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An Anthropological Study on the Health Seeking Behavior of Tomboy, *Bakla*, and *Minamagkit* From Mountain Province, Northern Philippines

Jennifer Curry Josef

ABSTRACT

This paper explores the health situation and health seeking behavior of tomboys, *bakla*, and *minamagkit* from Mountain Province. *Minamagkit* can be translated as "like a lady" referring to a person whose biological sex at birth is male, but whose gender identity and expression is female. The research objective is to document and analyze the general health situation of these groups and their sexual and reproductive health seeking behavior, using a gender and culturally sensitive approach. The research also employed the analytical lenses of intersectionality, critical medical anthropology, and ethnomedicine. Using intersectionality, the health situation and health seeking behavior of the tomboys, *bakla*, and *minamagkit* were analyzed taking into consideration the various dimensions of their identity such as gender, sexuality, ethnicity, indigeneity, socio-economic class, geographic location, culture, etc. The analytical framework of critical anthropology and ethnomedicine, i.e., using Western biomedicine, popular and folk medicine, were employed

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to arrive at a more nuanced understanding of the health seeking behavior. Like the general population in Tadian, Bontoc, and Sagada, the *minamagkit*, *bakla*, and tomboy key informants commonly rely on the popular and folk sectors of ethnomedicine. The popular sector includes strategies employed by the family and other significant social networks which are not part of the medical profession. The folk sector includes strategies employed by "nonprofessional" indigenous healers. Results suggest that the socio-economic status, gender/sexual identity, indigeneity and geographic location of residence, and the general situation of the health infrastructure in the Philippines and Cordillera significantly impact on the poor health situation and health seeking behavior of the tomboys, *bakla*, and *minamagkit*. The project consists of two parts. The first phase is the research on the health and well-being of the tomboy, *bakla*, and *minamagkit*. The second phase consists of sexual and reproductive health seminars, and providing medical tests related to cardiovascular, respiratory, sexual, and reproductive health.

Keywords: ethnomedicine, medical anthropology, lesbian and gay health, sexual and reproductive health, indigeneous peoples health

BACKGROUND

The Cordillera Administrative Region (CAR) is home to various indigenous peoples (IP) groups which are now collectively referred to as *Igorot* (Scott, 1962). Since 2016, I have conducted fieldwork in several *ili* or villages in three municipalities in Mountain Province in the northern Philippines, namely, Bontoc, Sagada, and Tadian.

Mountain Province is known to have a high incidence of people with non-heteronormative gender and sexual identities across generations. Anecdotal accounts point to the perceived openness and accepting attitude of the general community towards tomboy, lesbian, *bakla*, gay, and other non-heteronormative genders and sexualities. In fact, the *bakla* in Bontoc Province have even coined their own term, *minamagkit*, to refer

to themselves. *Minamagkit* comes from the Bontok word *magmagkit* which means a "young lady" or "maiden." The label *minamagkit* was adopted to refer to a person who is not a "young lady" or "maiden" as their sex assigned at birth is not female, but whose gender identification is female (Josef, 2020).

I have been conducting fieldwork in Mountain Province since 2016. I have documented a number of cases of individuals disclosing feelings of depression on account of their dire financial situation, aggravated by the issues relevant to their non-heteronormative identity. A couple of them admitted contemplating and even attempting suicide. I encountered three cases of tomboys with breast or cervical cancer, all of whom did not seek medical intervention after the initial diagnoses.

Moreover, I encountered one suspected case of punitive rape, with the survivor manifesting what can be described by Western biomedicine as symptoms of a form of psychological disorder. I say "suspected" case of punitive rape because the rape was not established. The said tomboy exhibited psychological issues after a night of heavy drinking with several young men who visited their village. After the drinking incident, the tomboy who was then in her mid-twenties was never the same. She allegedly confided to one of her tomboy friends that she was raped during the fateful drinking session. Soon after that incident, she started keeping to herself, became very quiet, stopped taking showers or performing even basic personal hygiene. She was last seen approximately 4 years ago, walking in the direction of the more remote mountain areas in the province. The family and community have organized search missions and performed indigenous rituals for her safe return. However, she has not come back home and is presumed dead.

Since 2019, three among my resource persons have died, all due to non-SARS-COV 2-related causes. Their deaths indirectly contributed to my decision to conduct this health research. The poverty, sense of helplessness, and poor health seeking behavior of the *bakla*, tomboy, and *minamagkit* are the main reasons that prompted me to do so.

I adopted the indigenous constructs and labels of tomboy, *bakla*, and *minamagkit* as the labels gay, lesbian, and transgender, while familiar to the key informants, do not resonate and do not capture their lived

identities and realities. More importantly, I intentionally employed the labels and identities of tomboy, *bakla*, and *minamagkit*, instead of the Western concepts and labels of gay, lesbian, and transgender, as part of my advocacy for vernacularization and indigenization.

Vernacularization involves the process whereby "ideas from transnational sources travel to small communities, are typically vernacularized, or adapted to local institutions and meanings." *Indigenization*, on the other hand, refers to "shifts in meaning—particularly to the way new ideas are framed and presented in terms of existing cultural norms, values, and practices" (Merry 2006). Vernacularization and indigenization address the issue of how concepts become adopted in different communities with diverse cultural contexts.

In legal anthropology, Bohannan (1997) is among those who advocated for understanding categories in their own terms. In the area of gender and sexuality systems in Thailand, Jackson (2000) has been implementing indigenization and vernacularization in his many researches. He has privileged and popularized the local terminologies of Thai gender and sexuality systems such as *phet*, *kathoey*, *ladyboy*, *tom*, and *dee*, over the Western labels such as gay, transgender or trannys, lesbian, femme, etc.

In the Philippines, Manalansan (2006), Garcia (2008), and Josef (2020) have argued that the term *bakla* is not the local counterpart of the Western concept and identity of gay, and that tomboy is not the local equivalent of lesbian. They contend that making a direct correspondence between the Western and local concepts of these non-heteronormative identities is tantamount to making a false equivalence. The Western concepts and labels of gay and lesbian, which are generally sexual identities, denote the sexual object of choice. They do not correspond to the local label and identities of *bakla*, *manimagkit*, and tomboy, which are mainly gender identities. The use of the labels in the vernacular and the corresponding identifications is aimed towards surfacing local identities, which in turn could contribute to a more nuanced understanding of the complexities of the gender and sexual identities in the local contexts.

METHODOLOGY

The research aims to study the health and well-being situation, and health seeking behavior of the tomboy, *bakla*, and *minamagkit* in Mountain Province, and analyze the rationale behind their decisions regarding their health seeking behavior and other health practices. Initially, the focus of the research was the health and well-being of maturing tomboys in select areas in Mountain Province. Based on the initial findings at the start of the study, the iterative research process and principle of inclusivity prompted the inclusion of *bakla* and *minamagkit*, especially in the sexual and reproductive health seminars and the provision of medical tests. The research employed the lenses of holistic health, sexual and reproductive health, medical anthropology, and ethnomedicine, and how intersectionality figured in the narratives.

The project was divided into two parts. One component of the project is the research on the health and well-being of the key informant tomboy, *bakla*, and *minamagkit*. The second part includes the conduct of sexual and reproductive health seminars, as well as providing medical tests related to cardiovascular, respiratory, sexual, and reproductive health.

I selected Likhaan Center for Women's Health, Inc. or simply referred to as Likhaan, as the partner NGO because of their 25 years of excellent track record in organizing, education, advocacy, and provision of primary health, sexual, and reproductive health care. They graciously accepted my request for their help. Likhaan's role in the project is to administer the HIV-AIDS test and the pap smears, as well as conduct public fora on sexual and reproductive health and rights. The public fora were conducted at the Mountain Province State Polytechnic College (MPSPC) campus in Bontoc municipality.

