PUTTING ATA LEARNERS' HEALTH KNOWLEDGE AND PRACTICES INTO A CULTURE RESPONSIVE K-12 CURRICULUM

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ABSTRACT: *This study presents the health knowledge and practices of the Ata learners in Canggohob, Mabinay District 1, Mabinay Negros Oriental, both in the elementary and secondary schools. The health and nutrition status of the elementary and secondary learners SY 2016-2018 served as the secondary data while the data from the beneficiaries' level of knowledge on health and nutrition habits, practices on proper personal hygiene and good grooming, and the accessibility and utilization of health facilities were gathered through a survey questionnaire. All of these served as bases for the analysis of the indigenization of health concepts and practices into a culture-responsive curriculums. The statistical tools used to analyze the data were frequently count, percentage, weighted mean and ranking. Finding shows that 51.5 % are male and 48.6% are female, and majority of the respondents belong to the appropriate school age group in their grade level. Findings also show that mostly of the respondents belong to household sizes of 6-9 followed by 3-5 household members, whose fathers are into manual labor as their means of living, and whose mothers doing household chores and dependent on the income of their husbands. Majority of these learners' parents just finished the elementary grade level of education. Results on the beneficiaries' level of knowledge on health and nutrition deficiencies and ailments had a decreasing trend. Furthermore, the study show that provision and utilization of the school health facilities are very irregular. As an output of the study, a five-year IPEd development intervention plan for a culture responsive curriculum is presented*.

Keywords: Indigenous Peoples Education (IPEd), Ata learners, health knowledge, health practices, culture-responsive curriculum, nutrition and hygiene.

1. INTRODUCTION

Good health is integrally linked and starts with a child's education.

Health and Education are human rights. The national mandate is,that the "state shall protect and promote these rights of the people and instill consciousness in them" Promoting health and education is for all. This underscores the fact that health and education go hand and in hand, and essential to all, thus it must be emphasized.

Dep.Ed. adopts the National Indigenous Peoples (IP) Education Policy Framework in line with the Sustainable Development Goal, and in pursuit of the 10-point Agenda of the Department's K -12 Curriculum implementation [1].

Cognizant to this, RA 8371 known as "The Indigenous Peoples Act (IPRA of 1997) [5] and the 2001 United Nations Declaration on the Rights of Indigenous Peoples" advocates the development and promotion of Filipino Cultural Knowledge and Practices where the Department of Education is mandated to provide a culture- responsive curriculum that ensures quality education to all ethnic groups.

Our country, the Philippines is a nation with a rich and various culture. To some extent, this variation of culture has a positive note on which Filipinos are proud of. However, this variation also poses health and education concerns to the different ethnic groups in the school - community setting because of their cultural beliefs, knowledge and practices that never changed. The Indigenous Peoples seem not to have evolved with the modern world and are living in geographically isolated and depressed areas. This mishap on health and education, affect their growth as a person, as a group, as a community and as important players of the society.

Moreover, the Philippine ranked 8th among countries in terms of ethnic diversity. It has 12-13 million estimated population of Indigenous Peoples composed of 80 to 110 ethnic linguistic groups distributed among the 7, 1007 islands resulting in a complex cultural variation in many aspects of life added by its geographical isolation, mostly living in the forests, mountains, remote villages and far-flung underdeveloped areas. Included in their variation are the two recognized Indigenous Peoples of Negros Oriental namely: the Ata of Canggohob, Mabinay Negros Oriental known to be "hunters-gatherers", and the Bukidnons of Bayawan and Basay called as "hill-mountain people" who need health education advocacy amidst socio-economic changes.

Health knowledge and practices is not just power but it can save life too. An urgent task before health and education professionals is to render health services and share health knowledge to those most in need. Public health workers and school health educators in both public and private sectors are in pivotal position for carrying out health education interventions in various settings and various cultures, and bridging the gap between health care and education needs of the school children in the indigenous communities [2]. Relevant to these are the functions of school-community health services and health education. Canggohob Ata community is one setting requiring a responsive health education program for the Ata learners both in the elementary and in the secondary schools. Therefore, there is a need to examine their health knowledge and practices together with the health programs, facilities and services implemented in the school system of the Ata tribal community.

At present, through exploration as who these Ata of Canggohob, Mabinay Negros Oriental are, their education and cultural health integrity have not been fully explored by research except from sociologist of Silliman University, Dumaguete City year back, has never been done.The researcher, through her recent community immersion study, finds it necessary to explore more the Ata learners present health knowledge and practices into a culture- responsive because many have change with the advent of the K – 12

Curriculum, and ASEAN Community reaching them out through Health and Education for All God in line with the Seventeen (17) Sustainable Development Goals, thereby capacitating them to become an important and productive player in this society of ours". Hence, this study is very much relevant to the researcher as the Senior Education Program Specialist in-charge of partnership and networking converging with all health-related sectors in bringing the Ata learners to a higher level of wellness and scholastic performance in the health-education continuum.

This study deals with the health knowledge and practices of Ata Learners in Negros Oriental as basis for developing a Culture-responsive curriculum.

This sought to answer the following specific questions:

1. What is the profile of the Ata Learners in Canggohob, Mabinay, Negros Oriental on the following:
   1.1 Age,
   1.2 Sex,
   1.3 Grade Level,
   1.4 Household size,
   1.5 Parents Occupations,
   1.6 Parent's Educational Background, and
   1.7 Health and Nutrition?
2. What is the respondents' knowledge on health and nutrition habits?
3. What are the present practices of the respondents in term of:
   3.1 proper personal hygiene,
   3.2 good grooming, and
   3.3 health facilities accessibility and utilization?
4. What culture-responsive curriculum can be designed/developed to address health education promotion among the Ata Learners in Canggohob, Mabinay Negros Oriental

2. REVIEW OF RELATED LITERATURE

This section is a review of various publications and related studies that add more strength on the research argument. This presents the theories, concepts and relevant informations related to the study as well as the studies conducted related to the topic that provide support to the development of a culture-responsive curriculum of the Ata Learners in Canggohob, Mabinay Negros Oriental.

Anthro-Historiographic background of the Indigenous Peoples in the Philippines and Negros Island

This research believes the importance of looking into the Indigenous Peoples' historical notes serving as basis in exploring their demographic profile. There is a need for our Indigenous Peoples to feel that they belong to their society where they can be who they are, feel that they are valued for who they are despite cultural diversity. The Philippines is a nation with a rich and variation of culture. To some extent, this variation of culture has a positive note on which Filipinos are proud of. It has more than 80 ethno-linguistic groups distributed among over 7,110 islands resulting in a complex cultural variation in many aspects of life. Adding to the complexity of variation is the geographical isolation of many groups of indigenous peoples, mostly in rural areas – forests, mountains, remote villages, and far-flung islands.

An international survey revealed that about 7.2 million Indigenous Peoples are found in Luzon, Visayas and Mindanao which comprise which comprise 10% of the total country's population. Luzon has the biggest concentration composed of 14 IP groups namely: Ibaloy, Kankaneye, Buntok, Kalinga, Igorots, Mangyans and Negrito or Agta and Aggay. Mindanao has another large group called the Lumads composed of Subanen, Higawnon, Manobo, Tiboli, B'laan, Moro, Maranaos, Maguindanaos, Mamanua, and Tausog. In Negros Island Region, two groups live in the hinterlands namely: the Negritos known as Ata in barangay Canggohob of Nabinay Neg. Or., Ati in Neg. Occidental; and the Bukidnons literally called the hill-mountain people of Bayawan, Basay and Kabangkalan They speak in languages of the Austronesian family [3].

