly agree with the converse idea that thin persons are usually sick.

2.2 Discussion on Factor Analysis of Illness Definition in Predominantly Christian and Muslim Communities

Table 5 on factor analysis shows that four factors underlie the PCCs definition of the illness concept. Variables 76, 72, 75, 71, 69, 67, 73, 77 and 70 are highly loaded on Factor 1, which is *General State of Ill-being* . This factor is thus a composite of abnormal physical , abnormal psychological, dormant behavioral and highly symptomatic indicators.

The second factor, *Abnormal Physical Appearance,* is composed of variables 65 and 66, both having negative loadings. This means that we have to take the opposite positive meaning of the variables into consideration. Thus, if a person's body is not yellowish, this means he is not sick and if he is not thin, he has no ailment.

Table 4. Means and Standard Deviations of Statements Involving the Concept of Illness As Perceived by Predominantly Christian and Muslim Communities

		PCCs		PMCs	
	S T A T E M E N T S	Mean	SD	Mean	SD
65	If a person's body is yellowish, this means he is sick.	4.0	0.7	4.4	0.5
66	If a person is thin, he has some ailments.	3.8	0.9	4.2	0.8
67	For example, previously a person was fat but gradually he lost weight — that person is sick.	4.1	0.6	4.1	0.5
68	It is easy to recoguize a sick person because you see growths on his body.	3.9	0.7	4.0	0.6
69	A sick person looks as if he is carrying a very heavy problem.	4.1	0.6	4.1	0.6
70	A sick person does not care about his hygiene.	3.8	0.8	4.0	0.6
71	A sick person has soulful eyes.	4.1	0.6	3.8	0.7
72	A sick person has fever.	4.1	0.5	4.3	0.7
73	A sick person is always deep in thought.	4.1	0.6	3.9	0.6
74	A sick person always spits blood.	3.6	0.8	3.8	0.8
75	A sick person does not sweat; consequently, his skin is dry.	4.1	0.5	4.0	0.5
76	When a person lies down on the mat and is very, very weak, he is sick.	4.2	0.6	4.1	0.6
77	Becoming thin or decreasing in weight indicates that a person is sick.	4.0	0.7	4.1	0.5

Table 5. Highest Loadings of Thirteen Variables of Illness Concept on Orthogonal Factors in Predominantly Christian Communities

Variables	S_1	S_2	S_3	h^2
76.) When a person lies down in the mat and is very, very weak, he is sick.	.7595			.72
72.) A sick person has fever.	.74035			.60
75.) A sick person does not sweat; consequently, his skin is dry.	.7308			.61
71.) A sick person has soulful/drooping eyes.	.7269			.60
69.) A sick person looks as if he is carrying a very heavy problem.	.7156			.59
67.) For example, previously a person was fat but gradually he lost weight — that person is sick.	.6833			.70
73.) A sick person is always deep in thought.	.6362			.66
77.) Becoming thin or decreasing in weight indicates that a person is sick.	.5920			.41
70.) A sick person does not care about his hygiene.	.5148			.50
66.) If a person is thin, he has some ailments.		-.7191		.63
68.) If a person's body is yellowish, this means he is sick.		-.5869		.69
74.) A sick person always spits blood.			.8867	.86

Step		Largest Eigenvalue	Variation	Common Variation
	1	4.810521883	.370040145	.370040145
	2	1.574584098	.121121854	.491161999
	3	1.031685103	.079360393	.570522391

Table 6. *Highest Loadings of Thirteen Variables of Illness Concept on Orthogonal Factors in Predominantly Muslim Communities*

Variables	S_1	S_2	S_3	S_4	h^2
65.) If a person's body is yellowish, this means he is sick.	.8211				.73
66.) If a person is thin, he has some ailment.	.8174				.69
67.) For example, previously a person was fat but gradually he lost weight — that person is sick.	.7546				.58
77.) Becoming thin or decreasing in weight indicates that a person is sick.	.5009				.43
69.) A sick person looks as if he is carrying a very heavy problem.		.7421			.73
70.) A sick person does not care about his hygiene.		.7288			.67
73.) A sick person is always deep in thought.		.51197			.37
72.) A sick person has fever.			.7222		.64
74.) A sick person always spits blood.			.6624		.60
68.) It is easy to recognize a sick person because you see growths on his body.			.5074		.71
76.) When a person lies down in the mat and is very, very weak, he is sick.				.7211	.71
75.) A sick person does not sweat; consequently, his skin is dry.				.5696	.64