The medical diagnostic tests were conducted in Mountain Province. Several months were devoted to establishing the partnership with the officials of Bontoc General Hospital (BoGH). For some reason, the partnership did not push through at the last minute as we experienced a breakdown in communications—despite all my efforts through emails, letters sent via courier delivery, text messages (short messaging system or SMS), phone calls, and personal visits to the Hospital Director of

BoGH. I subsequently found out that Provincial Board member Henry Bastian filed a case against the Bontoc Hospital Director at the Ombudsman for alleged grave abuse of authority. The case stemmed from allegations of misappropriation of cash donations to the hospital which were reportedly committed from 2018 to 2019 (Hent, 2020).

Fortunately, I was able to immediately put together an alternative arrangement with the officials and staff of the Luis Hora Memorial Regional Hospital (LHMRH). Majority of the medical tests were conducted at the LHMRH. However, since the key informants were very mobile, those who were temporarily based in Baguio or frequently travelled to Baguio availed of medical tests in a private medical facility in Baguio City.

The snowball and purposeful sampling techniques were used to locate and access the research informants. Semi-structured interviews were conducted using a combination of face-to-face and remote key informant interviews using electronic communication gadgets and apps. The transcripts of the interviews were analyzed thematically.

The ethnographic method helped to achieve a more nuanced understanding and analyses of the social phenomena within the specific social and cultural contexts. I spent months alternating my site visits and fieldwork to the three study sites in Mountain Province.

The confidentiality and anonymity of the key informants were maintained during the entire research process. The key informants accomplished and signed free prior and informed consent forms. Since the research topic was on sexual health and does not involve the ancestral domain, development projects, or extractive industries, the National Commission on Indigenous Peoples (NCIP) Administrative Order No. 3, series of 2012 on Free and Prior Informed Consent (FPIC) does not apply.

Gender-Sensitive and Culturally Sensitive Approach in the Research

The research adopted gender-sensitive and culturally sensitive approaches. The gender-sensitive approach I strove for is based on feminist approaches which try to build partnerships based on the principles of connection, and privileges the voices of women and other marginalized sectors (Slater et al., 2001). Feminist approaches privilege

the women's perspective/s, their experiences, ideas, and feelings about their specific social and historical contexts, and not just the technical details of the data analysis (Niha et al., 2016). In the case of this research, a gender-sensitive approach highlights the perspectives and voices of the marginalized sectors of tomboys, *bakla*, and *minamagkit* Bontoc and northern *Kankaka-ey* in Mountain Province.

Cultural sensitivity, on the other hand, includes techniques, methods, and perspectives that recognize the specific socio-cultural contexts, the agency and integrity of the key informants, other research participants, and stakeholders. Cultural sensitivity entails trying to understand the specific or peculiar character of ethnolinguistic groups of specific categories of people.

For example, the Bontok are generally reticent in accepting outsiders and in sharing information with them. Thus, they do not readily agree to participate in research by non-Bontok, and it takes longer before they disclose information to outsider-researchers. Awareness of this characteristic can lessen the frustration in the difficulty in establishing connection and rapport. In some cultures and ethnolinguistic groups, there can sometimes be resistance against outsiders conducting research. Such insights can be helpful in coming up with mechanisms to combat such resistance and facilitate a smooth research process resulting in accurate and meaningful data.

Cultural sensitivity may also involve appreciation that some data-gathering strategies and techniques might not be suitable or acceptable in some contexts. The focus group discussion (FGD), for instance, may not be an ideal or appropriate data-gathering method for the Bontok. The key informant interview (KII) is deemed a more effective technique as the Bontok have been observed to be more willing to talk and share information during one-on-one key informant interviews.

Anthropologist and Bontok studies expert June Chayapan Prill-Brett, herself a Bontok, advised me against using the FGD as the Bontok may not feel comfortable openly sharing information in a group setting, especially on delicate themes such as their gender and sexual identities and practices. I remember several incidents when I encountered serious difficulties in getting answers to my question regarding the Bontok's

sources of information on sexual practices. I asked the question several times, even citing examples to make myself clear. They either ignored my question or talked about other topics, or told stories about livelihood, not related to the question on sexual behavior and practices. When I recounted this experience to my friend who served as my community guide, he half-jokingly said, "That is how we are. The Bontok just do it (sex) but we do not talk about it." I was only able to get responses on sexual practices from the tomboy, *bakla*, and *minamagkit* informants after several months through key informant interviewing.

DISCUSSION

The health infrastructure in the Philippines remains dismal, leaving a huge percentage of the population without quality, affordable, and accessible health services. The costs of medicines for diabetes and cardiovascular diseases are so high that the average citizen could not afford them. Reforms in the health sector such as the Universal Health Care Law and the price regulation on medicines for conditions such as hypertension, diabetes, cardiovascular disease (CVD), chronic lung diseases, neonatal diseases, and major cancers, are welcome developments. However, the fact remains that the majority of Filipinos cannot afford to be sick as they cannot afford medical care. Another complicating factor is the general isolation or long distance from well-equipped medical facilities.

Health Infrastructure in Mountain Province

There are three major health institutions in Mountain Province, namely, Luis Hora Memorial Regional Hospital (LHMRH) in Bauko, Bontoc General Hospital (BoGH) in the municipal capital of Bontoc, and St. Theodore of Tarsus Hospital (StTH) in the town center in Sagada.

St. Theodore's Hospital was established by the Episcopal Church in the Philippines in the early 1900s. The church's mantra of "the cross and the sword" entailed catering to the spiritual, physical, and educational needs of the Filipinos (Dogue-Is, M.J.L., 2013). This was effected through the establishment of St. Theodore's Hospital and St.

Mary's School of Sagada, and the St. Luke's Nursing School and Hospital and Trinity College in Metro Manila.

St. Theodore's Hospital is a secondary hospital which was started in 1903 by Mrs. Eliza Staunton, the nurse-wife of Rev. John Staunton. It was established as a medical facility alongside the St. Mary the Virgin Parish Church and the St. Mary's School, in Anglican-majority Sagada. The hospital was given a license to operate in 1925. St. Theodore currently has a partnership with St. Luke's Medical Center, another Anglican-Episcopalian mission hospital (St. Theodore of Tarsus Hospital, n.d.). Before the Second World War, treatment at St. Theodore's Hospital and enrolment at St. Mary's School of Sagada were totally free of charge. St. Theodore's Hospital and St. Mary's School in Sagada started charging fees after WWII in order to rebuild and recover from the devastation wrought by the war (Longid, 1948).

St. Luke's Hospital was founded in 1903 by Reverend Charles Henry Brent of the Episcopal Missions. It started out as a free clinic in Tondo, Manila and was called the Dispensary of St. Luke the Beloved Physician. By 1910, it had developed into a 52-bed hospital referred to as the University Hospital. It also became a nursing school under the Directorship of Dr. Najib Mitry Saleeby. In the 1930s, its exemplary practice and facilities garnered the hospital various awards and citations. The hospital moved to its present location in Quezon City in 1961. It was renamed St. Luke's Medical Center in 1983 (St. Luke's Medical Center, 2017).

Three of my resource persons from Tadian related that, until the late 1970s, members of the Episcopal church enjoyed free hospitalization at St. Luke's Hospital, free enrolment at Trinity College, and free room and board in the dormitories at the Episcopal's Cathedral Heights complex in Quezon City. The key informants from Tadian were grateful for these services as seriously ill family members were able to enjoy months of confinement at St. Luke's free of charge. They were also welcomed in the dormitory whenever they travelled to Metro Manila for transactions with government and private institutions. These privileges were stopped in the 1980s, coinciding with the reorganization and rebranding of the hospital into the St. Luke's Medical Center in 1983.