According to Mrs. Ronita D. Capuno, the provincial officer of NCIP, Region VII that Central Visayas has a total of more or less 256, 498 recognized Indigenous Peoples situated and scattered in various parts of the region. The two tribes in Negros Oriental namely the "Negritos" or Atas of Canggohob and "Bukidnons" of Southern Negros totaled to 28, 272 Indigenous Peoples. One hundred twelve families (112) and five hundred seventy-five individuals and Atas of Mabinay who are under the leadership of chieftain Rostom Bornea at the same time the elected barangay captain of Canggohob, Mabinay, Negros Oriental [4]. Traditionally, the Atas in Mabinay, just like other tribes, are known to be called as nomadic people, a hunters-gatherers people, and skilled in jungle survival. The "Negritos" or Ata in Canggohob, Mabinay as well as the "Bukidnon" of Tayawan and Cabatuanan in the southern part of Negros island do not live in isolation from other cultural groups in their respective settlements. They said that this authentic member of the recognized indigenous cultural communities with these dwindling indigenous household numbers seem to indicate that the Negrito and Bukidnon culture in Negros Oriental are doomed to extinction of integration and other contributory factors are allowed to run their natural courses.

Thus, National Commission of Indigenous Peoples (NCIP), in their historical background of Indigenous Peoples in the Philippines reiterated that this particular group have generally fallen behind the mainstream population in terms of socio-economic development, massive exploitation of discriminatory laws and development projects. The promotion of their general welfare and development has become a special concern of government [5]. This historical background adds to the contention of the researcher to delve further on Indigenous Peoples health education concerns as basis in developing/designing a culture-responsive curriculum that suit to their needs in a culturally defined Ata tribal school-community.

Variation of culture poses health education issues to the different ethnic groups in our country because of their cultural beliefs, practices and knowledge that never change. The Indigenous Peoples seemed not to have evolved with the modern world and are deprived, depressed and underserved. They live in geographically isolated and disadvantaged areas.

World Health Organization (WHO) and Public Health [6], declared that health is "a source of everyday life". It should

emphasize the concept of achieving "Health Triangle" through social and personal resources as well as physical capacities. Thus, the researcher in this study attempted to illustrate the dynamic nature of Atas health and education.

Health and nutrition status is described as the individual's optimum level of wellness It is an indicator of their knowledge and practices on health which is multi-dimensional and multi-factorial. Morbidity-mortality rate of Indigenous Peoples are plagued by "numerator-denominator' or a difference in death and population. One of the most prominent socio-economic areas is on Indigenous health which is examined through analyzing a number of health indicators including life expectancy, children mortality rate and standard mortality ratios, and health infrastructure accessibility and utilization. These concepts are of importance to the study because it serves as an eye opener of the researcher to take into account IP learners health status that has an effect on their school performance [7].

Health together with education is wealth. The most important asset of any country is its human resources. The nation's strength depends basically upon a healthy and educated citizenry,

Richmond, C., et.al, [8] in his study on an approach towards understanding the health knowledge and practices of indigenous Canadians concluded that influencing them is through social support activities in order to promote thriving health. This study is essential in identifying and understanding behavioral factors of ethnic groups as it relates to their environment that reflects their health knowledge and practices.

In another, study by Abbot, S., et.al, [9] reveals that decolonizing indigenous knowledge, culture, and personal experiences can be decolonized through writings and group discussions viewing indigenous knowledge and practices related to place and sustainability. Local issues of traffic, air, and water quality were ident Health conditions are affected by local issues of traffic, air and water quality, thus empowering them through a culture-responsive curriculum in the daily teachings addressing prior knowledge, and cultural beliefs that would enhance and raise both health -education awareness based on experiences and cultural practices. This study greatly implied on the development of science and health framework for professional development in the indigenous community.

The researcher also felt the need of looking into studies done on the Ata of Canggohob years back. At present, through exploration as who this Indigenous Peoples of Negros Oriental are, has not been fully explored except from sociologists of Silliman University, Dumaguete City years back. Since then, the effort to know them better, their health knowledge and practices has never been done. It is necessary to know their present concerns because many have change in the advent of time reaching them out through health and education, thereby capacitating them to become productive and important player in this society of ours.

In an Ethnographic study made by Gercony [10] on Cultural Beliefs and Practices of Ethnic Filipinos, revealed that traditionally, pregnancy, child birth, marriage, death and burial are deeply rooted in animism and medicinal plants with their arbularios or babaylan known to be their quack doctors.and it has already been part of their tradition for years. Along this line, the researcher believes that the Atas in the rural school- community setting like the Ata learners in Canggohob, is necessary. These would show the direction of designing an appropriate culture=responsive curriculum in health education.

Accessibility and utilization of health facilities and services as defined by Webster [11], dictionary are the procedures, the infrastructures provided to individuals,the community, the society, the country as a whole, with appropriate intervention. DepEd-DOH Health and Nutrition Manual, [12], further states that this known as the Kalusugang Pangkalahatan and Oplan Kalusugan cover the following: health and nutrition appraisal for individuals /community; health and nutrition counseling follow-through and referral; proper management of communicable and non-communicable diseases in a wholesome and safe environment for a healthful living; and, community coordination for health and nutrition activities. During the Alma-Ata's International Declaration on Primary Health Care, the conference expressed the need for urgent action for the protection and promotion of the health and education to all the people of the world.

As stated in 17 Sustainable Development Goals [13], it is important to deliver health and education by the year 2040 which focus on the following: environmental sanitation; clean air and adequate- safe water supply; proper waste disposal; control of communicable and non-communicable diseases; food and proper nutrition; provision of essential drugs and medical care. These are important concepts that need indigenization of concepts in a culture-responsive health curriculum. As education planners, it is advantageous to look into the health programs implemented in the school system.

More than ever, Oplan Kalusugan in coordination with Kalusugang Pangkalahatan of DepEd.-DOH programs put the concept of teamwork.This is also in line with Memorandum Circular series 2009 signed by the different secretaries and different stakeholders articulating the collective and specific responsibilities of each partner agencies, expanding services to marginalized communities and including Indigenous Peoples in all programs and projects most especially as beneficiaries of the Pantawid Pamilya (4Ps) and GIDA programs of the government.

In this paper, there are many reasons that it is beneficial for health educators and health workers in the school-community setting to utilize cultural knowledge and practices of Indigenous Peoples like the Ata of Canggohob, Mabinay for an effective program implementation and partnership convergence. Using cultural knowledge and practices in coming-up with a well-structured health-education advocacies also helps on the effectiveness of health information, education, communication dissemination [28].

In a recent report by the Provincial 4Ps Coordinator, Mrs. Bella Tse on health and education [14], per inclusion of Indigenous Peoples in the program, 972 IP families with 1,203 learner-beneficiaries enrolled in the Department of Education, are adopted and are privilege to enjoy the two goals and conditionalities focusing on health and education of IP children of the Pantawid Pamilya Pilipino Program here

in our province, Negros Oriental including Ata learners of Canggohob, Mabinay, Negros Oriental. Trinidad, et.al, [15] added that this could be an additional step towards bringing basic health knowledge and practices of school children and serves as vital reference in integrating health concepts in an Indigenous school-community.

Larma [16] further added, in his study on "Asia's Indigenous Peoples Access to Health Education Services" revealed that malnutrition, undernutrition, and infectious diseases account to their disparate health conditions due to lack of access to health services which is a challenge for democratic governance, and of great relevance to this study especially on the accessibility and utilization of health programs and facilities offered to the Ata learners.

Gaps in health education and health care services is of great concern. Epidemiologic and biostatistics evidence on indigenous health shows that there is a systematic gap across the Asian status. Health gap is left unattended resulting to Asian Indigenous Peoples experiencing even poorer health due to lack of access to health education programs and services with the viewers' cycle created by extreme poverty, hunger, malnutrition and access to a culture-responsive curriculum despite the development goals [17].

Das, [18] in his study on Indigenous peoples' access to health service information on HIV-AIDS (Reproductive Health issues) revealed that Indigenous Peoples lack access to health service information especially on HIV-AIDS. .95% of never-married women is knowledgeable about HIV-AIDS and only 12% of ethnic group women is knowledgeable about HIV-AIDS and access to reproductive health education. This is an implication on the Ata community's health knowledge and practices as well as utilization of health facilities and services to address their health - education gaps.

Health Education strategies play a great role in empowering the Ata in Canggohob, Mabinay Negros Oriental.

Indigenizing the curriculum responsive to their culture, in its general sense can show the ability of indigenous peoples to gain general understanding and control over their personal and socio-cultural health knowledge and practices in order for them to take action in improve-ing life situations. It can be constructed as an "influential power" towards designing and developing a culture-responsive health curriculum.