		Largest Eigenvalue	Variation	Common Variation
Step	1	3.075668803	.236589908	.236589908
	2	2.138367310	.164489793	.401079701
	3	1.540807169	.118523628	.519603329
	4	1.166258869	.089712221	.609315550

The third factor, composed of variable 74, is *Presence of Internal Symptoms.*

To summarize, the underlying factors of the concept of illness as construed by the PCCs are: *General Ill-being State, Abnormal Physical Appearance, and Presence of Internal Symptoms.*

Among the PMCS, Table 6 shows that variables 65, 66, 67 and 77 are loaded on the factor *Abnormal Physical Appearance* since it deals with such symptoms as weight loss and yellowish skin color. (Note that variable 71 has been eliminated

because of its low correlation with the other variables).

Variables 69, 70 and 73 have high intercorrelation with the second factor, *Abnormal Psychological State*. It emphasizes "problems", being worried ("deep in thought") and an inability or unwillingness to even practice basic hygiene.

Variables 72, 74 and 68 have heavy loadings on the third factor, *Presence of Symptoms*.

The fourth factor, composed of variables 75 and 76, is labelled *Dormant Behavior*.

To summarize, for the PMCs, the four underlying factors of illness are: *Abnormal Physical Appearance, Abnormal Psychological State, Presence of Symptoms and Dormant Behavior*.

(C.) Illness Avoidance

The respondents were asked categorically if they believed whether illnesses could be avoided or not.

In Table 7, one hundred eighty-two or 72 percent of the PCCs and one hundred eight or 73 percent of the PMCs are of the opinion that illnesses could not be avoided. Conversely, seventy-one or 28 percent of the PCCs and forty or

Table 7. *Frequency Distribution of Responses on the Question "Can illness be avoided?" among Predominantly Christian and Predominantly Muslim Communities*

Categories	Christian		Muslim	
	F	%	F	%
Yes	71	28.1	40	27.0
No	182	71.9	108	73.0
Total	253	100.0	148	100.0

HO: There is no significant difference between the PCCs and the PMCs with regard to their opinion on illness avoidance.

Chi-square= .012 df=1 P=.9139 NS

27 percent of the PMCs say illnesses could be avoided. A chi-square test shows that there is no significant relationship between the two types of communities and their opinion on avoiding illness. The two types of communities are basically similar in the belief that diseases could not be avoided.

Table 8 shows that among the PCCs, of the majority who are of the opinion that illnesses could not be avoided, one hundred twenty-seven or 69 percent say that God wills everything, including the illnesses that befall men. This reflects the underlying fatalism of the Filipino. Among Christians, a sick patient is mostly relegated to God's will because of economic insufficiency. This tendency is strongly manifested in predominantly Christian rural areas where very few people have the means to subject a patient to a hospital or a doctor's regimen.

Forty or 22 percent of the PCCs say that no one has any control of the weather or environmental conditions. Sixteen or 9 percent say that accidents that could result in debilitating conditions could not be avoided.

Table 8. Most Important Reasons for Saying that Illness Could Not Be Avoided from the Viewpoints of Predominantly Christian and Predominantly Muslim Communities

Reasons for NO	Christian		Muslim	
	F	%	F	%
God's Will	127	68.7	78	71.0
No Control over Weather/ Environmental Conditions	40	21.6	27	24.5
Inherited Diseases	2	1.0	1	0.9
Cannot Avoid Interacting with People	-	-	1	0.9
Accident	16	8.7	2	1.8
Others	-	-	1	0.9
Total	185	100.0	110	100.0

Among the PMC's, seventy-eight or 71 percent believe that illnesses could not be avoided because, just like the PCC's, God wills everything, including illnesses. This belief has fatal consequences among the Maranaws. If the sick person is already in very serious condition, they may expend some effort in looking for the patient's cure but there is no sense of urgency at all because of the belief that if the patient dies, it is Allah's will; if he lives, it is Allah's will.[3] Saber said that Maranao literature, though scarce, supports this negative and fatalistic attitude which is present in many sectors of the Maranao community. He added that this fatalism is a customary means to conceal the truth that the patient's family lacks resources to afford him medical fees.(Saber 1976:84).To quote him fully,

> To them, death is natural (ganat sa maalom) or the will of God (pasad alahotaala). Suffering can be relieved, but from death there is no escape. So why spend too much for the patient? Why not reserve the money for his funeral expenses? Many sick persons... have died because of this attitude. But oftentimes such fatalistic utterances are a customary means to conceal the truth ... that the patient's family lacks resources to afford him medical fees".

