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Reproductive Health Practices of the Buhid Mangyans of Rizal, Occidental Mindoro, Philippines

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Abstract.

The study was conducted to determine the profile of the Buhid Mangyans mothers in Occidental Mindoro; their reproductive health practices; the relationship between the profile of the Buhid Mangyan mothers and their reproductive health practices; and the problems encountered in the reproductive health delivery system among the Buhid Mangyans and Municipal Health Office.

This study employed correlational research design. Sixty households from the three Buhid communities in Rizal, Occidental Mindoro, namely: Sitio Bato-Singit proper, Albunan and Natob were randomly selected for the study.

The Buhids were young and literate with small household size family. The reproductive health practices were categorized into family planning, prenatal care services, labor and delivery, Puerperium and newborn care. They "never" practice pre-natal care and family planning. However, Puerperium and newborn care were "often" practice.

Age and number of children are "not significantly related" to reproductive health practices. However, the number of years spent in formal education show "significantly related". The Buhid women considered the problem in the reproductive health delivery system as "serious". On the other hand, the Municipal Health Office regarded the problem as "moderately serious" in delivering health services.

The study recommends conducting similar study with other IP communities in Occidental Mindoro and correlating other variables such as source of information with their reproductive health practices.
Keywords: Buhid Mangyans, Buhid's profile, Reproductive Health Practices

Introduction

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity.

The International Conference on Population and Development Program of Action states that "reproductive health... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so(www.un.org.,2014).

Infant, child and maternal mortality rates are good indicators of the general health status, as they are affected by a range of factors, most important of which are malnutrition and poor access to health care, which are preventable. These rates continue to be significantly higher among indigenous people compared to the non-indigenous population (State of the World's Indigenous Peoples, 2010).

It is only the last decade that serious attention has been paid to health of woman around the world. Prior to this time, the best available estimates suggest that well over 500,000 women died each year from pregnancy-related causes World Health Organization, 2010); 99 percent of these occurred in developing countries. Almost all of these deaths are completely avoidable with improved standard of care (Seear, 2010).

The Philippines is a culturally diverse country with an estimated 14- 17 million Indigenous Peoples (IPs) belonging to 110 ethno-linguistic groups. They are mainly concentrated in Northern Luzon (Cordillera Administrative Region, 33%) and Mindanao (61%), with some groups in the Visayas area. Health services are ruefully inadequate in their territories.

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RH services in the Philippines continue to fall short of demand. Women, in particular those who cannot afford the services of the private sector, are directly affected as they are not given much options on the RH services available in government health units(Forum For Family Planning Development, 2014).

The eight indigenous tribes of Mindoro have known no other home since prehistory, although their ancestors probably migrated from Indonesia. The tribes, which are referred to by the general term "Mangyan," comprise the Alangan, Bangon, Buhid, Hanunoo, Iraya, Ratagnon, Tadyawan, and Tau-buid. The National Commission on Indigenous People estimates that the Mangyan population is over 100,000 at about 10 percent of the total population of the people who live in Mindoro Island.

The Integrated Development Program for Indigenous Peoples in Southern Tagalog (IDPIP-ST) recognizes that sexual reproductive health is a right in itself and a fundamental component of human rights, right to health and gender equality among all spectrums of society including indigenous peoples. Across the world, the depressing health situation brought upon by societal structurally-rooted factors such as poverty particularly on women and indigenous peoples in developing countries reflect as well the downcast sexual reproductive health conditions of these marginalized sectors (United Church of Christ Philippines-Southern Luzon Jurisdictional Area, 2012).

Because indigenous people are essentially invisible in the data collection of many international agencies and in most national censuses, the disparities in their health situation as compared to other groups continue to be obscured. Thus, there is a need for a study to determine the health status, practices and challenges among the Buhid Mangyans of Occidental Mindoro.

Objectives

The study was conducted to:
1. Determine the profile of the Buhid Mangyan mothers in Occidental Mindoro, in terms of:
a. Age;
b. Number of years spent in formal education; and
c. Number of children.
2. Determine the reproductive health status, in terms of:
a. Crude birth rate (CBR);
b. Crude death rate (CDR)
c. Infant Mortality rate rate (IMR);
d. Maternal Mortality rate (MMR); and
e. Morbididty rate (MR).
3. Determine the Buhid Mangyans' the reproductive health practices, in terms of:
a. Family planning;
b. Pre-natal care;
c. Labor and delivery;
d. Puerperium; and
e. New born care.
4. Test the relationship between the profile of the Buhid Mangyan mothers and their reproductive health practices.