Health together with education is wealth. It is a power to create a functiona citizens and a best investment of the country. Cecilia Lutrell, [19], operationalized a Framework within the generative "power to", "power with", and "power from within". This is exercise in the Department of Education implementing the Indigenous Peoples Education involving the elders in the indigenization of lesson plans for the IP learners.

Sofalvi [20] on "Health Education Films of the Silent Era: A Historical Analysis, have been used for health education empowerment describing pictures from the silent film era that were designed to educate people about health issues on tuberculosis, hookworms, breastfeeding, traffic safety, dental care, and children's health. Thus, these films are very useful especially in marginalized urban areas to present health messages. The importance of mass media to health education has been emphasized as well. The importance of awareness of history of health education has been accentuated to our present, and to our future which gives insights to the researcher in designing a culture-responsive curriculum. organizations.

Nutbeam [21] on his article for "Outcome Classification in Health Promotion and Prevention" categorize a system developing a health promotion model as basis for the basic assumption and promotion which cannot be achieved directly, but is attained through intermediate stages, being understood to be a social learning process taking place on the individual, group or organizational level. It consists of a health promotion measures on infrastructures and services, legal system administrations organization networks, groups, communities, populations and individual. This is done though development of health promoting services combined with advocacy cooperation of organizations, social mobilizations and development of individual skills. Factors influencing health determinants and the health status of the population are to take into consideration with the health promoting services, individual resources and behavioral patterns. This article serves as basis for the researcher in her health education promotion strategies for the Ata learners of Canggohob, Mabinay, Negros Oriental.

3. METHODOLOGY

This study used a quantitative technique utilizing a self- made survey questionnaire that collected information on the respondents' demographic profile, level of health knowledge, practices on personal hygiene and good grooming, and , health service accessibility and utilization. The results served as basis in coming up with an appropriate responsive K to 12 Curriculum.

The respondents of this study were the 100% elementary and secondary Ata learners of Canggohob, Mabinay Negros Oriental, School Year 2017-2018 who were listed in the National commission on Indigenous Peoples (NCIP). This study employed cluster sampling referred to as an area sample applied on a geographical basis selecting Canggohob as a district or block of the cluster sample among the Ata in the Municipality of Mabinay, Negros Oriental. The researcher found it useful in selecting the sample with block occupied by a heterogeneous group of Ata learners. By concentrating on this particular area, the researcher saved time, effort, and money than covering different communities throughout Mabinay. These Ata respondents belong to the third and fourth generation where the early inhabitants of Mabinay mountains believed to have descended from the first stock of Negritos who occupied the Negros Oriental Island during the Pre-Hispanic time and were considered today to be the last of the remaining groups who used to inhabit the hinterlands and outlying areas of Mabinay. They were described as very palliate black in skin color, curly and kinky hair, and thick lips, shirt – statured with undifferentiated characteristics.

This study was conducted in the elementary and secondary schools of Canggohob, one of the 32 barangays of Mabinay, Negros Oriental know to be settlement of the "Negros Ata" tribes of the province of Negros Oriental, and whose ancestral domain and genealogy is being recognized by the National Commission of Indigenous Peoples (NCIP) of this province.

Canggohob, being the setting of this study, is accessible by vehicle through the barangay feeder road where you can find uphill trail traversed by a creek and four strips of rocky narrow valley and hills, many of which are bereft by vegetation.

Located at the center of this barangay and part of its ancestral domain are the school facilities: an elementary and secondary schools of the Department of Education under the Division of Negros Oriental headed by the elementary school principal and secondary school head; and a Barangay Health Unit (BHU) manned by a midwife.

Barangay Canggohob is headed by Hon. Rostom Bornea, the elected barangay captain and at the same time, the chieftain of the Ata tribes, as well as the preacher of their religious beliefs. A few steps from the residence of the Ata Chieftain, is the so-called "make-shift/dilapidated" building – the "Ata Chapel" which serves their place of worship, the place where the council of elders meet for settlement of disputes, meetings and community assemblies with stakeholders including Dep. Ed.

A distance far from Hon. Bornea's residence and part of the Ata ancestral domain are their hunting grounds, Ata's cemetery called "Sam-ang", playgrounds and caves for worshiping their "anitos" and "deities" a place for the "Babaylans" or the "Ata quack doctors" to seek for herbal plants and herbal preparations. These are just walking distance from the elementary and secondary schools of which are a hundred percent Ata enrollees.

Canggohob, then is the territorial settlement of the Ata tribes of Negros Island, and according to Hon. Bornea, it covers more than 4,000 hectares of land area as their ancestral domain.

This study made use a self-made test using the questionnaire in four (4) parts as data gathering tool.

Part I focused on the demographic profile of the respondents in terms of age, sex, grade level, household size, parent's occupations and parent's educational background. Part II was on the level of knowledge of the respondents on desirable health and nutrition habits. Part II1 was on the present practices of the respondents in terms of proper personal hygiene, good grooming, and health facilities accessibility and utilization. Part 1V was the designing/developing of a culture-responsive K to 12 curriculum.

Moreover, in order to validate the content of the questionnaire, based on the researcher's approval of the Memorandum of Agreement (MOA) with the National Commission on Indigenous Peoples (NCIP), measures for content validation were peer and expert validations and review of related literature. A pre-test was conducted in the nearly sitio school Canggohob Elementary School named Lamdas Elementary School with Ata enrollees but not one hundred percent (100%). The English version researcher instrument was translated also tot the native tongue with assistance of the researcher's "LUDABI" dictionary in consultation with the MTB teachers and council of elders in Canggohob, Mabinay Negros Oriental.

Permission to conduct the study through letter address to the Ata Chieftain, the mayor of Mabinay, the Schools Division Superintendent of Negros Oriental the district supervisor and the school heads of Canggohob. A set of criteria was attached in the questionnaire. The criteria were as follows: length, adequacy of items and listed response. Clarity and relevance of question and appropriateness of terms used. Scale of 1-5 where 1 is the lowest and 5 is the highest is used as criteria.

As a pre-requisite of conducting a research study for the Indigenous Peoples, the researcher has accomplished the requirement embodied in the National Commission of Indigenous People (NCIP) laws on Indigenous Peoples Knowledge, Skills and Practices (IKSP) rules of securing permission to conduct such study which started from Pre-FPIC (Free-Prior Informed Consent) conferences to MOA signing. This research is one of the researcher's output of her five-year development plan for the Ata tribal community in Canggohob, Mabinay Negros Oriental.

Data collection by the researcher followed and started at Canggohob Elementary School, and then Canggohob High School. These was a face-to-face interaction with the respondents and followed -up questions were made for clarifications and validations of the answers during the final conduct of the questionnaires to the Ata learners of Canggohob, Mabinay Negros Oriental.

Collection of the answers questionnaire was made. All respondents were personally followed up by the researcher during school visits to ensure high percentage of response rate.

Ethnical Issues (Ethics of Research)

A proposal was submitted to Dep. Ed – Division of Negros Oriental Research Board for intensive examination and verification. The intellectual scrutiny was headed by the Schools Division Superintendent Salustiano T. Jimenez with the Assistant Senior Division Superintendent Lelani T. Cabrera, the two Chiefs (Curriculum and Schools governance operation Unit) Maam Erlin Calumpang and Maam Rachel Picardal, and the head of Planning and Research Division. The paper wias examined closely in view of the educational institutions plans, to wit:

The institution found out that the study is in line with health and education priority and health education services delivery system as the primary concerns.

The study adhered to the principles stating that "the research geared towards improving Ata Learners health and education knowledge and practices enhancing academic performance and health status of learners through a culture responsive K to 12 curriculum integration.

The researcher ensured confidentiality so as to "protect the dignity of the participants and shall not in any way be used as evidence against the respondents "Likewise the researcher also seek for the consent from the National Commission on Indigenous People following the NCIP – FPIC – KSA laws, where a Memorandum of agreement (MOA) signed between the researcher, the NCIP, the agency, the Ata tribal community. The family were informed of the nature and purpose of the study [22].

As the research procedure was found to be at par with the standards and does not undermine ethnical principles, an approval was given by the Research Board to proceed with the research study.