With this observation of Saber on affordability, it could be said that the situation of the people in the PMCs are no different from those in the PCCs, for their fatalism is possibly rooted on one single cause: economic insolvency.

The response on fatalism is followed by twenty-seven or 24.5 percent who say that the changes in the weather or environmental conditions are beyond man's control. Other respondents mention such factors as accidents, inherited diseases or even the idea that interacting with people could not be avoided. This latter view is, indeed, quite true among the Maranaws. Their sick ones, even those afflicted with highly communicable diseases, are not quarantined. The locally given explanation for this is that the other family members do not want to hurt the feelings of the sick person. In fact, respondents reported during the first phase of the study that when some family members would make moves to change the usual arrangements concerning interaction, the sick member would express hurt feelings and say that he is already being condemned to be left alone even if he is still alive. This is known as **damayan** , a cultural predilection wherein the members express

[3] Validated with Ms. Irene Macarambon and Ms. Edna Bobonga, the former a Christian married to a Maranao, while the latter, a pure Maranao herself.

their sympathy not only through words of comfort but through actions, particularly by not trying to avoid the sick person or acting squeamish in his presence. Dr. Luis Lacar attributes this damayan to the value of familism among the Maranaos. (Lacar n.d.:25). To quote him,

> "Among minority groups such as the Maranao and Maguindanao Muslims of southern Philippines, familism is also known to be as vibrant if not even more so as among other Philippine ethnic groups. The notion of *damayan, tinabangay, or awidan are social forces that galvanize the centrality of familism and the concomitant privilege-obligation syndrome attached to this value.* " (Lacar n.d.:25).

There are some respondents who believe that illnesses could be avoided and they have indicated some important steps that a person could take to avoid these. (See Table 8).

Of those who departed from the "No " response, among the PCCs, twenty-nine or 43 percent say that one can avoid illness by taking good care of oneself. In other words, becoming and staying healthy involves a conscious effort concerning one's health attainment and preservation. Of course, this has to be taken within the context of the culture, especially religion; it is the perception that although man can prevent illness, this is limited by the will of God.

Twenty-five or 37 percent recommend praying to God/Allah for good health. As He wills everything, He could will good health for anyone who storms Him with supplications.

Nine or 13 percent say that taking nutritious food will surely prevent diseases.

Five or 7 percent say that following doctor's advice will surely dispel diseases. The implication is that people tend to circumvent doctor's orders, that is why minor illnesses become major ones, or simple afflictions become complex.

Among the PMCs, twenty-five or 68% say that taking care of one's self is a must to avoid illnesses. Nine or 24% say that praying to God or Allah for good health could prevent illnesses. Only one respondent mentioned the need to follow the doctor's orders while none at all answered in terms of eating nutritious food.

To summarize the whole presentation, to the PCCs, health consists of three underlying factors: Normal Behavioral State, Normal Psychophysical State, and Normal Psychobehavioral State.

To PMCs, health consists of four underlying factors, namely: Normal Physical

Table 8. Most Important Steps to Take to Avoid Illness

Reasons for Believing that Illness can be Avoided	Christian F	Christian %	Muslim F	Muslim %
Nutritious food	9	13.2	-	-
To take care of one's self	29	42.6	25	67.6
Pray to God for good health	25	36.8	9	24.3
Follow traditional approaches to health	-	-	-	-
Follow doctor's advice	5	7.4	1	2.7
Others	-	-	2	5.4
Total	68	100.0	37	100.0

State, Normal Behavioral State, Normal Psychological State and Absence of Symptoms.

In addition, according to PCCs, illness consists of four underlying factors, namely: General State of Ill-being, Abnormal Physical Appearance, and Presence of Internal Symptoms.

For the PMCs, four underlying factors of illness are: Abnormal Physical Appearance, Abnormal Psychological State, Presence of Symptoms and Dormant Behavior.