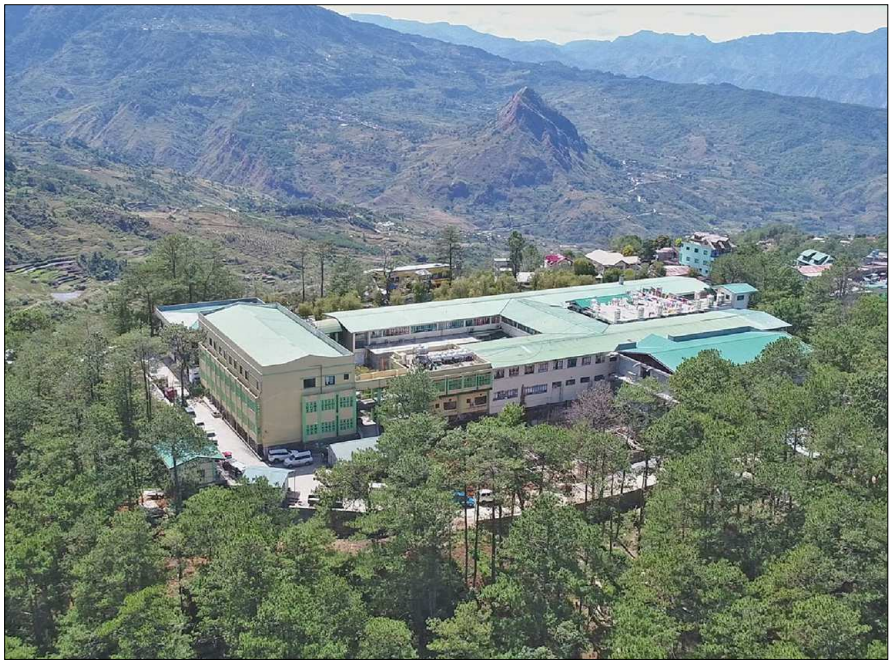

Figure 1
Luis Hora Memorial Regional Hospital, Abatan, Bauko, Mountain Province

Note. Photo from Luis Hora Memorial Regional Hospital Facebook page (https://www.facebook.com/Luis-Hora-Memorial-Regional-Hospital-Official-104885675014444/).

The Luis Hora Memorial Regional Hospital is a 100-bed tertiary hospital. It started as the Mountain Province General Hospital created in 1957 by virtue of Republic Act (RA) 1806. It is located in Bauko, Mountain Province. The hospital was made possible through the efforts of the late Congressman Luis Hora and the mayors of Sabangan, Bauko, and Tadian. In Mountain Province, it is the only tertiary hospital, i.e., capable of more complex medical and surgical interventions (Emory University School of Medicine, 2011). The Luis Hora Hospital is approximately 30 to 45 minutes by bus or jeepney from Bontoc Centro and approximately 1 hour from Tadian, Mountain Province. Public transport is limited, with approximately two jeepneys and two buses daily plying the Tadian-Bauko route.

The Bontoc General Hospital (BoGH) is located in the capital municipality of Bontoc which is also the commercial and educational capital of the province. For the past 5 years, BoGH has been mired in controversies. In 2017, a team from the Department of Health (DOH) found out that the hospital has been using expired reagents in the laboratory and expired medicine in the emergency room and dialysis unit. Consequently, an investigation was conducted on the medical staff of the hospital, members of the bids and awards committee, and the medical supply companies. There have been no updates on the results of the investigation (Osis, 2017).

In 2018, a new Hospital Director was appointed. However, 2 years into her term, several complaints were lodged against the new Hospital Director. She was accused by Provincial Board member Henry Bastian of several cases of misappropriation of donations for the treatment of dialysis patients and for grave abuse of authority (HENT, 2020).

The use of expired reagents and medicine, and the misappropriation of funds further endanger the already fragile state of the healthcare delivery system in the province. Fortunately, there are other positive developments related to Bontoc General Hospital.

In April 2018, Bontoc Gov. Bonifacio C. Lacwasan Jr. inaugurated the newly renovated hospital and pledged to continue working with the Department of Health in improving the health services for the people of Mountain Province (North Luzon Politics, 2018). In 2022, the hospital received a donation of a CT-Scan machine from the Department of Health. These welcome developments can greatly improve the medical care and services provided to the patients.

Intersectionality, Health Conditions and Health Seeking Behavior

Aside from the existing health infrastructure available to the people, it is also important to examine the various dimensions of the identities of individuals and social categories of people. The dimensions of identity saliently affect people's health conditions and decisions. Thus, this research employed the social concept of intersectionality. Intersectionality refers to the simultaneous and interconnected influences of race, socio-economic class, religion, gender, sexual identity, migration status, physical ability,

etc., as well as the resulting forms of resistance to discrimination, stigma, oppression, misogyny, homophobia, etc. (Crenshaw, 1991). Intersectionality is, therefore, deemed integral in understanding the health situations and health seeking practices of the tomboys, *bakla*, and *minamagkit* key informants in this study.

Traditionally, the northern *Kankana-ey* and Bontok have been predominantly engaged in labor-intensive agricultural work. After the end of WWII, there was a gradual shift to more sedentary economic activities such as office work mainly in government agencies, small retail trading, transportation, and jobs related to tourism. Today, the major economic activities in the province are generally related to ecological and cultural tourism.

From a traditional diet of generally low sugar and low salt, and with a predominantly plant-based source of protein, the diet of the general population can now be described as consisting of high sugar, high salt, high fat, and predominantly animal-based protein sources. The new diet and the more sedentary lifestyle have contributed to the high incidence of cardiovascular diseases (CVD) among my resource persons and their family members. There is a high incidence of diabetes, high blood pressure, heart ailment, and upper respiratory diseases as well.

I noted the widespread relative poverty, general poor health conditions, and poor health seeking behavior of the majority of my tomboy, *bakla*, and *minamagkit* key informants. All of them come from a poor socio-economic background, and are mostly engaged in the informal sector of the economy, mainly food vending and working in beauty parlors. These specific socio-economic situations affect their capacity to take in adequate and proper nutrition and foster good physical and social well-being. In cases of illnesses and disease, they cannot afford the necessary medical laboratory tests and quality health care.

The socio-economic contexts of the tomboy, *bakla*, and *minamagkit* likewise have a significant effect on their health seeking behavior and access to appropriate and quality health care. Those with chronic age-related diseases such as CVD, osteoporosis, diabetes, osteoarthritis, etc. are hindered by their dire economic situation from maintaining the required regular dosing of prescribed "maintenance medicines" such as

anti-hypertensive medication. When the family's economic resources are not even enough to buy food, "maintenance medicine" is relegated to one of the least priorities.

Three of my resource persons in 2016 have since died. One of them succumbed to complications from diabetes and high blood pressure, and another died of CVD with what was described as a massive heart attack. The third death remains an enigma. Around six more key informants are diabetic and can be considered morbidly obese (with a body mass index or BMI greater than 35).

Framework of Holistic Health and Well-Being

This research adopted the World Health Organization (WHO) definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." It is a sense of overall well-being derived from the social dimensions of work, family, community, and other relations, including psychosocial and spiritual (WHO, 2012). Health, therefore, is conceptualized as not only located in the individual. The WHO elaborates the social characteristic of health by framing health as "a state of well-being or restorative state that is culturally constituted, defined, valued, and practiced by individuals or groups, and that enables them to function in their daily lives" (Alligood & Tomey, 2010).