RESULTS AND DISCUSSION

Table 1.1 Age, Sex, and Grade Level of the Respondents

Grade Level		Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12	TOTAL	%
Enrollment	M	21	30	16	13	23	25	28	37	19	19	11	16	9	207	51.45
	F	19	20	14	15	16	25	24	38	11	30	11	16	9	252	48.55
	T	40	50	30	28	39	54	52	75	30	49	22	32	18	519	100.0
Age	5	38													38	7.3
	6		15												15	2.9
	7		18	12											30	5.8
	8		11	8	17										36	6.94
	9			2	4	19									25	4.82
	10					8	23								31	5.97
	11					5	18	29							52	10.01
	12						1	8	21						30	5.78
	13						2	9	18	17					49	9.44
	14					3	2	2	9	1	11				25	4.82
	15								5	2	11	5			25	4.82
	16						1		3	1	5	5	10		27	5.2
	17									1	2	2	11		18	3.47
	18								2	1		3	3	2	11	2.12
	19									2		2	1	2	9	1.73
	20									1			2	2	4	0.77
	21									1				2	4	0.77
	22													1	3	0.58
	Total	38	44	22	21	35	47	50	58	27	31	17	28	14	432	83.24
	%	100	88	73.33	75	89.74	87.04	96.15	77.33	90	63.27	77.3	87.5	77.8	83.2	83.24
Sex	M	20	28	13	10	19	22	27	27	17	16	8	14	7	228	43.93
	F	18	16	9	11	16	25	23	31	10	15	9	14	7	204	39.31
	T	38	44	22	21	35	47	50	58	27	31	17	28	14	432	83.24
	%	20	28	13	10	19	22	27	27	17	16	8	14	7	228	43.93

Table 1.1 depicts the grade level, age and sex profile of the 432 elementary and secondary Ata learners who participated in the survey. Data shows that most of the respondents from kindergarten to grade 12 started schooling at 5 years old to 22 years old.

Moreover, mostly of the respondents belong to their appropriate school age. Only a few of the senior high school learners belonging to 20 years old to 22 years of age or not appropriate to their school age. Furthermore, majority of the respondents started their Kindergarten to Grade 1 when they were 5-6 years old. This relates with the implementation of the kindergarten to Grade 12 to which correlates on Eric Erikson's developmental milestone of school age that is "Industry versus Inferiority", teaching these learners, giving them opportunity to ask questions and explain things. This would allow them to mentally manipulate information. This age group also start from childhood to puberty wherein emphasis on their reproductive system, maturity, creation and enhancement of life, intellectual and artistic creativity should be included in the teaching- learning activities of the spiral progression in the K-12 curriculum implementation [23].

The data above shows that at the scale of 3 to 12 on the household sizes of the respondents, 229 or 53.01 % belong to the household sizes of 6-9; 168 0r 38.89 % belong to the household sizes of 3-5; and only 36 or 8.10 % belong to the household sizes of 10-12. This is an implication that big family sizes with less source of income affects the health and nutrition status of family members

Memorandum Circular series of 2009 signed by the Secretaries of the different stakeholders articulated the collective and specific responsibilities of each partner agency on the implementation of Pantawid Pamilya Pilipino Program expanding its coverage on the inclusion of the Indigenous Peoples providing social assistance through conditional cash

Table 1.2 Household Size of the Respondents

Grade Level	House Size				
	3–5 (f, %)	6–9 (f, %)	10–12 (f, %)	TOTAL	%
Kindergarten	14 (36.84%)	24 (63.16%)	0	38	100
Grade 1	32 (72.73%)	10 (22.73%)	2 (4.54%)	44	100
Grade 2	14 (63.64%)	7 (31.82%)	1 (4.54%)	22	100
Grade 3	10 (47.62%)	10 (47.62%)	1 (4.76%)	21	100
Grade 4	16 (45.71%)	18 (51.43%)	1 (2.86%)	35	100
Grade 5	10 (21.28%)	33 (70.21%)	4 (8.51%)	47	100
Grade 6	15 (30%)	30 (60%)	5 (10%)	50	100
Grade 7	12 (20.69%)	40 (68.97%)	6 (10.34%)	58	100
Grade 8	13 (48.15%)	10 (37.04%)	4 (14.81%)	27	100
Grade 9	14 (45.16%)	13 (41.94%)	4 (12.90%)	37	100
Grade 10	8 (47.06%)	7 (41.18%)	2 (11.76%)	17	100
Grade 11	6 (21.43%)	18 (64.29%)	4 (14.28%)	28	100
Grade 12	4 (28.57%)	9 (64.29%)	1 (7.14%)	14	100
TOTAL	168 (38.89%)	229 (53.01%)	35 (8.10%)	432	100

grants for health and education of school children and their family [5].

Table 1.3 Parents Occupation

OCCUPATION	Father	Mother	Total (431)	%
	F (229)	F (203)		
Farmer•	134	4	138	31.94
Vendor•	5	28	33	7.64
Driver•	21	0	21	4.86
OFW/SEAMAN*	7	2	9	2.08
Fisherman•	9	0	9	2.08
Carpenter•	20	0	20	4.62
Housekeeper/House Wife•	0	143	143	33.10
Baker/Cook•	2	4	6	1.39
Laborer•	8	0	8	1.85
Tailor/Dressmaker•	1	5	6	1.39
Salesgirl/Delivery Boy•	3	0	3	0.70
Laundry Woman•	0	8	8	1.80
House helper/House Maid•	0	9	9	2.09
Construction Worker/Mason•	16	0	16	3.70
Factory Worker•	3	0	3	0.70
Not Indicated•	0	0	0	0
TOTAL	229	203	432	100

Legend: • Manual Labor

* White Collar Jobs/Professional Jobs

Data above reveals that 143 or 33.10% of the 432 respondents' mothers are housewife/housekeepers; 138 or 31.94% of their fathers are farmers; and the rest of the respondents' parents belong to the different level of occupation ranging from 33 or 7.63% to 3 or 0.69%.The occupation as categorized and grouped into two : namely the white collar jobs and the blue collar jobs, out of the 15 categories, only 9 respondents' parents or 2.08% are OFW/Seaman being categorized as white collar jobs, the professionals and the educated groups. This would imply that majority of the respondents' parents are into manual labor as their means of livelihood. Mothers are dependent on the income of their husbands and they are staying at home doing household chores. According to the historiographic background of the Indigenous Peoples in the Philippines and Negros Oriental with UNESCO Institute for Education [3] on an international survey for adult education, these groups live in forest as their ecosystem and the Ata men of Canggohob, Mabinay Negros Oriental are known to be called as hunters gatherers who became agricultural laborers working in lands that were formerly their own, and women were hired to weed fields or serve as maids in Christian families.

Table 1.4 Parents Education Background

Educational Qualification	f (432)	%
Elementary Level	270	62.5
Secondary Level	115	26.62
College Level	21	4.86
Not Indicated	26	6.02
TOTAL	**432**	**100**

The above data reveal that out of 432 respondents' parents, 270 or 62.5% belong to the elementary level; 115 or 26.62 belong to the secondary level; 21 or 4.87% are college level. This would mean that majority of the respondents' parents educational background are elementary. Only a few have gone to college or are college level although 6.02% of them did not indicate their educational background. This would imply that families educational background relates on their understanding about health knowledge and practices of a family member. According to Richmond, C. et al, [8] in his study on an approach towards understanding health knowledge and practices in Indigenous Canadians through social support activities that is significantly mediated by age, aboriginal status, educational attainment and labor force status.