Both the PCCs and the PMCs generally believe that illnesses could not be avoided because God wills everything and if the patient dies, it is God's/Allah's will.

A few in both the PCCs and the PMCs believe that illnesses could be avoided by a person's conscious effort of attaining and maintaining one's good health.

Discussion

Health is **emically** defined in general by both sets of respondents as composed of factors like positive behavior, positive psychological state and positive physical appearance. Illness, on the other hand, has been defined as composed of factors like abnormal physical appearance, presence of symptoms, and the like. The manner their definition fits the etic definition is quite interesting. Guided only by their five senses, rural folk from both the PCCs and the PMCs have come up

with a definition wrought out of their own peculiar cultural circumstances which sometimes even tended to oppose one another in specific forms but which, when brought to a higher level of generalization, manage to appear similar. In fact, their similarities reach the point that their definition of health comes in close correspondence with the WHO's general definition of health (which is an etic definition) that health is a state of complete physical, mental and social well-being.

Erasmus explains how rural folk arrive at their definitions through their experience in much the same manner that modern science does, to wit, "...the nature of inductive inference that underlies systems of explanation comes down to a 'matter of experience and not of reason', and that all systems of thought rest on increments of probable rather than absolute knowledge". In all belief systems, says Erasmus, there is a reliance on 'posits' that are more likely to be true since "posits are the instruments of action", and the objective of knowledge is action. Erasmus then shows how the folk medical systems he observes seem to operate, as do the scientific, in just this fashion. Knowledge is thus always empirically relative and always functions within the boundaries of certain limitations and variations. (Landy 1977:264-265).

The implication of this for the purveyors of modern medicine is that if they want 'converts' out of the rural folk, these people must have positive experiences in their encounters with modern doctors, nurses and paramedical people, and with the medical system as a whole. For example, doctors should not only look at the effects of microbes on body tissues as the only cause of illnesses but that they should consider "...that disorders and diseases dominant are due not to specific pathogens, but rather to economic, social, political and cultural factors. The resultant pathology is manifested in physiological, functional, behavioral and psychological disorders". (Lieban 1974).

It has been previously mentioned that in its present form, the emic definition of health fits with the etic definitions. However, there are certain instances when, in their specific or detailed forms, emic definitions deviate from the etic. Some illness indicators of modern medicine are considered by rural folk as signs of health or without any medical significance for them. For illustrative purposes, two will be mentioned. One concerns fatness. Emic definition of rural folk considers this as desirable, although at a certain point, some respondents indicated uncertainty over the desirability of this condition or of considering this condition as healthy. Different people have different perceptions or definitions of fatness — it could mean flabby fatness to some of the rural folk (obesity to modern science), a condition which is definitely considered as a disease from the etic point of view of modern

medicine, or it could mean plain overweight. From the emic point of view, overweight or plumpness is all right, and may even be a status symbol which advertises that one could afford good food. Even to modern medicine, it is not outrightly a negative condition, except in cases when it could wreak havoc on the heart and cause high blood pressure.

Another condition which was very much absent from the responses of the respondents is parasitic infection. There was no mention whatsoever about distended abdomens as a sign of parasitic infection when the respondents were asked about possible illness indicators during the first phase of this study. Of the many indicators of health or illness for children mentioned by the rural folk, the respondents failed to mention distended abdomen as one of them. Yet, this is quite common as this condition almost always figures in the ten leading causes of morbidity in the five municipalities. The reason for the people not recognizing this condition as unhealthy may well be due to its commonness, that is, it is so common for children in the rural areas to have distended abdomens that rural folk have come to consider it as something normal. Thus, since it is defined as normal and therefore acceptable, people do not do anything to eradicate the illness. Another reason could be the fact that persons afflicted with parasites may still be able in many cases to carry out their normal day-to-day functions without being forced to rest and recuperate. In other words, they are not sick (from the emic point of view) because they are not acting in accordance with the socially prescribed sick role. Perhaps, they are looking for dramatic signs or symptoms like fever or spitting of blood, yellowing of the skin, or drastic decrease in weight, as evident in statements 72 and 74 in Tables 5 and 6, which definitely will force a person to adopt the sick role. (Parsons 1980:78). Related to this are "minor" symptoms wherein an individual can still function but which are actually early warnings of something serious, as in heart disease or cancer. If a person is panting heavily as he negotiates a flight of stairs, or if he has lumps in the body, these could be indicators of a heart ailment or cancer. When do or should persons adopt the sick role?