Health is analyzed from the perspectives of the societal factors that affect the distribution of health resources and threats to health. Aside from physical and biomedical aspects, health involves social and personal resources (Durch et al., 1997). Health conditions are affected by political decisions regarding resources for immunizations, access to care and nutrition, and exposure to environmental conditions and socially produced risks such as poverty and crime. There are reciprocal cross effects between health and the social, economic, and environmental factors. It is therefore imperative to pay close attention to the interactions between biological and social conditions (Winkelman, 2008).

In this research, health and well-being were viewed within the contexts of specific social, cultural, economic, religious, and emotional

contexts. Health seeking behavior, which includes self-medication, practicing contraception, various health and medical regimes, etc.—which seem to be patently individual decisions—are in fact undergirded by social structures and contexts such as religion, politics, economics, cultural history, life span values, kinship, and philosophy of living (Leininger, 2007).

Moreover, the understanding of health and well-being in this research was not limited to Western biomedical health systems and epistemologies. Medical anthropology and ethnomedicine are indispensable analytical frameworks in this study.

Critical Medical Anthropology: Culture as an Indispensable Lens on Health

The concept of culture is fundamental in understanding health and medicine because personal health behaviors and professional practices of medicine are deeply influenced by culture. Medical anthropology underscores not only the individual dimension but also the social, cultural, and structural character of health and health care systems. Medical systems are intricately intertwined with the cultural, economic, social, political, and philosophical systems. The cultural systems model posits culture as being at the crux of all medicine, biomedicine, ethnomedicine, and health care practices (Winkelman, 2008).

Noted medical anthropologists such as Winkelman (2008) and Kleinman (2006) argue for the importance of medical anthropology in health research, and in the development of health policies and programs. They position medical anthropology as the primary academic discipline addressing the interfaces of medicine, culture, and health behavior. They underscore the necessity of integrating the cultural perspective to make health intervention programs more responsive and effective (Winkelman, 2008).

Relatedly, Durch et al. (1997) posit that health intervention programs require culturally appropriate engagements. To maximize the efficacy of programs and strategies, health personnel should understand the cultural systems, health beliefs, and practices in the community. Health involves not only the physical, mental, and social well-being but also the ability to participate in everyday activities in family, community, including work.

It also involves mobilizing personal and social resources necessary to adapt to changing circumstances.

This research adopts ethnomedicine as an analytical framework which posits that health issues should be conceptualized within cultural frameworks. Bannerman et al. (1983) argue that "culture directly affects the manifestations of conditions, their assessment and social implications, and processes of treatment." Ethnomedicine acknowledges the therapeutic properties of medicine while at the same time focusing on the often-overlooked aspects of social, cultural, economic, religious, and emotional effects. Ethnomedical analyses show the importance of understanding healing from the cultural perspective of the group (Rubel & Hass, 1990).

Ethnomedicine: Health Regimen Integrating Folk Healing, the Popular Sector, and Biomedicine

The ethnomedical perspective is necessary to understand the intersecting and interrelated social arenas of culture and medical activities. The ethnomedical analyses show the importance of understanding health from the cultural perspective of the group, their social dynamics, the social roles of healers, and the conceptual and cosmological systems (Rubel & Hass, 1990).

Medical anthropology and ethnomedicine frame medical activities as intersecting and interrelated in the different social arenas which include: (1) the *professional or biomedical sector*, which consists of the professional biomedical specialists who operate in the Western medical tradition (Kleinman, 1980); (2) the *popular sector* which includes the health seeking strategies employed within the realm of the extended family; and (3) the *folk sector* which consists of nonprofessional healers or folk specialists, who utilize a large body of indigenous knowledge about medicinal plant species, inherited personal skills, and various types of ritual approaches (Gaioni, 2002).

In the Philippines, the folk sector was hitherto associated and described as consisting of non-professional healers. In recent years, however, there have been efforts to professionalize some elements of folk medicine, especially acupuncture and bone-setting and integrate these into the

"legitimate Western professional biomedicine sector." Some non-Western biomedical treatment and/or "folk medicine" have been included in medical health insurance coverage in some countries mainly in Europe and Asia. Thus, they can be viewed as straddling the sectors of biomedicine and the folk sector.

In medical anthropology, it is important to understand that specific cultural and individual contexts profoundly affect health and health seeking behavior of people. In many areas in the Philippines, communities continue to practice a medical regimen that combines folk, popular, and Western medicine, with each having their own set of epistemologies and medical practices.

The professional or biomedical sector, as described in a preceding section of this paper, consists of professional biomedical specialists engaged in the Western medical tradition. Meanwhile, ethnomedicine includes "folk medicine" and "popular medicine" (Kleinman, 1980).

The popular sector or arena is an important aspect of the local health care system. It includes health seeking strategies employed within the realm of the extended family. The popular sector of medical activities includes popular health beliefs which may or may not be based on verifiable evidence. The popular sector includes the contexts of medical health situations and medical decisions (Winkelman, 2008).

On the other hand, the folk sector consists of practices hitherto associated with "non-professional healers or folk specialists, who utilize a large body of indigenous knowledge about medicinal plant species, inherited personal skills, and various types of ritual approaches" (Gaioni, 2002).

The people of the Cordilleras can be said to be engaged in a combination of biomedical, popular, and folk medicine. The Cordilleras has a rich tradition of indigenous healers and ritualists. Cawed (1972) gave accounts of the Bontok rituals called *sup-ok* performed by an *in-ina* or old woman. The *sup-ok* is performed for various cases. For example, the *tot-oya* is the blowing away or begging the departure of the spirit that caused the illness. The *wal-lit* involves deeper contact with a possibly malevolent spirit. For more serious cases, the *papadching* is performed which involves offering a feast, incantations, supplications, etc. to plead

with the spirit to facilitate the positive resolution of the health problem (Cawed, 1972).

Pacyaya (1961) relates the Sagadan practice of communicating with deceased relatives, hoping for the transference to them of the positive attributes of the deceased such as good fortune and abilities. Pacyaya adds that the Ifugao has the *lennawa*, in which the souls of their deceased ancestors are invited to participate in certain rituals. The Ifugao also have the *mumbaki* who is a local shaman, knowledge bearer, and medicine man (Sicat & Codamon-Dugyon, 2016).

In 2001, indigenous health knowledge and practices especially the traditional birthing processes, persisted in many isolated villages in Benguet. In Badeo, Kibungan, a municipality of Benguet, there was continued reliance on herbalists or the *herbolario* or *albularyo*, the *manghihilot* (experts in muscle and bone setting/realignment), and the *hilot* who are usually elderly women who are called to assist in the delivery of babies in remote areas far from medical facilities. Some of these women were integrated into the formal health care structure at the local level as barangay (village) health workers (Palaganas et al., 2001). Thus, the indigenous health knowledge and practices persisted alongside the practice of Western modern medicine.

The findings of Malanyaon and Concepcion (1995) and that of Gaioni (2002) support the observation that Filipinos—and more specifically, those in parts of the Cordillera—employ a combination of strategies from biomedicine and ethnomedicine. This was also true for my key informants in Mountain Province.

Like Gaioni's informants who were residents of Bauko, Mountain Province, some sectors of the population in the municipalities of Bontoc, Sagada, and Tadian, in Mountain Province also practice combining biomedicine and ethnomedicine. They consult medical doctors as well as traditional healers, depending on the ailment. For what is perceived as a predominantly serious medical condition, they seek the help of medical professionals. For what they believe to be minor health issues, they turn to traditional healers and members of the family and the general community who are perceived to have knowledge and/or experience of the same health issue. For very serious illnesses that are deemed incurable,

they resort to performance of indigenous practices and rituals, asking the intercession of ancestors for the sick family member.