Table 1.5 Number of Respondents with hygiene-deficiency ailments

Grade Level	Attendance	Hygiene-Deficiency Ailments										Average Number of pupils with hygiene-deficiency ailments	%
		Pediculosis	Otitis Media	Dental Caries	Enlarged Cervical Glands	Tinia Flava	Ringworm	Minor Injuries	Infected wound	Pale conjunctiva	others		
Kindergarten	38	6	2	8	2	0	0	2	3	2	0	23	60.53
G1	44	10	2	11	2	0	2	3	2	3	0	35	79.55
G2	22	6	1	6	1	0	1	2	1	2	0	20	90.91
G3	21	4	1	4	1	1	1	2	1	2	0	17	80.95
G4	33	4	0	6	2	4	3	3	3	2	0	27	77.14
G5	47	4	1	8	3	5	3	4	2	5	0	35	74.47
G6	50	3	2	8	2	10	3	4	3	4	0	39	78
G7	58	4	0	13	3	11	4	3	2	5	0	45	77.59
G8	27	3	0	4	3	4	3	3	1	1	0	22	81.48
G9	31	4	0	5	1	2	2	1	2	2	0	19	61.29
G10	17	2	0	3	1	3	1	2	0	1	0	13	76.47
G11	28	3	0	6	2	4	2	2	1	2	0	22	78.57
G12	14	2	0	3	1	2	1	1	0	2	0	12	85.71
Average	432	55	9	85	24	46	26	32	21	32	0	329	76.16

The secondary data on Hygiene Deficiency Ailments of Ata respondents (elementary & secondary learners) in Canggohob Elementary and Secondary Schools of the Division of Negros Oriental as reflected in Table 1.5 from the Health and Nutrition Section, SY 2015-2016, shows that the average percentage of learners found to have hygiene deficiency ailments is 329 or 76.16% top ten leading ailments varies. Among the top ten leading hygiene- deficiency ailments, dental caries is the most common ailments manifested by the learner respondents with an average frequency of 85, followed by pediculoses that is 55 then tinia flava as top 3 with an average score of 46. pale conjunctiva, minor injuries, ringworm, enlarged cervical glands and infected wounds ranges 26 down to 21 average score. This is an indicator that

there is a need to emphasize proper personal hygiene and good grooming among the Ata learner respondents due to the fact that this will be the leading causes of non-communicable and communicable diseases of the school children that will in turn greatly affects their health and nutrition status as well as their academic performance in school. Sofalvi [20] describes the importance of health education empowerment to present health messages to educate the marginalized urban areas, the Indigenous Peoples on the importance of preventing the occurrence of non-communicable and communicable diseases due to lack of personal hygiene and grooming that may result to intestinal parasitism such as hookworms, tuberculosis, dental problems and other skin infections...This will give insights in designing a culture-responsive curriculum.

Table 1.6 Percentage of Learners who are Malnourished

Grade Level	Attendance	Malnourished Learners						Total	%
		Undernutrition			Over nutrition		Stunted		
		Under weight	Wasted	Severely wasted	Obese	Overweight			
Kindergarten	38	3	5	3	1	1	10	23	60.53
G1	44		11	6	1	1	16	34	77.27
G2	22		4	4	0	1	16	25	11.36
G3	21		6	3	1	0	3	13	61.90
G4	35		9	5	1	1	9	25	71.43
G5	47		5	4	0	2	11	22	46.81
G6	50		8	2	2	1	12	25	50.00
G7	58		5	3	1	1	8	18	31.03
G8	27		3	3	2	1	7	16	59.26
G9	31		4	1	0	0	4	9	29.03
G10	17		2	1	1	0	5	9	52.94
G11	28		3	2	2	2	6	15	53.57
G12	14		2	2	1	1	2	8	57.14
AVERAGE	432	3	67	39	13	12	109	232	53.70

Table 1.6 reveals that there is a trend on the prevalence rate of malnutrition among learner respondents in the average percentage of 232 or 53.70 Ata learners, SY 2015-2016. Out of 432 respondents, 109 are with stunted growth, 67 are wasted, 39 are severely wasted13 are obese and 12 are overweight.

Table 2. Respondents Level of Knowledge on desirable health and nutrition habits

Level of Knowledge	Primary Level(K-Gr3) (125)		Elementary Level (Gr4-Gr6 (132)		Junior High school (Gr7-Gr10)- (133)		Senior High School Gr11-Gr12-(42)		Total	%	Rank
	f	%	f	%	f	%	f	%			
41-50(5)(Excellent)	0	0	21	4.86	10	2.31	4	0.93	35	8.10	4
31-40(4)(Very Good)	17	3.94	40	9.26	38	8.80	6	1.39	101	23.38	2
21-30(3)(Good)	53	12.27	46	10.65	69	16.00	25	5.79	193	44.68	1
11-20(2)(Fair)	39	9.03	22	5.09	10	2.31	4	0.93	75	17.36	3
1-10(1)(Poor)	16	3.70	3	0.69	6	1.39	3	0.69	28	6.48	5
Total	125	28.93	132	30.56	133	30.79	42	9.72	432	100	
Mean Score	2.57	Fair 2	3.41	Very Good	3.27	good	3.10	good	3.09	Good	

This is an indicator of their health knowledge in a given community which can be multi-dimensional or multifactorial in nature affected by their beliefs and practices. Racelis [24] states that IP children's wellbeing is threatened by malnutrition, experience fear and trauma and has a life expectancy shortfall of 13 years below .These concepts are of importance to the study because it serves as an opener of the researcher to take into account IP learners health and nutrition status that has an effect on their school performance , and serves as a guide on how to put nutrition concepts into a culture-responsive curriculum correlating it with the 17 Sustainable Development goals .

Table 2.1 shows the respondents' level of knowledge on desirable health and nutrition concepts which was based on a fifty-item multiple choice test. As can be seen in Appendix C, items 1 to 18 on determining health and nutrition status of school children, proper health and nutrition. three basic food groups, conserving nutrients in foods, desirable eating habits, items 19 to 46 is on keeping the environment clean, safe and healthy for the promotion and prevention of common communicable and non-communicable ailments and diseases during childhood and school age; from 47 to 50 is on first-aid emergency situations. The highest score is between 21 to 30 or "good "where mostly are from the junior high school that is 69 or 16%; 53 or 12.27% from the primary grades; 46 or 10.65% from the elementary grades; and 25 or 5.79% from the senior high school.

Furthermore, when categorized and grouped by grade level, only Grades 4 to Grade 6 or the elementary level respondents got the mean score of 3.41 or "very good". The junior high

school and senior high school got an average score ranging from 3.10 to 3.27 or "good "; and the primary grade level or the kindergarten to grade 3 got a mean score of 2.57 or "fair ". The over-all mean score for all grade levels of the respondents' level of knowledge on desirable health and nutrition habits is 3.09 or "good". This is an implication that there is a great need to indigenized health and nutrition concepts starting from the primary grades that is from kindergarten to grade 3, and in spiral progression, emphasis should also be taken into account by the junior high school learners. Abbot [9] in his study revealed that indigenous knowledge, culture and personal experiences that local issues of traffic, air and water supply viewed thru writings and group discussions were identified as having a great effect on the health conditions of an individual, thus empowering them through a culture-responsive curriculum in the daily teachings addressing prior knowledge and cultural beliefs that would enhance and raise both health-education awareness based on experiences and cultural practices.

Cognizant to tie role of education in health and education, the present spiral progression curriculum and the MAPEH subject integrating music, arts, physical education and health, growth and development of the nation's human resources particularly the school-age group, there is a need to follow up the integration of concepts in the IPEd plan through formal and informal health education, and the health services for a healthy school-community environment..