According to Wolinsky (1980:102), the sick role refers to an institutionalized role-set or pattern of behavior associated with being sick. The sick role concept tells us what type of behavior we should expect from and associate with the sick person. The four aspects of the sick role are: (1) the nonresponsibility of the individual for his or her condition; (2) the exemption of the sick individual from normal task and role obligations; (3) the recognition that being sick is undesirable; and (4) the obligation to seek out competent help.

From the data, there are indications that respondents have culturally con-

structed notions of calling themselves sick. Statement 19 which goes "A person who feels pain and discomfort yet continues doing his work is considered healthy" was regarded with uncertainty by the PCCs (surely leaning, however, towards agreement), but with agreement by the PMCs. This renders support to the view that in these cultures, people postpone calling themselves sick despite manifestations of "pain and discomfort", until, to quote statement 76 "...a person lies down in the mat and is very, very weak", a very dramatic manifestation, which is a recognition or acceptance of the sick role. Mechanic says (in Wolinsky 1980:78) that the assumption of illness behavior and the sick role is much more of a negotiated process between the individual and those with whom he or she interacts and depends on many factors. These are: (1) visibility, recognizability, or perceptual salience of symptoms; (2) the perceived seriousness of symptoms; (3) the extent to which symptoms disrupt family, work, or other social activities; (4) the frequency of the appearance of symptoms, their persistence, or frequency of recurrence; (5) the tolerance threshold of those who are supposed to evaluate the deviant signs and symptoms; (6) available information, knowledge and cultural understanding of the evaluators (number 5); (7) perceptual needs which lead to subjective psychological processes; (8) needs competing with illness responses; (9) competing possible interpretations that can be assigned to the symptoms once they are recognized; (10) availability of treatment resource, physical proximity, and psychological and monetary costs of the action .

In these two communities, the respondents' non-assumption of the sick role might be due to the inability to recognize from the etic point of view certain conditions as the symptoms/signs of illness, like obesity or parasitic infection. Another could be the communities' general poverty. Declaring one as sick and , therefore, freeing one's self from responsibilities could mean the forfeiture of the family's food for the day; or because of scarcity, declaring one's self sick would not do much good because there are scant or no resources for treatment of one's illness. Another possibility is the reluctance on the part of others in a person's circle to let him assume the sick role.

Definitely, a person's assumption of the sick role has policy implications. Parasitic infections might invade the brain; abdominal infections might cause rapid deterioration because of liquid loss; highly communicable diseases might become epidemics or worse, pandemics; degenerative diseases like heart disease, arthritis, may debilitate seriously; and the like. People must know when to assume the sick role and one way to do this earlier is to recognize signs/symptoms, including the "minor" ones. The DOH at the barangay and municipal levels have a very

important role to play by way of information and educational campaigns.

In their definition of health and illness, the rural people seem to perceive both concepts to be obverse of the other. This fact supports Wilson's definition of health as "the absence of symptoms" or disease as that which does not constitute health. According to him, health becomes a residual category, the opposite of disease. (Wilson 1970:3).

One important point raised by the rural folk is the involvement of a person in becoming and staying healthy. Although most responded that illnesses could not be avoided, there were a few who responded that it could be avoided by "going the extra mile", like doing some exercises or taking vitamins. These people who believe in man's capacity to change things have the trademark of the modern man and they ought to multiply in number. According to Inkeles, the outstanding characteristics of a modern man are:(1) openness to new experience both with people and with new ways of doing things; (2) the readiness for social change which refers to the acceptance of changes in social organizations such as greater political participation by wider segments of the population, increased social and physical mobility, fuller opportunities for women, freer relations between superior and subordinate and between young and old; (3) disposition to form or hold opinions, awareness of the diversity of attitude and opinion around him and putting a positive value on variations in opinion; (4) being more energetic in acquiring facts and information on which to base opinions; (5) time consciousness; (6) possessed of a sense of efficacy which would express his confidence in his ability, alone and in concert with other men, to organize his life so as to master challenges ; (7) interest in carefully planning affairs in advance; (8) calculability or trust in a reasonably lawful world under human control; (9) valuing technical skills and accepting it as a valid basis for distributing rewards; (10) high aspirations for education and occupation; (11) awareness of, and respect for, the dignity of others; and (12) understanding production. (Inkeles 1974: 21-25).