In a study on adolescents, Booth et al. (2004) posit that young people with serious health concerns will most likely seek help from familiars rather than from health professionals. The findings of a research study in 2001 suggest that the Filipino family is a very significant micro-world for Filipino adolescents as it provides biological support, emotional security, protection, and status to members (Cruz et al., 2001).

For the tomboy, *bakla*, and *minamagkit* Bontoc and northern *Kankana-ey* key informants, health is a family and community matter. It is the family that decides as to who to consult and what course of action to take for the medical issue at hand.

Poor Health Seeking Behavior

Health seeking behavior is defined as "any activity undertaken by individuals who perceive themselves to have a health problem or to be ill, to find an appropriate remedy and develop protective behaviors" (Basch et al., 2018; Martisen et al., 2016). Studies on Filipino health seeking behavior suggest that Filipinos tend to delay or ignore preventative health-care measures until the illness becomes very evident (Malanyaon & Concepcion, 1995).

A study on young Filipino nurses referenced cultural perspective in understanding health seeking behavior. The researchers posit that the *matiisin* character of Filipinos, which is translated as "long suffering," is a possible factor contributing to the delay in health seeking behavior. They enumerated other well-known dominant character traits of Filipinos which include patience and the capacity to endure hardships and difficulties (De Guzman et al., 2020).

Health seeking behavior among people with cardiovascular diseases (CVD), for example, is complicated by the fact that these diseases generally do not present symptoms. Thus, the patients tend to underestimate the disease and consequently, do not heed the prescriptions of a medical doctor. Instead of regular dosing, they engage in intermittent taking of the prescribed medicine—and usually when the symptoms become severe. Having low incomes further prevents them from buying the correct or

adequate quantity of medicine, causing them to scrimp on the frequency or dosage or fail to buy the prescribed medicine altogether.

Popular Medical Sector and Self-Medication

The most common practice of health seeking behavior falling under the rubric of "popular medical sector" is self-medication. Self-medication is considered the most common form of self-care. Paulo and Zanini (1988) define *self-medication* as "the use of a product for the treatment of a disease or symptom or for disease prevention or promotion of health, without a professional prescription." Self-medication can take the form of consuming commercially available medicine or home remedies such as teas, herbs, and decoctions.

Self-medication is done through various activities which include the following: (a) acquisition without prescription; (b) using old prescriptions to buy medicines; (c) sharing medicines with relatives or members of one's social circle; (d) using leftover medicines stored at home; (e) failing to comply with the professional prescription, either by prolonging it or interrupting it too early or decreasing or increasing the originally prescribed dosage (Paulo & Zanini, 1988).

Self-medication has become a global problem on account of the very high incidence of this practice in many countries in the global south. The reported prevalence rates in some developing countries are as follows: India – 79%, Pakistan – 84%, Saudi Arabia – 78% (Kumar et al., 2013), and 67% in Nigeria (Al Rasheed et al., 2016). Economic, political, and cultural factors have stimulated a constant increase in self-medication worldwide, turning this practice into a major public health problem.

Self-medication poses a serious threat as research studies suggest that it "results in adverse drug reactions, disease masking, inaccurate diagnosis of disease, increased morbidity, drug interactions, antibiotic resistance and wastage of healthcare resources" (Oshikoya, 2009; Gualano et al., 2015; Loyola et al., 2004).

One major factor contributing to the rampant practice of self-medication is the perception that formal health care is unaffordable and inaccessible. The costs of medical consultations, laboratory tests, and

medicine are often beyond the financial capacity of the family. The long distance from the home to the town centers where medical health facilities are located also serves as a barrier to seeking professional medical care. The time spent traveling to the medical facilities in the town centers is often viewed as time spent away from agricultural work or daily wage-work that earns income for the family. In these contexts, resorting to the popular sector mainly through self-medication becomes a very convenient and attractive option.

The most common modality of self-medication reported by the key informants is acquisition of medication without prescription. They related that many drug stores allow them to purchase antibiotics without prescription for as long they purchase the equivalent dosage for 7 days. In other cases, being familiar with the owner or staff in the drugstore or being a *suki* or regular customer affords them the privilege of purchasing medicine without the required prescription. Sometimes, it is the drug store attendant who recommends the medicine.

In terms of factors affecting choice of medication, it is often based on the advice of family, friends, and neighbors who have had positive experiences with the recommended medicine. This is consistent with research findings that cultural social networking was acknowledged to be an important resource in practicing health seeking behavior (Maneze et al., 2015).

Health Situation and Health Seeking Behavior of Tomboy, *Bakla*, and *Minamagkit*

My tomboy, *bakla*, and *minamagkit* key informants reported that they typically delay seeking health consultation and services, until the symptoms can no longer be ignored or when the pain becomes unbearable. Seven of my resource persons have CVD and have been prescribed antihypertensive medication, but not all of them are taking the prescribed medicine.

The tomboy key informants only go to the hospital or consult doctors when the pain is unbearable, usually when the ailment has become severe. One tomboy key informant, Ronalda, delayed her medical consultation until she experienced excruciating pain in her abdomen. Consequently,

what could have been an elective surgery to remove the cysts inside one ovary had they been detected or diagnosed early, became an emergency surgery removing the uterus and the two ovaries. She also risked sepsis, serious complications, or even death.

She tried to convince herself with the thought that, "*Kaya ko pa naman tiisin, hindi naman siguro seryoso ito. Kaya siguro sa* Alaxan (brand name of painkiller) *at pahid-pahid* (application of liniment oil). *Tinakbo ako sa* Bontoc Gen (Bontoc General Hospital) *nung sobrang sakit na. Nagalit nga si doktora. Bakit daw kasi pinatagal ko pa.*" (I thought I could bear the pain, that it was not anything serious. Taking painkiller and applying liniment oil would be enough. They rushed me to Bontoc General Hospital when the pain became unbearable. The doctor was angry and asked why I delayed consulting.)

One reason for poor health seeking behavior of the tomboys, *bakla*, and *minamagkit* is the attitude *takot malaman* or fear of knowing. They claimed to prefer not knowing their health situation and their ailments, as knowing would only make them worry more and worsen their condition. The phrases "*patay kung patay*" ("dead if dead") or "one-time, big-time" were articulated by the resource persons. These phrases pertain to their preference not to be made aware of their health situation and the "willingness" to risk death from, in their case, a major cardiac arrest. One prominent and well-loved *bakla* in the community died after suffering his first massive stroke. After his death, his *bakla* and *minamagkit* friends admitted regret over not being able to convince him to seek medical attention for his heart condition.

Tomboy, *Bakla*, and *Minamagkit* Health Situation and Practices

This research views culture as a significant analytical lens on health. Medical anthropology and the cultural systems models provide appropriate frameworks in understanding culture and its effect on sexual and reproductive health of people with non-heteronormative gender and sexual identities (Winkelman, 2008). Thus health, well-being, health care systems, health seeking behavior (HSB), self-medication, sexual and reproductive health, and other relevant concepts are framed using culture as such a lens.

For the three cases of cancer I documented among my key informants, the socio-economic situation of the family was among the major considerations in deciding whether to seek medical intervention and what course of action should be taken by the family. Unfortunately, all the families of the tomboys with cancer who reside outside the provincial center where the hospitals were located decided not to pursue Western biomedical intervention. The dire financial situation of the families prevented them from considering accessing biomedical interventions such as chemotherapy, radiation, and/or surgery. The distance from the residence to the medical facilities also figured into the decision, as well as not being able to afford to send anybody to accompany the sick family member or patient to the medical facility located in the provincial capital.

All three cases were forced to make do with herbal decoctions, liniment oil or gel, and over the counter (OTC) generic painkillers to ease the pain of the sick family member. For those who are Christians, they intensified their prayers in the hope of getting divine intervention to cure the patient.