Table 3.1. Activities on Personal Hygiene

Personal Hygiene Activities	K- G3 (125)		G4- G6(132)		G7-G10(133)		G11-G12 (42)		Over-all (432)		Ranks
	WM	Verbal Description	WM	Verbal Description	WM	Verbal Description	WM	Verbal Description	WM	Verbal Description	
1. I take a bath with soap a d water	4.0	O	4.0	O	3.92	O	3.98	O	3.98	O	16.5
2. I use shampoos on my hair	4.2	O	4.0	O	4.0	O	3.04	S	3.81	O	20
3. I keep my fingernails and toenails clean and trimmed	4.2	O	4.0	O	3.84	O	3.98	O	4.01	O	6.5
4. I wash my hands before, and after eating, and after using the toilet with soap and waters	4.0	O	4.0	O	3.98	O	3.98	O	3.99	O	10.16
5. I brush my teeth properly	4.0	O	4.0	O	4.0	O	4.08	O	4.02	O	5
6. I change and wear my clothes	4.0	O	4.0	O	3.98	O	4.0	O	3.99	O	10.16
7. I go to the comfort room to move my bowel	4.0	O	4.0	O	4.02	O	3.96	O	3.99	O	10.16
8. I go to the comfort room to urinate	3..8	O	4.0	O	4.02	O	4.0	O	3.96	O	18
9. I do bodily exercise	3.9	O	4.02	O	3.98	O	4.0	O	3.98	O	16.5
10. I clean my ears before going to school.	3.9	O	4.02	O	4.02	O	4.02	O	3.99	O	10.16
11. I clean my eyes before going to school	4.8	A	3.98	O	4.02	O	4.0	O	4.21	O	1.5
12. I clean my nose before going to school.	4.0	O	4.02	O	4.0	O	4.0	O	4.01	O	6.5
13. I wash my face with soap and water	4.0	O	4.02	O	4.0	O	4.0	O	3.99	O	10.16
14. I change my underwear	4.0	O	4.0	O	4.0	O	4.0	O	4.0	O	8.5
15. I drink plenty of water	4.0	O	4.0	O	3.98	O	3.98	O	3.99	O	10.16
16. I eat fruits and vegetables	4.0	O	4.02	O	4.02	O	3.4	S	3.86	O	19
17. I eat nutrition fruits	4.9	A	4.02	O	4.0	O	3.9	O	4.21	A	1.5
18. I wear my shoes or slippers	4.3	A	4.0	O	4.0	O	4.0	O	4.08	O	4
19. I clean my bedroom before sleeping	4.0	O	3.98	O	4.0	O	4.02	O	4.0	O	8.5
20. I do half-bath before sleeping	4.0	O	3.98	O	4.04	O	4.38	A	4.1	O	3
Over-all weight Mean	4.1	O	4.01	O	3.99	O	3.94	O	4.01	O	
Rank	1		2		3		4				

Legend:

4.21-5.00 (5-7 times a week)	Always (A)
3.41-4.20 (3-4 times a week)	Often (O)
2.61-3.40 (twice a week)	Sometimes (S)
1.810-2.60 (Once a week)	Rarely (R)
1.60-1.80 (Never)	Never (N)

As manifested in the table above, the values ranges from 3.81 to 4.21 or "often to always". However, the over-all weighted mean of the four category- grade level from Kindergarten to Grade 12, is described as "often" which would mean that the Ata learner respondents practiced proper personal hygiene three to four times a week. This scenario also reveals that out of the 20 activities on personal hygiene, 19 activities registered weighted means described as "often", and only 1 activity was described as "always". This implies that the Ata learner respondents "often" take a bath with soap and water,

use shampoos in their hair, keep fingernails and toenails clean and trimmed, wash hands before and after eating, and after using the comfort room with soap and water, brush their teeth properly, change their clothes, go to the comfort room when moving their bowel and urinating, do bodily exercises, clean their ears, eyes, nose and face before going to school, change underwear, drink plenty of water and eat fruits and vegetables, wear shoes or slippers, clean their bedroom and do half-bath before sleeping. These are done three to four times a week. This is a significant impact on the different health and nutrition programs/projects implemented in the Department of Education in collaboration with other related agencies and partners. Namely the Department of Health Oplan Kalusugan at Pangkalahatan in coordination with other line agencies and organization for Ata learners' growth and development. The findings will also serve as a guide for MAPEH teachers in the indigenization of the IPEd plan. Thus, this data on personal hygiene relate with the learner respondents' level of knowledge on health and nutrition habits which scored and rated as "good" as well as the accessibility and utilization of health programs and facilities in the school-community setting as well as parents educational background, their occupation and household sizes. It is therefore imperative for school personnel to work hand in hand as they are expected to provide sufficient knowledge and practices on health especially with the indigenous and marginalized groups, advocate and link the school with the community, find time to monitor and evaluate whether the basic facts learn in school are being practiced at home or in their community. Putting health knowledge and practices into a culture-responsive curriculum, according to Field [25] and Nutbeam [21] in their articles on adult learning, health and well being-changing lives, and outcome classification in health promotion and prevention respectively for indigenous peoples encompasses community health education promoting indigenous knowledge and practices; linkaging and networking with different indigenous organizations which serves as basis for developing an indigenized and culture-responsive health education promotion strategies for the Indigenous Peoples like the Ata learners.

Table 3.2. Activities on Good Grooming

Activities	K- G3 (125) WM	Verbal Description	G4- G6(132) WM	Verbal Description	G7-G10(133) WM	Verbal Description	G11-G12 (42) WM	Verbal Description	Over-all (432) WM	Verbal Description	Ranks
1. Has taken a bath with soap and water	3.60	O	3.85	Often	3.88	O	3.60	O	3.73	O	3
2. Has cleaned my face	3.58	O	3.85	O	3.71	O	3.60	O	3.69	O	6.25
3. Has cleaned my nose	3.60	O	3.85	O	3.72	O	3.72	O	3.43	O	15.33
4. Has cleaned my ear	3.60	O	3.85	O	3.65	O	3.60	O	3.68	O	10
5. Has cleaned my eyes	3.62	O	3.85	O	3.56	O	3.60	O	3.66	O	13.5
6. Has brushed my teeth and gums	3.58	O	2.89	S	3.15	S	3.60	O	3.31	S	18
7. Has cleaned my skin	3.60	O	3.85	O	3.72	O	3.60	O	3.70	O	5
8.Has washed my hands	3.58	O	3.85	O	3.72	O	3.60	O	3.69	O	6.25
9. Has washed my feet	3.66	O	3.85	O	3.72	O	3.60	O	3.69	O	4
10. Has changed my clothes	3.60	O	3.85	O	3.72	O	3.72	O	3.69	O	6.25
11. Has combed and fixed my hair	3.60	O	3.85	O	3.72	O	3.60	O	3.69	O	6.25
12. Has worn my slippers	3.60	O	3.85	O	3.58	O	3.60	O	3.65	O	15.33
13. Has worn my shoes	3.62	O	3.84	O	3.75	O	3.43	O	3.66	O	13.5
14. Has brought my handkerchief	3.60	O	3.76	O	3.62	O	3.60	O	3.65	O	15.33
15. Has cut and trimmed my nails	3.60	O	3.85	O	3.61	O	3.60	O	3.67	O	11.5
16. Has cleaned and fixed my school bag	3.60	O	3.85	O	3.61	O	3.69	O	3.67	O	11.5
17. Is physically fit and healthy	3.60	O	3.85	O	3.94	O	3.669	O	3.77	O	1.5
18. Is happy and smiling	3.60	O	3.85	O	3.94	O	3.69	O	3.77	O	1.5
Over-all weight Mean	3.24	S	3.60	O	3.27	S	3.19	S	3.30	S	
Rank	3		1		2		4				

Legend:

4.21-5.00 (5-7 times a week)	Always (A)
3.41-4.20 (3-4 times a week)	Often (O)
2.61-3.40 (twice a week)	Sometimes (S)
1.810-2.60 (Once a week)	Rarely (R)
1.60-1.80 (Never)	Never (N)

The table above shows that the values ranges from 3.31 to 3.77 or "sometimes" to "often". However, the over-all weighted mean of the four categorized grade level from Kindergarten to Grade 12 is described as "sometimes which would mean that the Ata learner respondents have been doing good grooming activities twice a week before going to school although they are also practicing proper personal hygiene 3-4 times a week. The scenario also reveals that majority of the desired responses on activities on good grooming were weighted as "often" which implies that the Ata learner

respondents has usually taken a bath, cleaned their nose, eyes, ears, and skin, washed their hands and feet, used slippers or shoes and handkerchiefs, trimmed their nails and cleaned then fixed their bag ready to go to school physically fit, healthy and happy. On the other hand, the Grade 4 to 10 Ata learner respondents brushed their teeth and gums twice a week or "sometimes" before going to school. This would greatly relate to the secondary data on hygiene deficiency ailments which dental problems and dental caries ranked number 1. Furthermore, this would relate to the results on Ata learner respondents "good" knowledge on health and nutrition habits, the activities on proper personal hygiene that are "often" done only, their attitudes and beliefs towards the utilization of health programs and projects implemented. According to an international survey for indigenous peoples by the UNESCO Institute for Education [3], states that IPs in the Philippines have diverse culture though there are similarities in their traditional health beliefs, knowledge and practices that are intergenerational and should be taken into account in designing a culture-responsive curriculum.