According to Inkeles, those who come from very traditional backgrounds and received little schooling can, under the right circumstances, become modern. The onslaught of mass media that reach even the hinterlands, a person's employment in a factory, or even the very presence of a factory in the midst of a gessel-schaft kind of community, and the convergence of people from far and wide in a particular place (a process generally termed urbanization) are examples of circumstances that provide opportunities for modernization.

Another writer, Everett Rogers, as quoted in Woods (1975: 17-19) has expounded the concept of modernity in terms of attitude or behavior toward innova-

tions. He said that some people adopt innovations sooner than others. Once an innovation is made available to a particular group the process of adoption proceeds from individual to individual. And because different people have varying motivations, values, vested interests, and predisposition to change, some will adopt the new practice sooner than others. The *innovators* are those who first adopt a new practice; early *adopters* are respected individuals who have greater vested interests in the local cultural traditions than innovators; the *early majority* are less likely to hold positions of leadership and will ponder carefully the consequences of adoption prior to taking action; *the late majority* adopt just after the average member and are characterized as skeptical people who need peer pressure for them to go along with the rest of society; and the *laggards* who are the more traditional members of the group who tend to be suspicious of any kind of change.

Within the context of the foregoing literature, the majority of those who responded that illness could not be avoided, may not have shown modernness in attitude or behavior. They may have remained fatalistic. They leave to God conditions like health and do nothing to enhance whatever God decides to do about it. They leave to God conditions like illness and wait for his intervention.

Implications/Recommendations

From the findings in this research are some implications/recommendations which the DOH and the local government units (municipal and provincial levels) may find useful in policy- and decision-making in their respective levels of governance.

1. 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. Fever in a child, which traditionally people dismiss lightly, may already be dengue fever in progress.

In this regard, a massive information and education campaign about illness episodes 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.

2. Most of the specific/emic indicators for health that respondents identified do correspond with medical science's etic indicators. These are good launching pads for a more intensified campaign for people to maintain and attain health through preventive medicine.

In relation to the respondents' definition of illness, fatness is considered unhealthy by many, yet they do not know what to do about this while others are not sure if this condition is unhealthy. They also may not know the possible pathological consequences of this condition. Thinness also is one such condition. More information/education on the etic indicators of health and illness are needed to be carried out by the rural health units and the barangay health centers .

3. Findings show that majority of the rural folk believe that illnesses could not be avoided. Preventive medicine will have to be promoted more intensively in this regard. However, according to Erasmus, preventive medicine is more difficult for rural folk to accept because its explanations do not jibe so much with folk explanations, especially about the etiology of diseases.

One finding which could make the campaign for preventive medicine easier is the recognition of the fact that rural respondents themselves know that they should take an active part in becoming and remaining healthy. This could be a very effective entry point.

The emphasis on preventive medicine as a thrust could be made by DOH. Since the problem with preventive medicine is its being a cognitive and an attitudinal problem, a policy of national application is important , which will adopt programs and services through strategies that will change people's perception and attitude toward the avoidability of illnesses.

4. Findings show that respondents are very poor. Poverty is the roat cause of many problems of which health is no exception. Helping rural folk to have access to resources that will upligt their social and economic conditions will definietly empower them to prevent the occurence of illnesses in the family. One such is health insurance, but it should be tailored to the poor people's capacity to pay. Another is the propagation of herbal medication, a time-tested practice of alleviating and treating variegated illnesses in the rural areas.

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Bibliography

Ackerknecht, Erwin H.
1946 "Natural Diseases and Rational Treatment in Primitive Medicine". *Bulletin of the History of Medicine*. 19:467-497.

Alland, Alexander, Jr.
1977 "Medical Anthropology and the Study of Biological and Cultural Adaptation" in Landy, David ed. *Disease and Healing: Studies in Medical Anthropology*. New York: MacMillan Publishing Co.,Inc.

Blalock, Hubert M.
1960 *Social Statistics*.. 2nd ed. U.S.: McGraw-Hill Book Company.