Two cases sought the help of traditional healers and resorted to the performance of their indigenous rituals, asking for the intercession of departed relatives and local deity to help heal the seriously ill family member. No further medical intervention was sought after the initial diagnoses of cancer.

This grim scenario is most likely happening in many areas in the Philippines. This situation in which people just give up in the face of helplessness and inaccessibility of health care services is unjustifiable and unconscionable.

Another case was that of a tomboy who had undergone hysterectomy (removal of the uterus) and bilateral oophorectomy (removal of both ovaries) to reduce the risk of ovarian cancer. She was able to avail of these biomedical interventions as she resides near the provincial capital and had relatives who were able to help her with the financial costs of the medical procedure.

There were two cases of tomboys who were diagnosed with uterine myoma. This research helped in the early detection of the myoma, and

the two tomboys were put on medical therapy protocols. A series of follow up and monitoring was recommended for them.

Illness Due to Lifestyle: High Alcohol Consumption and Cigarette Smoking

There is a tradition of winemaking in Mountain Province, as well as in other areas in the Cordillera region. Drinking *tappey* (sometimes spelled *tapuy* or *tapuey*) or the local rice wine is rooted in the culture, often associated with the celebration of indigenous rituals and feasts for their deities, seeking intercession from departed ancestors, healing rituals, and occasions for community bonding and solidarity.

Cawed (1972) mentions *tappey* in relation to the *mangmang* ritual for the seriously ill. Eggan and Scott (1963) made reference to Dalmacio Maliaman's description of a "rock fight" in Bontoc and Sagada. There is an account of a "big feast of rice, beans, meat and *tapoi*" prepared for the village boys after such a rock fight (Eder, 1957). Rice wine is also used as offerings to the deities and ancestors in rituals and feasts.

Over the years, *tapuey* or the locally produced rice wine was replaced by commercially produced hard liquor such as gin, brandy, whisky, etc. Drinking, which hitherto had some attributes of being sacralized, gradually became secularized and gained the status of a vice.

As with adolescents in other areas in the Philippines, there is early initiation and experimentation in drinking and smoking among the tomboy, *bakla*, and *minamagkit* key informants in Mountain Province. Their drinking and smoking would usually peak during the economically active years with incomes they could spend on alcoholic beverages and cigarettes. For some of them, the smoking and drinking would then decline in their early 50s when they started to feel the early effects of the long period of excessive drinking and smoking. For a couple of them, it was too late as they succumbed to complications of diabetes and cardiovascular diseases.

In Mountain Province, gin is among the most popular and bestselling hard liquors. For the older key informants, they would

usually drink their gin neat or straight, or with a chaser of water and local lime or lemon, and iodized salt, similar to that of tequila shots. The most popular gin brand is Ginebra San Miguel. They love their Ginebra so much that they have come up with monikers for their Ginebra bottles and the mixer or cocktails favored by the younger generation. They prefer the smaller sized 250 ml bottles, either "round post" or the "2 by 2" referring to the iconic 4-cornered glass bottle.

The younger generation of tomboy, *bakla*, and *minamagkit* drink the "do it yourself" or DIY cocktail they call "C2, 2 by 2." It consists of the C2 brand of lemon-flavored iced tea in a PET bottle and a 250 ml bottle of Ginebra San Miguel.

The high incidence of cardiovascular diseases (CVD) among the tomboy, *bakla*, and *minamagkit* is partly attributable to their high alcohol and cigarette consumption. Three out of the 12 key informants are heavy cigarette smokers. The daily quantity of cigarettes consumed is from one pack to three packs per day. Two of the *bakla* or *minamagkit* drink Ginebra San Miguel or Red Horse Beer nightly, while four of them are heavy social drinkers, often consuming more than 10 bottles for a group of five drinkers. Among the tomboys, two drink Ginebra nightly, consuming one to two bottles. The rest are social drinkers but are heavy smokers. The heavy drinking, smoking, and high fat, high sugar, high salt diet of most of them increase the likelihood of developing CVD. These cultural health patterns and behaviors can be associated with the concept of "death due to lifestyle" of poor diet, high alcohol and cigarette consumption, lack of sleep, and risky behavior.

For the younger tomboys, *bakla*, and *minamagkit*, they have become consumers of sex hormone products. The internet and e-commerce have become their popular source not only of information but also of goods and services—among which are cosmetic and beauty products, diet pills and mineral supplements, contraceptive pills, and sex hormone products.

Tomboy, *Bakla*, and *Minamagkit* Reproductive Health Seeking Behavior

The tomboys, *bakla*, and *minamagkit* encounter additional problems in accessing both general health services and sexual and reproductive health services on account of their gender and sexual identity.

Reproductive health is conceptualized within the broader framework of overall health or holistic health. Moreover, reproductive health involves the health status over the various stages in the entire lifecycle, and its impact on overall health (Gill et al., 2007). Reproductive health encompasses the reproductive processes, functions, and systems at all stages of life. It likewise affects women's capacity to access and use services during pregnancy and childbirth and achieve good maternal health (Littleton-Gibbs & Engebretson, 2012).

Good reproductive health denotes people can have a responsible, satisfying, and safe sex life, and that they have the capability to reproduce, and the freedom to decide all aspects such as if, when, and how often (WHO, 2012; Niha et al., 2016).

Regarding the reproductive health of tomboys, *bakla*, and *minamagkit*, the relevant issues include the non-heteronormative gender/sexual identity vis-à-vis accessing sexual and reproductive health services. For the stereotypically feminine presenting lesbians, one common issue is the heterosexual assumption by health care professionals. This refers to the situation when medical practitioners assume that all patients are heterosexual (Simkin, 1993). Other issues include the perception by non-heteronormative individuals of the medical system and environment as either a safe or unsafe place. This may affect the disclosure of their gender and sexual identity to medical practitioners, with such non-disclosure leading to the possibility of misdiagnoses.

For the majority of tomboys, lesbians, gays, *bakla*, *minamagkit*, and transgender individuals, there are serious problems with regard to bias, discrimination, stigma, and homophobia that profoundly affect their access to general health, as well as sexual and reproductive health services. The socio-cultural context thus provides an important lens and loci in understanding their health situation and health seeking behavior.

Positive health seeking behavior can never be overemphasized as it leads to faster diagnosis, better treatment compliance, and improved health promotion strategies (Mackian, 2003). Health seeking behavior stems from a decision-making process contingent on individual or household behavior, as well as community norms and expectations. This decision-making process is in turn conditioned by several factors such as socio-economic status, state health policies, and cultural attitudes (Olenja, 2003).

Individuals and communities adopt health practices that may either foster or hinder positive health seeking behavior (Choi, 2008). Culture is a very significant influence on the health and health seeking practices (Suggs et al., 2010). All these are applicable to the situation of the tomboy, *bakla*, and *minamagkit* in Mountain Province.

Despite the acknowledged openness of the general community in Mountain Province to the tomboy, *bakla*, and *minamagkit*, other aspects such as cultural and personal specificities significantly affect their health seeking behavior, especially regarding sexual and reproductive health.

Figure 2
Young Bakla and Minamagkit in Bontoc Awaiting Their HIV-AIDS Test Results, September 2019

Note. Photo by the author.

Among the factors affecting their health seeking behavior are stigma, shame, age, and other personal circumstances, cultural beliefs, etc. (Bloch et al., 2011). In addition, the unique character of the people in the three municipalities where the research was conducted is another major factor, especially in seeking medical care in the local facilities.

Figure 3 and Figure 4

Students of Mountain Province State Polytechnic College in Bontoc Attending One of the Four Seminars on Sexual and Reproductive Health, September 2019

Note. Photos by the author.