Table 3.3 Accessibility and Utilization of Health Programs and Facilities of Ata Learner Respondents

This table presents the health programs and facilities provided by DEpEd and other line agencies and organizations made accessible/available and to be utilized by the Ata learner respondents.

Table 3.3.1 Accessibility of Health Programs and Facilities

Health Facilities/Programs	K to Grade 3		Grade 4 to Grade 6		Grade 7 to Grade 10		Grade 11 to Grade 12		Over-all		Rank
	WM	VD	WM	VD	WM	VD	WM	VD	WM	VD	
A. School Health Programs:											
Gender and Development	2.34	LA	4.11	VMA	3.75	VMA	4.11	VMA	3.6	VMA	13
Reproductive Health	2.34	LA	4.11	VMA	3.87	VMA	4.11	VMA	3.61	VMA	12
Drug Abuse Prevention	3.25	MA	3.25	MA	4.11	VMA	4.11	VMA	3.84	VMA	3
Child Welfare and Protection	4.02	MA	4.23	EA	4.11	VMA	4.02	VMA	2.85	MA	29
Disaster Risk Reduction Management	4.11	VMA	4.23	EA	4.11	VMA	4.02	VMA	4.2	VMA	1
B. Child Health Program											
School based Feeding	4.23	EA	4.23	EA	1.80	NA	1.80	NA	3.01	MA	27
Health/Nutrition Assessment and Screening	4.11	VMA	4.02	VMA	4.02	VMA	4.02	VMA	4.04	VMA	2
Expanded Program on Immunization	3.95	VMA	4.02	VMA	3.05	MA	3.87	VMA	3.72	VMA	5.5
Iron and Vitamins Supplementation	3.95	VMA	3.95	VMA	3.05	MA	3.95	VMA	3.72	VMA	5.5
Deworming	4.11	VMA	3.57	VMA	2.70	MA	3.95	VMA	3.36	MA	20
C. Oral Health Programs											
Oral Examination	3.34	MA	3.34	VMA	3.34	MA	3.96	VMA	3.40	MA	18
Oral hygiene Education	3.25	MA	3.25	MA	3.25	MA	3.34	MA	3.27	MA	24.5
Fluoride Therapy	3.00	MA	3.00	MA	2.32	LA	2.18	LA	3.27	MA	24.5
Permanent Filling	2.86	MA	2.86	MA	2.18	LA	3.10	MA	2.75	MA	30
Gum Treatment	2.80	MA	2.80	MA	2.80	MA	3.10	MA	2.87	MA	28
D. Healthy Lifestyle Program											
Prevention of Cardiovascular Diseases	2.23	LA	3.52	VMA	3.52	VMA	3.05	MA	3.33	MA	22
Cancer Prevention and Control	2.23	LA	3.05	MA	3.52	VMA	3.52	VMA	3.08	MA	26
Prevention of Diabetes	2.23	LA	3.96	VMA	3.52	VMA	3.68	VMA	3.35	MA	21
E. Other Basic Health Services											
Curative Consultations	3.89	VMA	3.89	VMA	3.89	VMA	3.89	VMA	3.89	VMA	4
Wound care and dressing	3.64	VMA	3.64	VMA	3.64	VMA	3.64	VMA	3.64	VMA	9
F. Environmental Health Program											
Environmental Preservation/Conservation	2.68	MA	4.05	VMA	4.05	VMA	3.74	VMA	3.63	VMA	10
Environment Cleanliness/Sanitation	2.55	LA	3.80	VMA	3.80	VMA	3.52	VMA	3.42	VMA	16
Water and Sanitation Hygiene	3.18	MA	3.77	VMA	3.77	VMA	3.77	VMA	3.62	VMA	11
Zero open Defection (ZOD) and Zero Waste Management	2.55	LA	3.57	VMA	3.57	VMA	3.57	VMA	3.31	MA	23
Food Production/ Gardening/ Greening/Gulayan at Palaisdaan/ Tree planting	3.52	VMA	3.52	VMA	3.52	VMA	4.05	VMA	3.65	VMA	8
G. Health Facilities											
District Hospital	2.91	MA	3.93	VMA	3.93	VMA	3.50	VMA	3.57	VMA	14
Rural Health Unit	2.91	MA	3.73	VMA	3.66	VMA	3.65	VMA	3.54	VMA	15
Barangay Health Unit	3.61	VMA	3.66	VMA	3.73	VMA	3.73	VMA	3.68	VMA	7
School Health clinic	2.81	MA	3.61	VMA	3.50	VMA	3.51	VMA	3.41	VMA	17
School Canteen	2.81	MA	3.50	VMA	3.50	VMA	3.69	VMA	3.37	MA	19
Overall Weighted Mean	3.18	MA	3.38	MA	3.60	VMA	3.47	VMA	3.41	VMA	
Rank	4		3		1		2				

Legend: Accessibility of Health facilities and programs

Rating	Range	Verbal Description	Definition
5	4.21-5.00	Extremely Accessible (EA)	96-100% accessibility of health programs/ facilities at hand to the greatest extent
4	3.41- 4.20	Very much Accessible (VMA)	91-95% accessibility of health programs/facilities at hand to the great extent
3	2.61-3.40	Moderately Accessible (MA)	86-90% accessibility of health programs/facilities moderately at hand
2	1.81-2.60	Less Accessible (LA)	81-85% accessibility of health programs/facilities at hand to the lesser extent
1	1.00- 1.80	Not Available (NA)	76-80% no accessibility of health programs/facilities at hand or not at all.

As revealed in Table 3.3.1, the extent of accessibility of health programs and facilities is very much accessible with an over-all weighted mean of 3.41. Of the thirty (30) sub-activities, eighteen (18) has a rating of very much accessible, and twelve (12) got a rating of moderately accessible. As to the ranking of the extent of accessibility of health programs

and facilities, Grade 7 – G10 got a weighted mean of 3.60 or "very much accessible " and ranks number one (1) grade level; followed by G11- G12 with a weighted mean of 3.47 or "very much accessible", then Grade 4 to Grade 6 with a weighted mean of 3.38 or "moderately accessible", and the last ranks is kindergarten to Grade 3 with a weighted mean of 3.18 or" moderately accessible". Moreover, as to the ranking of the seven (7) health programs and facilities with the thirty (30) sub-activities, the following is the ranking: 1).School Health Programs on Disaster Risk Reduction Management with a weighted mean of 4.20 or "very much accessible"; 2) School Health Program on Drug Abuse Prevention with a weighted mean of 3.84 or "very much accessible"; 3) Child Health Programs on Health Nutrition Assessment and Screening with a weighted mean of 4.04 or" very much accessible"; 4) Other Basic Health Services on Curative Consultation with a weighted mean of 3.80 or" very much accessible"; 5.5) Child Health Program on Expanded Immunization and Iron Vitamins Supplementation with a weighted mean of 3.72 or" very much accessible"; 7) Health facilities on Barangay Health Unit with a weighted mean of 3.68 or" very much accessible"; 8) Environmental Health Programs on Food Production /Greening/Gulayan at Palaisdaan Sa Paaralan /Tree Planting with a weighted mean of 3.62 or" very much accessible" 9) Other Basic Health Services on Wound Care and Dressing with a weighted mean of 3.64 or "very much accessible", and 10) Environmental Health Program on Environmental Presentation and Conservation with a weighted mean of 3.62 or" very much accessible" Findings also show that number 30 on the ranking belongs to Oral Health Program on Permanent Filling with a weighted mean of 2.72 or" moderately accessible.". The results correlate with the secondary data health and nutrition status of the learner respondents which states that. dental problem among Ata learners contributed much to the health and nutrition status.