Bonifacio, Manuel Flores.
1979 "The Disease Model as a Determinant of the Health Care Organization Model". Presented in a Workshop on Psycho-Social Factors Affecting Health: Assessment, Clarification and Utiliation. Bellagio,Italy, 6-10 November , WHO.

Burton, Erlinda, Ph.D.
1982 *The Impact of Modern Medical Intervention on the Agusan Manobo Medical System of the Philippines*. Unpublished doctoral dissertation. University of Pittsburgh.

Burton, Linda M.
1985 "Choice of Curative Resorts: Coping with Illness among the Manobo" in *Philippine Sociological Review*, Vol. 33, N0. 1-2.

Campos, Paulo C., M.D., ed.
1975 *Comprehensive Community Health*. University of the Philippines.

Dubos, Rene.
1980 "The Mirage of Health" in Mechanic, David, ed. *Readings in Medical Sociology*. New York: The Free Press.

Campos, Paulo C., M.D., ed.
1975 *Comprehensive Community Health*. University of the Philippines.

Carroll, John J.
1970 *Philippine Institutions*. Manila: Solidaridad Publishing House.

Clements, Forrest E.
1932 *Primitive Concepts of Disease*. University of California Publications in American Archeology and Ethnology. 32:185-252.

Cultural Research Center, Silliman University.
1968 *Sorcery in a Folk Medicine Framework on Siquijor Islands: A Preliminary Report (Abstract)*. PSR 16 (Jan-Oct):197-198. As quoted in Valencia and Palo.1979. "Community Responses to Mental Illness and Utilization of Traditional Systems of Medicine in Three Selected Study Sites in MetroManila:Some Implications for Mental Health Planning" in PSR 27 (1979):103-115.

Denzin, Norman K.
1989 *The Research Act: A Theoretical Introduction to Sociological Methods*. Englewoods Cliffs. New Jersey: Prentice-Hall.

Dubos, Rene.
1980 "The Mirage of Health" in Mechanic, David ed. *Readings in Medical Sociology*. New York: The Free Press.

Duff, R.S., Hollingshead, A.B.
1968 *Sickness and Society*. New York:Evanston, and London: Harper and Row.

Dunn, Frederick L.
1976 "Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive Systems" in Leslie, Charles, ed. *Asian Medical Systems: A Comparative Study*. Berkeley, Los Angeles, California: University of California Press.

Field, David
1976 "The Social Definition of Illness" in Tuckett, David, ed. An Introduction to Medical Sociology. London: Tavistock Publications, Ltd.

Flieger, Wilhelm and Josefina Cabigon
1994 Life Table Estimates for the Philippines, Its Regions and Provinces, by Sex: 1970, 1980 and 1990. HEDP Monograph No. 5. Makati: Health Finance Development Project.

Frake, Charles O.
1977 "The Diagnosis of Disease among the Subanun of Mindanao" in Landy, David, ed. *Culture, Disease and Healing: Studies in Medical Anthropology*. New York: MacMillan Publishing Co., Inc.

Glaser, Barney G. and Anselm L. Strauss
1967 The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Publishing Co.

Hardon, Anita P. *Confronting Illness: Medicines, Self-Care and the Poor in Manila*. Quezon City, Philippines: Health Action Information Network (HAIN).

Hughes, Charles
1968 "Ethnomedicine" in David Sills, ed. in *International Encyclopedia of the Social Sciences.* Vols. 9 and 10. New York: MacMillan Co. and The Free Press.

Kerlinger, Fred N.
1964 *Foundations of Behavioral Research.* New York: Holt, Rinehart and Winston, Inc.

Kidder, L.H., Selltiz, C., Wrightsman, L. and Cook, S.W.
1981 *Research Methods in Social Relations.* 4th ed. New York: Holt, Rinehart and Winston, Inc.

Lacar, Luis, Ph.D., et al.
1982 *Traditional Medical Practitioners in an Industrial City in Southern Mindanao.* Research Note No. 1. CCRD, MSU-IIT.

Lacar, Luis, Ph.D.
no date *Deviations from and Adherences to Familism among Muslims and Christians in the Philippines: A Comparative Sociological Analysis.* MSU-IIT: Office of the Vice-Chancellor for Research and Extension.

Landy, David, ed.
1977 *Culture, Disease and Healing: Studies in Medical Anthropology.* New York: MacMillanPublishing Co., Inc.