Sexual and Reproductive Health: Issues With Familiarity, Anonymity, Stigma

The situation in such communities is that everybody knows everybody. This can potentially be an advantage in terms of group cohesion, solidarity, and community action. However, it is a disadvantage when it comes to health seeking behavior by community members regarding sexual and reproductive health.

The tomboy, *bakla*, and *minamagkit* key informants in this research were not open to undergoing reproductive medical examination by the local doctors and other medical practitioners. For them, it would be embarrassing and a potential source of shame. Although there are *bakla* and *minamagkit* nurses and medical doctors employed in the local hospitals, the key informants were still wary of seeking medical care from the local medical facilities.

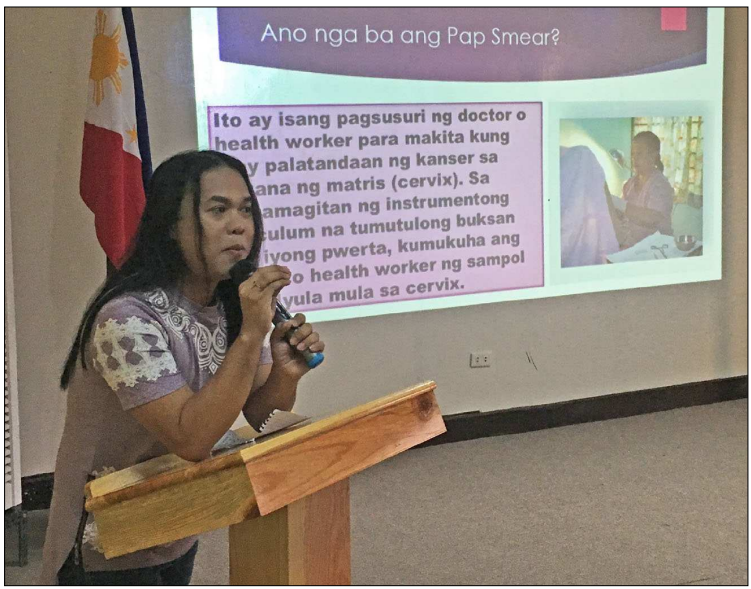

Figure 5

Mark John Abellon of Likhaan Inc. Explaining Pap Smear to the Students of Mountain Province State Polytechnic College, September 2019

Note. Photo by the author.

Despite assurances of protecting anonymity and confidentiality, they were not amenable to be examined by the local doctors. This is the reason why I had to bring non-local clinicians to conduct the HIV test and pap smear. The key informants would rather feel exposed and vulnerable to medical practitioners who are outsiders rather than to the locals. This can be associated with the important specific cultural characteristic of avoidance of losing face. Losing face is very important to the Bontok and Kankana-ey so they go to extra lengths to avoid it.

The common sentiment on consulting local medical practitioners is that, "*Kakilala namin sila, siyempre nakakahiya na magpatingin kami sa kanila. Makikita nila yung* private parts *namin. Basta nakakahiya pa rin. Gusto ko iyong hindi ko kakilala at hindi ko makakasalubong sa* town*, sa palengke, sa kalsada.*" (We know each other, so of course it is embarrassing for us to seek medical services from them. It is embarrassing if they see our private parts. I want someone I do not know and who I won't bump into in town, in the marketplace, on the streets.)

Their fears also include making public possible cases of sexually transmitted infections including HIV. One incident noted was a case of rectal or anal sphincter bleeding gossiped to be caused by "overindulgence in anal sex," when it was in fact a case of hemorrhoids. The informants want to avoid being the subject of community gossip or an object of ridicule.

The tomboy, *bakla*, and *minamagkit* relate their difficulty in undressing or exposing parts of their bodies to health professionals in the conduct of physical examinations. Compared to the tomboys, the *bakla* and *minamagkit* report a less severe aversion to body exposure during medical examinations. The tomboys, on the other hand, are more strongly averse to this. This can perhaps be partly explained by the gender socialization that Filipino women are generally expected and trained to be modest and conservative in exposing body parts.

Another insight from the research is that the *bakla* and *minamagkit* are more open to physical examinations compared to the tomboys. This may have something to do with the physiology of the sex genitalia. The male genitalia are perceived as "more external" while the female vagina is more internal and the procedure and tests for women involving the

vagina can be perceived and deeply felt as intrusive and unpleasant. This is the main reason why the tomboys find it extremely difficult to agree to a pap smear procedure. After weeks and months of back-and-forth negotiations and exchanges of scientific information on pap smear and other gynecological procedures, most of them still backed out of the pap smear at the last minute. After the medical mission, they related feeling conflicted. They are aware of the importance and the need for the pap smear, but they could not bring themselves to undergo it because of the feelings of anxiety and discomfort that even just the idea of the pap smear brings them.

Moreover, the tomboys shared stories of an extreme sense of alienation from their female bodies. The common narrative is that they perceive themselves to be male, but their female bodies belie their gender identity. They feel a disjunction between the female physical body, especially those relevant to their primary and secondary characteristics, and their identification as male. This contradiction is palpably manifested in their sexual identity and practices. Because of the contradiction between sex characteristics vis-à-vis gender/sexual identity, majority of the tomboy key informants practice one-way sex, do not take off their clothes during sex, and experience extreme discomfort with or aversion to gynecological procedures.

Despite the integration of tomboys and their partners or girlfriends in the everyday life of the community, there are still manifestations of unconscious bias or microaggressions. Unconscious bias is very common as these include beliefs about various social and identity groups (e.g., race, gender, age, social class, etc.), which stem from one's tendency to organize social worlds (Fitzgerald & Hurst, 2017).

On the other hand, microaggression has been described as "brief and commonplace daily verbal/nonverbal behavioral, and environmental indignities whether intentional or unintentional that communicate hostile, derogatory or negative racial/ethnic, gender, sexual orientation, and religious slights and insults" (Sue et al., p. 271, 2007). Some groups of people suffer a lifetime of microaggressions that can take a severe physical and/or psychological toll (Banaji & Greenwald, 2013). These sometimes take the form of seemingly minor and innocent

offenses such as insulting comments and jokes, but can potentially lead to anger and depression.

For the tomboy key informants, microaggression often takes the form of jokes or comments like "*Apay, adda lawit mo?*" Loosely translated, it means, "Why, do you have something hanging between your legs?" referring to a penis. The other version is "*Awan, awan lawit mo*" or "None, there is nothing hanging between your legs," again referring to a penis. These phrases, perhaps, meant to elicit laughter, remind the tomboy that he is not a real man because he does not have a penis. This exacerbates the feelings of inadequacy of the tomboy, and the inconsistency between the sex characteristics and the gender identity. Often, the effect is depression, low self-esteem, and a negative self-concept.

Age is another factor affecting access to sexual and reproductive health services. *Bakla* adolescents and young adults who are at the peak of their sexual experimentation and engagement in risqué behavior with tourists and other transient populations complain that they feel uncomfortable and embarrassed to procure condoms or avail of STI and HIV tests from the public medical facilities in the area. Since many of them cannot afford to buy condoms, and if they cannot procure these from the public health facilities, they end up engaging in unprotected sex. The wariness to go to the public health facilities that offer free services is for fear of ridicule, stigma, and discrimination.

Some young adult *bakla* are braver and are able to go to the public medical facilities to ask for free condoms and oral contraceptive pills. They use the contraceptive pills for their do-it-yourself (DIY) non-prescribed sex hormone therapy. The matter of the safety of DIY non-prescribed cross-sex hormone therapy is another matter.