Methodology

The study was conducted in sixty households from the three Buhid communities in Rizal, Occidental Mindoro, Philippines, namely: Sitio Bato-Singit proper, Albunan & Natob were randomly selected for the study. To comply with research ethics protocol, the researchers obtained informed consent from the gatekeepers of the community such as the NCIP, DepEd, LGU-Barangay, Council of Elders and other religious organization. It was conducted on January 2017-2018.

The mothers in each household served as the respondents. They were chosen based on the following criteria: 1) those that had already bore a child; and 2) those who had resided in the area for at least five years.

Survey questionnaires and interview schedule were the research instruments used to gather data for the study. The data gathered was analyzed using descriptive statistics such as frequency, percentage and weighted mean. Pearson Product Moment Correlation was also employed for the test of relationship between variables.

Results and Discussion

Profile of the Buhid Mangyan in Rizal, Occidental Mindoro

Table 1 shows the characteristics of 60 households from the three Buhid communities in Rizal, Occidental Mindoro, Philippines, namely: Sitio Bato-Singit,Albunan and Natob.

Their average age is 29 years old ranging from 18-49 years old, which means that they were still young and can still perform the work requirements in doing reproductive as well as productive activities. Moreover, they have small household size family with a mean number of children of 3.033. Result of the study shows that the Buhids were educated only up to some elementary school levels with a mean of 1.4 years. It could be attributed to the fact that formal elementary and secondary school was established in the early 2000's with a multi-grade level.

The findings corroborate with the study of Declaro-Ruedas (2014) that although the Buhids had undergone formal schooling, but merely at lower level of basic education. The majority did not acquire formal basic education, but they can read and write their names and perform basic mathematical operations.

It also confirms the results of the National Demographic and Health Survey of the National Statistics Office (1998), which revealed that the basic education was the highest educational attainment of many male and women household population in Southern Tagalog.

Table 1.Profile of the Buhid Mangyan.

Variables	SD	Mean	Range
Age	8.375	29.133	26-71 years old
Number of years spent in formal education	2.01	1.4	0-8 years
Number of children	1.506	3.033	1-6 children

Reproductive Health Status of the Buhid Mangyan in Rizal, Occidental Mindoro

Table 2 shows the reproductive health status of Buhid Mangyan from 3 representative areas of Buhids, Rizal, Occidental Mindoro. Sitio Bato-Singit proper, Albunan and Natob.

One of the issues raised about health statistics in the Buhids is their accuracy, completeness and reliability. Different sources sometimes quote different figures. However, the statistical data does not reflect in the vital health indices reported by the Local Government Health Unit to the Provincial Health Office (PHO) regarding the maternal and infant mortality of the Buhid Mangyans. As explained by the Public Health Nurse during interview, No death certificate was issued by the Local Civil Registrar and they cannot officially tabulate the numbers. This was further confirmed by the barangay health worker assigned in the area. She explained that the families involve did not bother to get the papers needed because of financial constraints and the problem of proximity to the Municipal Office. The output was directly given by the para-teacher and volunteer health workers who immersed with the Buhid Mangyans. Nonetheless, the intention of this study is to give a general idea of the major reproductive health needs, problems and concern of the Buhid Mangyans.

The Crude Birth Rate (CBR) in 2013 was 25.29% per 1,000 populations while the Crude Death Rate was 6.89%. Based on these figures, the rate of the natural increase in the Buhids' population for the same year was 18.4 % (25.29 minus 6.89). The Infant Mortality Rate (IMR) was 181.8% per 1,000 live births. This figure surpassed the WHO global MDG for IMR of not more than 50/1000 live births. One of the Millennium Development Goals is to reduce child mortality by two-thirds from 1990 to 2015.

The Philippines is one of 42 countries contributing to 90% of all global under-five mortalities. It is estimated that 82,000 of the 2.4 million live births die before reaching their fifth birthday. Half of these deaths occur in the first 28 days and one-fourth in the first 2 days of life. Millennium Development Goal no. 4 by 2015 will not be met. (Acta Paediatrica, 2011)

On the other hand, the findings of Maternal Mortality Rate was 90.9% per 1,000 live births where the leading cause of death is post partum bleeding. This is a major indicator of a woman's health status. Any pregnancy-related death signifies that the program implementation is poor. However, the refusal of the Buhid mother to seek hospitalization during this emergency, further exacerbate the situation, thus death becomes inevitable.