Lewis, Aubrey
1980 "Health as a Social Concept" in Mechanic, David, ed. *Readings in Medical Sociology.* New York: The Free Press.

Lieban, Richard W.
1974 "Medical Anthropology" in Honigman, John J., ed. Handbook of Social and Cultural Anthropology. Chicago: Rand

McNally College Publishing Company.

Lieban, Richard W.
1977 "The Field of Medical Anthropology" in Landy, David, ed. Culture, Disease and Healing: Studies in Medical Anthropology. New York: MacMillan Publishing Co., Inc.

Messing, Simon D.
1976 "Emics and Etics of Health Problems in Ethiopia" in Grollig,S.J., Francis X. and Harold B. Haley. *Medical Anthropology*. The Hague, Paris: Mouton Publishers.

Mish, Frederick C.
1990 *Webster's Ninth New Collegiate Dictionary*. Springfield, Massachusetts, USA: Merriam- Webster, Inc.

Morgan, David L.
1993 "Qualitative Content Analysis: A Guide to Paths Not Taken" in *Qualitative Health Research*. Sage Publications, Inc., Feb. 1993, Vol. 3, #1.

National Statistics Office
1990 *Census of Population and Housing. Report No. 2-481: Lanao del Norte (Population by City, Municipality, and Barangay)*. Manila, Republic the Philippines: NSO.

Norilla, Manuel C.
1971 *Implications of the Traditional Beliefs and Practices Regarding Illness, Death and Burial for Elementary Education in AlangAlang, Leyte*. Tacloban: Divine Word University. Master's thesis, MA Education.

Olano, Bonifacio, M.D.
Provincial officer
1991 An interview on the relevance of social science research on health. September 10, 1991 at Tubod Provincial Hospital

Compound.

Paul, Benjamin D.
1977 "The Role of Beliefs and Customs in Sanitation Programs" in David Landy, ed. *Culture, Disease and Healing: Studies in Medical Anthropology.* New York: MacMillan Publishing Co., Inc.

Pfifferling, John Henry
1976 "Medical Anthropology: Mirror for Manking" in Grollig and Haley. *Medical Anthropology.* The Hague, Paris: Mouton Publishers.

Quintanilla, A.
1976 "Effects of Rural-Urban Migration in Beliefs and Attitudes Toward Disease and Medicine in Southern Peru" in Grollig, S.J. and Harold B. Haley, eds. *Medical Anthropology.* The Hague, Paris: Mouton Publishers.

Reich, Warren T., editor-in-chief
1978 *Encyclopedia of Bioethics.* Vol. No. 3. New York: Free Press.

Risse, Guenter B.
1978 "History of the Concepts" in Warren T. Reich, *Encyclopedia of Bioethics.* Vol. No. 3. New York: Free Press.

Rurrmel, R.J.
1970 *Applied Factor Analysis.* Evanston: Northwestern University Press.

Saber, Mamitua et al.
1961 "The Maratabat of the Maranaw". *Philippine Sociological Review.* Vol. 3, 1961.

Sills, David, ed.
1968 *International Encyclopedia of the Social Sciences*. Vols. 9 and 10. New York: MacMillan Co. and The Free Press.

Tan, Michael L.
1987 *Usug, Kulam, Pasma: Traditional Concepts of Health and Illness in the Philippines*. Quezon City: AKAP.

Tuckett, David, ed.
1976 *An Introduction to Medical Sociology*. London: Tavistock Publications, Ltd.

Valencia, Luzviminda B., Elizabeth R. Ventura, Consuelo J. Paz and Adelina Ortega
1986 "Society and Leprosy: A Philippine Experience" in *Philippine Sociological Review*. Vol. 34, Nos. 1-4.

Valencia, Luzviminda B. and Ma. Erie M. Palo
1979 "Community Responses to Mental Illness and Utilization of Traditional Systems of Medicine in Three Selected Study Sites in Metro Manila: Some Implications for Mental Health Planning" in *Philippine Sociological Review*. Vol. 27.

Wilson, Robert N.
1970. *The Sociology of Health: An Introduction*. New York: Random House, Inc.

Wolinsky, Frederic D.
1980 *The Sociology of Health: Principles, Professions, and Issues*. Boston, Toronto: Little Brown and Co.