Table 3.3.2 Utilization of Health Programs and Facilities for the Ata Learner Respondents

Health Facilities/Programs	K to Grade 3		Grade 4 to Grade 6		Grade 7 to Grade 10		Grade 11 to Grade 12		Over-all		Rank
	WM	VD	WM	VD	WM	VD	WM	VD	WM	VD	
A. School Health Programs:											
Gender and Development-	2.27	LU	2.74	MU	2.61	MU	2.95	MU	2.64	MU	19
Reproductive Health	2.18	LU	2.74	MU	2.74	MU	2.95	MU	3.34	MU	3
Drug Abuse Prevention	2.48	MU	2.34	LU	3.10	MU	3.09	MU	2.75	MU	11
Child Welfare and Protection	3.66	VMU	3.66	VMU	3.10	MU	3.09	MU	3.43	VMU	2
Disaster Risk Reduction Management	3.10	MU	3.66	VMU	3.10	MU	3.09	MU	2.59	LU	21
B. Child Health Program											
School based Feeding	3.66	VMU	3.66	VMU	1.80	NU	1.80	NU	2.73	MU	12.33
Health/Nutrition Assessment and Screening	3.96	VMU	3.09	MU	3.09	MU	3.66	VMU	3.45	VMU	1
Expanded Program on Immunization	3.05	MU	3.02	MU	3.05	MU	2.47	LU	2.90	MU	8
Iron and Vitamins Supplementation	3.05	MU	3.05	MU	3.05	MU	2.48	LU	2.91	MU	7
Deworming	3.57	VMU	2.70	MU	2.34	LU	2.18	LU	2.70	MU	16
C. Oral Health Programs											
Oral Examination	3.10	MU	2.48	LU	2.48	LU	3.10	MU	2.79	MU	9
Oral hygiene Education	2.45	LU	2.45	LU	2.45	LU	2.23	LU	2.39	LU	26
Fluoride Therapy	2.32	LU	2.32	LU	2.32	LU	2.18	LU	2.28	LU	29
Permanent Filling	2.18	LU	2.18	LU	2.18	LU	2.18	LU	2.18	LU	30
Gum Treatment	2.27	LU	2.27	LU	2.50	LU	2.18	LU	2.30	LA	27
D. Healthy Lifestyle Program											
Prevention of Cardiovascular Diseases	2.23	LU	3.10	MU	2.23	LU	2.34	LU	2.47	LU	25
Cancer Prevention and Control	2.23	LU	2.48	LU	2.23	LU	2.23	LU	2.29	LU	28
Prevention of Diabetes	2.23	LU	3.10	MU	2.23	LU	2.47	LU	2.51	LU	23
E. Other Basic Health Services											
Curative Consultations	2.68	MU	2.68	MU	2.68	MU	2.68	MU	2.68	MU	18
Wound care and dressing	2.50	LU	2.50	LU	2.50	LU	2.50	LU	2.50	LU	24
Environmental Preservation/Conservation	2.68	MU	2.68	MU	2.68	MU	2.85	MU	2.72	MU	15
Environment Cleanliness/Sanitation	2.55	LU	2.55	LU	2.68	MU	3.30	MU	2.77	MU	10
Water and Sanitation Hygiene	3.18	MU	3.18	MU	3.18	MU	3.18	MU	3.18	MU	4
Zero open Defection (ZOD) and Zero Waste Management	2.55	LU	2.55	LU	2.55	LU	2.55	LU	2.55	LU	22
Food Production/ Gardening/ Greening/ Gulayan at PalaisdaanTree planting	3.30	MU	3.30	MU	3.30	MU	2.68	MU	3.14	MU	5
G. Health Facilities											
District Hospital	2.52	LU	2.52	LU	2.91	MU	2.52	LU	2.62	MU	20
Rural Health Unit	2.52	LU	2.75	MU	2.82	MU	2.67	MU	2.69	MU	17
Barangay Health Unit	3.05	MU	2.82	MU	2.75	MU	3.05	MU	2.92	MU	6
School Health clinic	2.52	LU	3.05	MU	2.82	MU	2.55	LU	2.73	MU	12.33
School Canteen	2.52	LU	2.91	MU	2.82	MU	2.67	MU	2.73	MU	12.33
Overall Weighted Mean	2.75	MU	2.82	MU	2.67	MU	2.70	MU	2.73	MU	
Rank	2		1		4		3				

Legend: Utilization of Health facilities and program

Rating	Range	Verbal Description	Definition
5	4.21-5.00	Extremely Utilized (EU)	96-100% utilization of health programs/facilities at hand to the greatest extent
4	3.41-4.20	Very much Utilized (VMU)	91-95% utilization of health programs/facilities at hand to the greater extent
3	2.61-3.40	Moderately Utilized (MU)	86-90% utilization of health programs/facilities at hand to the moderate extent
2	1.81-2.60	Less Utilized (LU)	81-85% utilization of health programs/facilities at hand to the lesser extent
1	1.00-1.80	Not Utilized (NU)	76-80% utilization of health programs/facilities at hand to no extent or not at all

Table portrays the Ata learners' utilization of the different health programs and facilities accessible and available to them being provided by the Department of Education and other health-related agencies and organizations for them to be used.

Table 3.3.2 portrays the extent of utilization of Health Programs and facilities of the elementary and secondary Ata learner respondents of Canggohob, Mabinay District, Mabinay Negros Oriental.

As seen on the table above, the extent of utilization of health programs and health facilitis is moderately utilized with a weighted mean of 2.73. Grade 4 to Grade 6 ranks no.1 as to grade level categorization with a weighted mean of 2.82 or moderately utilized, followed by kindergarten to Grade 3 with a weighted mean of 2.75 or moderately utilized, then Grade 11 to Grade 12 with a weighted mean of 2.70 or moderately utilized, and Grade 7 to Grade 10 with a weighted mean 2.67 or moderately utilized. Of the 7 Health Programs and Health Facilities category of utilization, these are the following top 10 ranking:1. Child Health Program on Health Nutrition Assessment with a weighted mean of 3.45 or very much utilized ; 2. School Health Program on Child Welfare and Protection with a weighted mean of 3.43 or very much utilized ; 3. School Health Program on Reproductive Health with a weighted mean of 3.34 or moderately utilized ; 4.Environmental Health Program on Water and Sanitation with a weighted mean of 3.18 or moderately utilized ;. 5. Environmental Health Program on Food Production/ Greening/ Gulayan at Palaisdaan/Tree Planting with a weighted mean of 3.14 or moderately utilized; 6. Health Facilities on Barangay Health Unit with a weighted mean of 2.92 or moderately utilized ;7. Child Health Program on Iron and Vitamin Supplementation with a weighted mean of 2.91 or moderately utilized;8. Child Health Program on Expanded Program of Immunization with a weighted mean of 2.90 or moderately utilized;9. Oral Health Program on Oral Examination with a weighted mean of Moreover, findings also shows that the no. 30 in the rank is Oral Health Program on Permanent Filling with a weighted mean of 2.77 or moderately utilized 2.79 or moderately utilized; 10. Environmental Health on Environmental Cleanliness and Sanitation with a weighted mean of 2.77 or moderately utilized. Findings also revealed that the no. 30 in the rank is Oral Health Program on Permanent Filling with a weighted mean of 2.18 or less utilized. Moreover, the extent of accessibility of health programs and health facilities is very however, the extent of utilization is minimal. This minimal availment of health programs and health facilities could be due to their attitude, their knowledge and health practices as reflected on the findings of their health and nutrition status on their top ten leading ailments as well as their nutritional status, and the results of the data gathered about their health knowledge and practices. In the study of Hongbo [26], Indigenous Peoples experienced structural barriers in accessing health care programs and services because of the many health issues and challenges in the provision and utilization of health programs and facilities. Moreover, Migero, [27], in her study reveals that access to health services by Indigenous Peoples in African Region decelerates with the advent of the millennium and from other goals and aspirations that address access and utilization of health services for the Indigenous Peoples and other poor marginalized groups to have better access to the programs.They also need to be educated on how to have access on the health services because it was admitted a barrier to their effectiveness. Aspects on health generates interesting information which is moderately utilized or less accessible and utilized. For instance, in Oral Health Programs on Permanent Fillings and Oral Examination wherein the Ata learners still adhere to alternative ways in caring of their teeth, and on environmental health programs like cleanliness and sanitation. These aspects need to be addressed for effective utilization of health programs and facilities.

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