Minamagkit: The Organization of Bontok *Bakla*, Transgenders, and *Minamagkit*

The label *minamagkit* which was coined to refer to the Bontok *bakla* and gays has also been used as the name of their organization, Minamagkit, which was officially founded in 2006. The label and identity *minamagkit*, originally described as "like a young lady," was redefined by the founders of the organization to mean "any gay/*bakla* residing in Bontoc, Mountain

Province with commitment and accountability towards achieving reproductive health in the community."

Starting in 2005, the group organized the annual World AIDS Day parade in Bontoc. Minamagkit and other informal groups of *bakla* in Mountain Province also organized annual volleyball games participated in by *bakla*, gays, and *minamagkit* from the various municipalities. The reasons for the institutionalization of the Minamagkit was mainly to address the sexual and reproductive health issues confronting their sector. They received technical and financial support from UNFPA Philippines.

In the early phase of the existence of Minamagkit, they went through training such as STI/HIV AIDS awareness, AIDS proficiency training, training on condom use, condom distribution, team building, and training in psychosocial processing and peer facilitation. They also implemented activities such as the annual conduct of "gaylimpics"; advocacy campaigns in parlors, bars, and hotels; and clean-up drives in the municipality and Chico River. A couple of Minamagkit representatives are currently active members of the local AIDS council.

During this same period, Bontoc was fast developing as a tourism hub. Aside from its own "Instagrammable" rice terraces, it served as a springboard to the more famous Ifugao rice terraces, the many tourist attractions in Sagada, and the renowned Whang-od, the indigenous tattoo artist or *mambabatok* in Buscalan, Kalinga. Unfortunately, tourism in Mountain Province is not just about the scenic spots and the indigenous culture. It brings with it problems like prohibited drugs, criminality, peace and order concerns, including issues related to sexual and reproductive health.

The cases of sexually transmitted infections (STIs) in Bontoc are on the rise. In 2017, there have been three documented cases of HIV/AIDS in Bontoc municipality. The adolescent and young *bakla* and *minamagkit* in the area have been found to be very sexually active, engaging in risky sexual behavior. The early 2000s was the start of the phenomenon of young boys and adolescents being solicited to perform sex acts with tourists and some locals in Bontoc and Sagada. All these were among the impetus for the founding of the Minamagkit organization in 2006.

In July 2016, Minamagkit became a member of the Local Health Board of the Municipality of Bontoc. The organization became an active partner in the continuous advocacy on sexual and reproductive health in the community. The Minamagkit officers and members refer patients for counselling and treatment at the Bontoc Municipal Health Office.

The original members of Minamagkit who are now in their 40s and 50s, and consider themselves sexually inactive or retired, are alarmed at the risky sexual behavior being engaged in by the young *bakla* and *minamagkit* in Bontoc and in other areas in Mountain Province. Their primary concern is for the current leaders of Minamagkit to address this problem effectively.

CONCLUSION

There is an urgent need to address the sexual and reproductive health of the tomboys, *bakla*, and *minamagkit* in Mountain Province, especially among the youth. The youth are characterized as curious risk-takers including in their sexual behavior—as this is also the time when they explore and are initiated into smoking, drinking, and sex. The influx of tourists in Bontoc, Sagada, and other areas in Mountain Province, has hastened the proliferation of sexual liberal ideologies, and easier "hook ups" facilitated by electronic communication technology and social media apps. There is a lack of open communication and meaningful discussion of sex between parents and children as sex remains a taboo topic in the culture and in the family. All these profoundly affect the sexual practices, and consequently the health conditions, of the tomboy, *bakla*, and *minamagkit*. Limited family and individual income is also seen as a major factor restricting the means to achieve good health and afford proper sexual and reproductive health care.

Any sexual and reproductive health program to be implemented in Mountain Province should take into account the specific contexts of these groups of people. They belong to the marginalized category of indigenous peoples, with most of them also belonging to the lower socio-economic income bracket, without any economic security. The program to be implemented should also consider cultural specificities.

Since part of the proposed target clientele or partners are the youth, sexual and reproductive health programs should likewise take into account the limitations placed on them by virtue of not being considered of legal age under formal laws.

Culture also places limitations on what an adolescent can and cannot do, especially as it relates to sexual and reproductive health. Are there limitations on the teenagers' access to sexual and reproductive health services? All these things need to be given appropriate attention.

Note on the COVID-19 Pandemic

The research was conceptualized before the COVID-19 pandemic. However, the implementation and completion of the research was affected by resulting public health protocols and lockdowns. Thus, the COVID-19 pandemic is an important context of the research that is necessary to factor in. Fortunately, we were able to conduct the reproductive health seminar and medical tests before the outbreak of the pandemic. For the next phase, I was scheduled to travel to Mountain Province in March 2020. My travel permits were all processed and signed, and I was about to travel when a lockdown in the Cordilleras was declared, effective March 10, 2020. All travel permits were cancelled, and strict community lockdowns were implemented.

The community lockdowns associated with the pandemic had devastating effects on the already limited economic resources of the tomboys, *bakla*, and *minamagkit* in the provinces of Bontoc and Mountain Province. Most of the Bontok and northern Kankana-ey key informants are engaged in the informal sector of the economy, mostly in retail vending, small and micro-enterprises such as beauty parlors and shops, and activities dependent on tourism—all of which were hard hit by the lockdowns

There were virtually no tourism-related economic activities, the beauty parlors and barber shops were closed, restaurants and *carinderias* were subjected to various restrictions. Without any available jobs in the community and with businesses closing, even without the government restrictions, very few could still afford to go to the beauty parlors, barber shops, dine out or buy take-out food. This severe economic downturn

brought on by the pandemic had significant negative effects on the health of the people, including the tomboys, *bakla*, and *minamagkit* key informants.

With the tourism industry grinding to a complete standstill, agriculture (i.e., the export of agricultural products to Metro Manila) was the only viable economic activity in the region. People would still eat and need to purchase food items, this time through e-commerce. The vegetable supply chain was transformed with cause-oriented groups facilitating the partnerships between local government units (LGUs), vegetable growers, and local artisans on the one hand, and the cause-oriented groups and buyers in Metro Manila on the other. Through this arrangement, middlemen were eliminated from the process cycle. The end consumers in Metro Manila did not mind so much that the products remained expensive, as the profits went directly to the producers. These new arrangements continue to persist even post-pandemic, although at a much-reduced degree. Nevertheless, the experience taught us that the system can be tweaked. Perhaps the tomboys, *bakla*, and *minamagkit* can continue to explore alternative livelihood activities that emerged during the pandemic instead of limiting themselves to food vending and employment in beauty parlors.

Similarly, this pandemic may have in fact provided an occasion and opportunity to reboot the system and design health programs that are intersectional, culturally and gender sensitive, and hopefully develop a new and more appropriate system and practice of culture of care for all.

IMPLICATIONS

This research is among the first to explore the topic of health of indigenous peoples with non-heteronormative gender and sexual identities. The research did not focus on the psychological health and well-being as Mountain Province, specifically Bontoc, Sagada, and Tadian are deemed very friendly to tomboys, *bakla*, and *mimamagkit*. Mountain Province, especially Tadian, is sometimes referred to as the gay capital of northern Luzon. It is however likely that the lesbians,

tomboys, gays, *bakla*, etc. within indigenous peoples groups and ethnicities in other geographic locations in the Philippines find themselves in very different contexts, which might necessitate a focus on mental health for these groups.

I hope that this research can make a small contribution towards economic and health policies addressing the situation of the indigenous peoples, especially those with non-heteronormative gender and sexual identities. At the same time, I hope it can spur similar health research, especially in areas that are not so friendly to people not subscribing to heteronormativity. Finally, it is my wish that this research can convince other researchers and academics to take on the advocacy for vernacularization and indigenization, especially in gender and sexuality studies.

DISCLOSURE STATEMENT

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