Maternal mortality should be viewed within the greater context of women's health. Analysis of women's poor health and maternal mortality should consider the overall social, cultural and economic environment. The woman who dies from pregnancy-related causes is more likely to be poor, with low educational status, a multipara and anemic. More likely she comes from an area where: the antenatal services are inaccessible; transport facilities are poor; vital drugs, supplies and equipment are not available and adequately skilled help in labor and delivery is not available. (Philippine National Health Statistics, 2011). In addition, the Maternal Morbidity Rate (MR) was 45.45% in 2013. The common cause of maternal disease is hypertension. Other pregnancy related diseases were not recorded and undiagnosed. This was due to the fact that pregnant Buhid mothers do not practice ante-natal examination.

Table 2.Reproductive health status.

Reproductive Health Status	Rate
1. Crude Birth Rate (CBR)	25.29
2. Crude Death Rate (CDR)	6.89
3. Infant mortality Rate (IMR)	181.8
4. Maternal Mortality Rate (MMR)	90.9
5. Maternal Morbidity Rate (MR)	45.45

Buhid Mangyans' the reproductive health practices

Reproductive health is a universal concern, but is of special importance for women, particularly during the reproductive years. In this study, reproductive health practices were categorized into family planning, pre-natal care, labor and delivery, puerperium, and newborn care.

Pregnant women should have at least four prenatal visits with time for adequate evaluation and management of diseases and conditions that may put the pregnancy at risk. However, result shows the Buhid 'never' practice pre-natal care (mean=1.24). This is due to the proximity of their community to the health centers. In addition, family planning practices (FPP) was also 'never' practice (mean=1.50) by the Buhids. FPP includes proper counseling of couples on the importance of FP will help them inform on the right choice of FP methods, proper spacing of birth and addressing the right number of children.

This is in contrast with the findings of The Allan Guttmacher Institute (2003) that currently married women with an unmet need for effective contraception declined slightly during the 1990s but still is extremely high. In 1998, 50% of women did not want a child soon, or did not want any more children, but were not using a modern method. The 'often' practice reproductive health practices was puerperium (mean=3.67). It is commonly known as the diet, which is one of the most important stages for the mother-child dichotomy, and has been influenced by multiple cultural practices and beliefs transmitted from generation to generation.

The findings show that the Buhid employed traditional beliefs and practices concerning body care, based on culture and taboos, aimed basically at preserving the balance between heat and cold within the body and the balance of the body with the environment.

It is also necessary to have precautions with the head, eyes and ears, to bath with warm water with antiseptic solution such as guava leaves, to avoid exposure to strong air currents, and avoid the cold. In the least severe cases, physical effects like decrease of breast milk production, headache, shivers, *pasma*, fever, aching of the bones, and in the most extreme cases, mental effects like madness. Some forms of protection include covering the head with a cap and wearing wide and warm clothing like sweats and sweaters, in order to avoid the penetration of cold to the body through different routes.

Neonatal health is the key to child survival. Care practices during delivery and neonatal period contribute to risk of mortality and morbidity. It is noteworthy that it is 'often' practice (mean=3.0) by the Buhid mothers, which includes thermal care through skin to skin contact, delaying the newborn's first bath for at least six hours or several days to reduce hypothermia, hyponatremia and hypoglycemia risk leading to death.

Table 3. Reproductive health practices of the BuhidMangyan.

RH Practices	Mean	Inter.
Family Planning Practices		
1. I use contraceptive methods.	1	Never
2. We use Natural Family Planning Methods.	1	Never
3. We attend the Health Education given by the Rural Health Midwife (RHM) or BHWs	1	Never
4. We discuss the number of children we will have.	1	Never
5. I do not use any abortifacients for unwanted pregnancy.	3.51	Often
Overall mean	**1.5**	**Never**
Prenatal Care Practices		
1. I visit a doctor, nurse or RHM for check up.	1	Never
2. I increase my diet on fruits and vegetable.	2.03	Sometimes
3. I visit the clinic if I am not feeling well.	1.07	Never
4. I take vitamins and minerals given by the health workers	1.03	Never
5. I complete my Tetanus Toxoid immunization.	1.08	Never
Overall mean	**1.24**	**Never**
Labor and Delivery Practices		
1. The doctor/nurse/midwife handled my delivery/labor.	1.4	Never
2. I gave birth in a District Hospital/Lying-In/BEmONC .	1	Never
3. My husband/mother or any relatives is/are with me when I give birth	3.01	Seldom
4. I eat small amount of food prior to delivery.	1.95	Sometimes
5. I was not on Intravenous Fluid during labor and delivery.	4.71	Always
Overall mean	**2.14**	**Sometimes**
Puerperium Practices		
1. I wash with water from antiseptic solution (guava leaves).	4.1	Often
2. I breastfeed my baby	4.93	Always
3. I take a bath a day after birth.	4.55	Always
4. I eat nutritious foods like fruits and vegetables.	2.77	Seldom
5. I gently massage my uterus after birth.	1.98	Sometimes

Overall mean	**3.67**	**Often**
Newborn Care Practices		
1. The newborn was placed on my chest immediately after delivery	5	Always
2. Sterilized equipment was used in cutting the umbilical cord.	1.8	Sometimes
3. Nothing was put on the umbilical stump.	4.5	Always
4. I do not use abdominal binder for my baby.	5	Always
5. Baby bath was done 6 hours or more after delivery.	4.55	Always
6. I breast feed initially after 20-60 minutes.	4.95	Always
7. I allow my baby to be immunized.	1.5	Never
Overall mean	**3.9**	**Often**
Grand Mean	**2.57**	**Seldom**
Legend:0.50-1.50=Never;1.51-2.50=Sometimes;2.51-3.50=Seldom;3.51-4.50=Often;4.51-5.50=always		

Bathing the newborn in less than six hours after delivery appears to be a common practice within many cultures. In contrast with a study in Nepal reported that newborn babies are considered dirty since they came out of their mother's womb, so almost all newborn babies are bathed within the first hour of birth (Yaday, 2007). Another study conducted in low socioeconomic settlements of Karachi, Pakistan, revealed that newborns were bathed immediately after delivery as the vernix caseosa was considered "dirty looking" and it was felt it should be removed (Fikree, et al., 2005).

With regards to early initiation of breastfeeding, it is encouraged for a number of reasons. Mothers benefit from early suckling because it stimulates breast milk production and facilitates the release of oxytocin, which helps the contraction of the uterus and reduces postpartum blood loss.

It is an established fact that the suckling reflex of a newborn is at its height 20 to 30 minutes after birth. If the infant is not fed at this time, the reflex diminishes rapidly to reappear adequately 40 hours later. Breastfeeding soon after delivery also has a laxative effect on the meconium. The early evacuation of meconium tends to decrease the reabsorption of bilirubin (the yellow pigment responsible for jaundice). Bilirubin is liberated by the breakdown of cast-off red blood cells present in the intestines. Decreased reabsorption of bilirubin reduces the appearance of jaundice.

The first breast milk contains colostrum, which is highly nutritious and has antibodies that protect the newborn from diseases. Early initiation of breastfeeding also fosters bonding between mother and child.

However, the Buhids use bamboo blades to cut the umbilical cord of their babies and uses ash from coconut shell and oil to help it dry.

Relationship between the profiles of the Buhid Mangyan mothers and their RH Practices

The circumstances in which a Filipino woman today becomes a wife, a mother and a productive person in society are very different from those of the past. Though women's levels of education and participation in the country's development have increased, large gaps remain in their ability to achieve their reproductive goals.

Using the Pearson Product Moment Correlation results shows that age and number of children are 'not significantly related.' However, the number of years spent in formal education is 'significantly related' to their reproductive health practices.

According to Araya (2013), the demographic characteristics higher educational status, being married, having a job, and maternal age at the time of first marriage, first child birth, and age at the time of data collection were related with better reproductive health knowledge and practice. Education exercises a stronger influence in

early and later childhood than in infancy. Economic advantages associated with education account for about one-half of the overall education-mortality relationship. The influence of use of preventive and curative health services as a group of intervening variables is complex and variable. There are countries whose primary health services are so weak that they have no effect on the health of mothers and children; there are also other countries whose health services may tend to accentuate educational disparities because of differential access (Cleland&Ginneken,1988)

Table 4.Relationship between the profile of the BuhidMangyan mothers and their reproductive health practices.

Socio Demographic Characteristics	Coping Strategies		Inter.
	Computed *r*	Critical *r*	
Age	0.016	0.211	Not significant
No. of years spent in formal education	0.255	0.211	Significant
No. of children	0.029	0.211	Not significant

Conclusions

The following are the conclusions drawn by the researchers:

1. The Buhids were young and literate with small household size family.
2. The health, reproductive status was classified as CBR, CDR, IMR, MMR and MR. CBR was at 25.29% and CDR at 6.8%. The IMR was 181.1%, while the MMR was 90.9%. MR was 45.45% per 1000 population.
3. The reproductive health practices were categorized into family planning, pre-natal care services, labor and delivery, puerperium, and new born care. They 'never' practice pre-natal care and family planning. However, puerperium and newborn care were 'often' practice.
4. Age and number of children are 'not significantly related' to reproductive health practices. However, the number of years spent in formal education shows 'significant relationship.'

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